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

Thu 24 February 2022, 09:45 - 13:00

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-3FLrluzYSc29211EQ).

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 27th January 2022

David Highton

Board minutes, 27.01.22 (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 Feb.pdf (1 pages)

02-6

Report from the Chief Executive

Miles Scott

Chief Executive's report February 2022 FINAL 16022022.pdf (4 pages)

Reports from Trust Board sub-committees

02-7
Quality Committee, 09/02/22

Maureen Choong

Summary of Quality C'ttee, 09.02.22.pdf (1 pages)

02-8
Finance and Performance Committee, 22/02/22

Neil Griffiths

N.B. This report will be issued after the Committee's meeting on 22/02/22.

02-9
People and Organisational Development Committee, 18/02/22

Emma Pettitt-Mitchell

Summary of People and Organisational Development Cttee, 18.02.22.pdf (1 pages)

02-10
To approve revised Terms of Reference for the Remuneration and Appointments Committee (annual review)

David Highton and Kevin Rowan

Revised Terms of Reference for RemCom.pdf (3 pages)

Integrated Performance Report

02-11
Integrated Performance Report (IPR) for January 2022

Miles Scott and colleagues

Integrated Performance Report (IPR) for January 2022.pdf (40 pages)

Planning and strategy

02-12
The Exceptional People Outstanding Care programme - the future of the strategy deployment work

Steve Orpin and Bilal Wahid

N. B. This item is scheduled for 11:20am

The Exceptional People Outstanding Care programme - the future of the strategy deployment work.pdf (11 pages)

02-13
Cardiology public engagement feedback

Amanjit Jhund

Cardiology public engagement feedback.pdf (18 pages)

02-14
Approval of the Initial planning submissions for 2022/23

Amanjit Jhund

Approval of the initial planning submissions for 202223.pdf (20 pages)

Assurance and policy

02-15
Infection prevention and control board assurance framework

Sara Mumford

IPC Board Assurance Framework 24.2.22.pdf (30 pages)

02-16
Emergency Planning Annual Report, 2021 and future emergency planning

John Weeks

N.B. This item is scheduled for 12:05pm

Emergency Planning Annual Report, 2021 and future emergency planning.pdf (21 pages)

02-17
To consider any other business

David Highton

02-18
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 WEDNESDAY 27TH JANUARY 2022, 9:45 AM, VIRTUALLY VIA WEBCONFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board (Chair)	(DH)
	Sean Briggs	Chief Operating Officer	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	Jo Haworth	Chief Nurse	(JH)
	David Morgan	Non-Executive Director	(DM)
	Steve Orpin	Deputy Chief Executive/Chief Finance Officer	(SO)
	Emma Pettitt-Mitchell	Non-Executive Director	(EPM)
	Miles Scott	Chief Executive	(MS)
	Wayne Wright	Non-Executive Director	(WW)
In attendance:	Richard Finn	Associate Non-Executive Director	(RF)
	Amanjit Jhund	Director of Strategy, Planning and Partnerships	(AJ)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Sue Steen	Chief People Officer	(SS)
	Jo Webber	Associate Non-Executive Director	(JW)
	Kevin Rowan	Trust Secretary	(KR)
	Sarah Blanchard-Stow	Divisional Director of Midwifery, Nursing & Quality (for item 01-12)	(SBS)
	Ola Gbadebo-Saba	Deputy Freedom to Speak Up Guardian (for item 01-14)	(OGS)
	Christian Lippiatt	Freedom to Speak Up Guardian (for item 01-14)	(CL)
Observing:	The meeting was livestreamed on the Trust's YouTube channel.		

01-1 To receive apologies for absence

Apologies were received from Neil Griffiths (NG), Non-Executive Director; and Peter Maskell (PM), Medical Director. It was also noted that Karen Cox (KC), Associate Non-Executive Director, would not be in attendance. DH then welcomed WW to his first Trust Board meeting since being appointed as a Non-Executive Director.

01-2 To declare interests relevant to agenda items

No interests were declared.

01-3 To approve the minutes of the meeting of 22nd December 2021

The minutes of the meeting of the 22nd December 2021 were approved as a true and accurate record of the meeting.

01-4 To note progress with previous actions

The content of the submitted report was noted.

01-5 Report from the Chair of the Trust Board

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

- WW had been appointed to replace Sarah Dunnett as a Non-Executive Director, who remained on the Board at East Kent Hospitals University NHS Foundation Trust.
- WW would become the Trust's the Wellbeing Guardian and also become a member of the Quality Committee, which MC chaired.
- Two Consultant appointments had been made.

01-6 Report from the Chief Executive

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

- The third wave of COVID-19 had been very different from the previous two waves, which had involved the Trust having to cancel almost all other clinical activity. The third wave had started in August 2021, so had lasted several months, and the peak had been reached more gradually. The decline from the peak had therefore also been more gradual, while the staff absences relating to the third wave had also been steadier. However, COVID-19 had not gone away, and the Trust still had to contend with considerable issues, at the same time as dealing with record numbers of emergency patients. MS therefore wanted to thank and commend all Trust staff for their response, as the current pressures had affected all staff. The position reiterated the importance of ensuring that vacancies were recruited to rigorously, to ensure a resolute workforce, and SS and JH would speak more about that aspect later in the meeting.
- Despite the pressures, and COVID-19, the Trust continued to proceed with developments, and the report described some of the developments that were planned for the four quarters of 2022/23.
- Henry Taylor would stand down as the Chief of Service for Cancer Services from the end of March 2022 and Philippa Moth would take on that role.
- The Trust's Staff Networks continued to strengthen.

DH noted the 12-week engagement on the proposed changes to cardiology services, and stated that DH and MC had been contacted by Healthwatch Kent to be informed that the Trust would be given an award in recognition of the quality of that consultation. MS welcomed that news, and thanked AJ and the Stroke Programme Director for their work on the consultation. MS also noted that the outcome from the engagement would be submitted to the Trust Board in February 2022.

DH then also noted the reference to the appointment of the Designate Chair and Chief Executive of the Integrated Care Board (ICB), and highlighted that the implementation of the legislation relating to ICBs had been delayed from 01/04/22 to 01/07/22. The point was acknowledged.

Reports from Trust Board sub-committees

01-7 Quality Committee, 12/01/22 (incl. approval of revised Terms of Reference)

MC referred to the submitted report and highlighted that it had been agreed that the Sepsis Committee should become a sub-committee of the Quality Committee, so the Trust Board was asked to approve the Quality Committee's revised Terms of Reference to reflect that change. MC also stated that she would like to thank all those who had prepared and submitted reports to the meeting in the face of significant operational pressure, and noted that the meeting had given positive assurance on many aspects, although not everything was perfect.

The revised Terms of Reference for the Quality Committee were approved as submitted.

01-8 Finance and Performance Committee, 25/01/22

DM, who chaired the meeting in NG's absence, referred to the submitted report and highlighted the following points:

- The Terms of Reference for the Green Committee had been discussed, and further comments provided, which emphasised the need to inculcate the green agenda into the Trust's work.
- Two Business Cases had been reviewed, one of which (for the lease of new office accommodation in Unit F of Hermitage Court) was approved; while the other (for the People and Culture Structure and Operating Model) had been recommended for the Trust Board's approval.

01-9 People and Organisational Development Committee, 21/01/22 (incl. quarterly report from the Guardian of Safe Working Hours

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

- The Committee had conducted an initial review of the implications of the "The Future of NHS Human Resources and Organisational Development report", and that would be discussed further at future meetings.
- An update had been given on the Trust's COVID-19 Vaccination plan (including vaccination as a condition of deployment (VCOD)).
- The quarterly update from the Guardian of Safe Working Hours was received, and that had been submitted to the Trust Board as Appendix 1 of the report.

Integrated Performance Report

01-10 Integrated Performance Report (IPR) for November 2021

DH firstly noted that it was the first time that the new IPR had been considered at a 'Part 1' Trust Board meeting. MS then introduced the IPR and explained that instead of each relevant lead reporting content under the Care Quality Commission domains, as had been the case at previous Trust Board meetings, each lead would now focus on the areas listed under the "Escalations by Strategic Theme" section on page 5 of 43. SS therefore explained the latest position in relation to the "Climate Survey Responses" metric. DM stated that the countermeasures summary for the "Climate Survey Responses" metric, on page 9 of 43, indicated that all the Divisions had similar performance apart from Cancer Services, so asked whether anything could be learned and applied to other Divisions. SS agreed to explore the issue further.

Action: Explore whether any lessons could be learned from Cancer Services' performance on the "Climate Survey Responses" metric that could be applied to the other Divisions, to help improve their performance (Chief People Officer, January 2022 onwards)

SS then continued and explained the latest position in relation to the "Vacancy Rate" metric. JW asked how the Trust compared, vis à vis, with other local Trusts. SS replied that the Trust's position was broadly comparable with other Trusts and also noted that work was underway at an Integrated Care System (ICS) level to try and address the issues.

DH then noted that there would be a low financial risk of over-recruitment, but asked whether there were any barriers to over-recruitment being pursued by departments. SS confirmed there were no specific restrictions, but there were some cultural issues relating to recruitment as a Trust rather than via individual departments. JH added that there was some cross-fertilisation of recruitment, but emphasised the importance of ensuring ward leaders were engaged and felt some ownership of the recruitment process. The point was acknowledged.

WW asked whether the target for turnover was a national or locally-set target. SS confirmed that the target had been set according to national benchmarking. WW also asked whether the Trust understood best practice from elsewhere. SS confirmed that was the case and gave some examples of the initiatives that had been applied or were planned.

DM stated that he understood the Trust's internal targets would be reviewed as part of the introduction of the new IPR, noted that the vacancy and sickness rate targets were questionable, so asked whether the targets had been reviewed. MS acknowledged that as the two targets in question were not related to the NHS Constitution, it would be feasible to review them, although it was important to acknowledge that the actions required to address the current performance issues were known and just needed to be implemented. MS continued that he believed the governance issue for the Trust Board was the need to be clear on the Trust's agreed priorities, and not be distracted. DH agreed, but noted that any new targets for the vacancy and sickness rates needed to reflect the fact that the last two years had been non-standard, so the targets would be better linked to pre-COVID-19 pandemic levels. The point was acknowledged.

SM then explained the latest position in relation to the "Incidents Resulting in Harm" (which included the application of the duty of candour to the patients who had died as a result of contracting COVID-19 whilst in hospital) and "Infection Control" metrics (which related to the number of Clostridiodes difficile infections and the one case of MRSA bacteraemia that had occurred in December 2021).

DH referred to the harm events arising from hospital-acquired infections and asked whether any analysis had been undertaken on the link with patients' COVID-19 vaccination status. SM replied that it was difficult to be certain but reported the currently understood position.

JH then explained the latest position in relation to the "Falls Rate" and "Safe Staffing" metrics. DH emphasised that the Trust would need to exceed the safe staffing levels with the new nursing recruits before a reduction in temporary staffing expenditure would be seen. The point was acknowledged.

RF then asked how the Trust's employee value proposition differentiated from NHS Trusts in London, given that the Trust would not be able to complete on salary. JH replied that a range of ideas to attract and retain staff would be implemented and provided some examples.

JW asked for details of the current situation regarding the VCOD changes. SS explained that the change of legislation was being managed very carefully, and just over 200 staff who were 'in scope' remained unvaccinated. SS continued that compassionate awareness-raising conversations were being held with such individuals, but the first vaccination had to be administered by 03/02/22 in order to meet the deadline for the second vaccination, by 31/03/22.

SB then explained the latest position in relation to the "RTT Standard & 52 wk Waiters", "Diagnostics <6 weeks", "A&E Performance", "Ambulance Handovers >30 minutes", "Super-Stranded Patients", "Outpatient Calls answered <1 minute", "Outpatient Clinic Utilisation", "% Emergency Admissions to Assessment Areas", and "Ensuring Activity Levels Match those Pre-Covid – Inpatients, Outpatients & Colonoscopy metrics" metrics.

DM noted that the medically optimised for discharge (MOFD) position was often discussed at the Trust Board, but there was no associated metric. SB agreed that such a metric should be added to the IPR, but confirmed that the number of MOFD patients was reviewed daily by his team, including the Deputy Chief Operating Officer.

Action: Arrange for future versions of the IPR to incorporate a metric relating to MOFD patients (Deputy Chief Executive/Chief Finance Officer and the Chief Operating Officer, January 2022 onwards)

MS highlighted the need to consider the Breakthrough Objectives for 2022/23 and suggested that the number of MOFD patients was an appropriate area for such an objective. The point was acknowledged. DH then reported that the site report for 6am that morning has identified 155 MOFD patients. MS pointed out that there may be some issues with data quality but acknowledged that the number was high.

JH then explained the latest position in relation to the "Friends & Family Response Rates" and "Friends & Family % Positive Rates" (which included that a fishbone analysis had been undertaken, & the target had now been reduced to 20% following liaison with colleagues at other Trusts) metrics. WW referred to the fishbone analysis and asked whether JH had adopted an '80/20 principle' to that analysis, on the basis that not everything could be prioritised. JH explained the approach that had been applied.

JH then continued and explained the latest position in relation to the "Complaints" metrics. RF asked about the themes arising from complaints, and from new complaints in particular. JH stated that the main theme was communication, which included how staff spoke to patients and the challenges in relatives communicating with clinical staff to obtain updates on their inpatient relatives' clinical status.

SO then referred to the "Sustainability" Strategic Theme and explained that the "Reduce the amount of money the Trusts spends on premium workforce spend…" metric had only not been identified for escalation because of a data adjustment that had to be made in the month. SO continued that the metric would be re-adjusted for the next month, and would therefore likely be included in the "Escalations by Strategic Theme" metrics. The point was acknowledged.

DM then commented that he found the discussion of the IPR very useful and even though the discussion had taken longer than usual, he believed the extra time spent had been beneficial.

DH then concluded the item by stating that he did not understand the target relating to the non-elective bed days metric. AJ therefore agreed to check and explain the rationale for the development of the target.

Action: Explain the rationale for the development of the target for the non-elective bed days metric (which was for a monthly average of <550) (Director of Strategy, Planning and Partnerships, January 2022 onwards)

Planning and strategy

01-11 <u>To approve a Business Case for the People and Culture Structure and Operating Model</u>

DH referred to the submitted report and highlighted that the Finance and Performance Committee had reviewed the Case in depth on 25/01/22 and recommended that the Trust Board approve the Case. SS also added the following points:

- The Case had also been reviewed by the People and Organisational Development Committee and Executive Team Meeting (ETM).
- The Case had been developed in response to the previous external review of the Trust's workforce function, which had identified a history of underfunding, which was estimated at that time to be 40% lower than the national average, and which benchmarked the Trust as the ninth lowest in the country against comparable NHS data.
- The Case was divided into three phases, and the recruitment under Phase 1 had proceeded at risk because of the operational demands.

MC asked whether there was a requirement for any consultation process, given the number of new posts involved in the Case. SS confirmed that most of the additional roles had no impact on existing roles, although the plans had been consulted on with existing staff, so SS believed the consultation aspects had been covered.

WW welcomed the investment but emphasised the need to be clear on the return of investment and seeing the details of that in the future. DM concurred. SS acknowledged the point and gave assurance that Key Performance Indicators (KPIs) would be monitored.

KR & JW then asked for clarification that the Trust Board was being asked to approve Phases 1 and 2 of the Case, as Phase 3 would be subject to an additional approval process. SS confirmed that was correct, but noted that she wanted the Trust Board to be aware of the plans regarding Phase 3.

The Business Case for the People and Culture Structure and Operating Model was approved as submitted.

Quality items

01-12 <u>Quality Maternity Services report</u>

JH introduced SBS to the Trust Board. SBS referred to the submitted report and highlighted the following points:

- The report had been considered at the 'main' Quality Committee meeting in January 2022, and no changes had been required.
- The data for Hypoxic-ischaemic Encephalopathy rates across the Kent and Medway Local Maternity & Neonatal System showed a comparatively high rate at the Trust, so a task and finish thematic review was currently in progress, led by a neonatologist
- A workforce review was undertaken in October 2021.
- SBS wanted to thank the two maternity safety champions, MC and JH, who had undertaken a 'walkabout' recently, which had been well-received by staff.
- The community midwifery service had been very supportive of the Trust during the times it had had to close some services, but the Maidstone Birth Centre had now reopened following a short period of closure due to staffing challenges & out of area bookings had also now been reinstated.
- The plans to reinstate the home births service would be considered at the ETM on 01/02/22, and there were also plans to re-open the Crowborough Birth Centre.

WW asked what support was available for parents and staff involved in stillbirths. SBS explained the arrangements that were in place, and the future plans, which included the potential development of a memorial garden. WW offered to be involved in such plans, should that be beneficial and SBS welcomed the offer.

JW commended the plans to re-open Crowborough Birth Centre.

DH then noted that the Secretary of State for Health and Social Care had announced, on 26/01/22, that a new Special Health Authority would be established to carry out investigations of maternity

services, which were currently a responsibility of the Healthcare Safety Investigations Branch (HSIB), and asked SBS to comment. SBS stated that she understood the HSIB staff would be transferred to the new organisation.

01-13 Annual Report from the Director of Infection Prevention and Control (incl. Trust Board annual refresher training)

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

- The Deputy Director of Infection Prevention and Control's secondment to NHS England/Improvement, and SM's secondment to a neighbouring Trust for half of her time during the year meant that the team had been depleted during the year, but the team had still managed to continue with the 'normal' infection control work as well as the additional COVID-19 requirements.
- There had been small improvement in Clostridiodes difficile cases from the previous year.
- The Trust had its first case of COVID-19 on 16/03/20, via an inpatient, and the three priorities during the first wave were safety, education, and planning.
- The impact of the second wave of COVID-19 was much greater, given the spread of the Kent-based variant that was not formally recognised for two months. The Trust experienced 23 outbreaks of COVID-19 during the year, 22 of which were during the second wave.
- The "What the Board needs to know in order to fulfil its responsibilities …" section represented the Trust Board's annual refresher training in Infection Prevention and Control, and included details of how the Trust complied with the Hygiene Code, although the list in the report was not exhaustive.
- Page 42 of 59 reported the details of the work undertaken by the microbiology laboratory, particularly during the COVID-19 period, and the staff should be commended for maintaining their existing microbiology workload in addition to the significant additional COVID-19 activity.
- Page 48 of 59 contained the comprehensive "Infection Prevention and Control work plan 21/22", which addressed all areas of infection control.

SM also asked the Trust Board to formally commend the Infection Prevention and Control Team for their work during the COVID-19 period. DH duly commended the Team, on behalf of the Trust Board, and also commended the Microbiology department for their work during the pandemic.

DH then asked whether SM had any areas of concern in relation to the 2021/22 workplan. SM stated that besides COVID-19, there was some concern regarding the number of Clostridiodes difficile cases, which reflected national circumstances, and the Trust would breach its trajectory for the year.

DH then commended SM for her personal contribution over the past year, and the commendation was echoed by all Trust Board members.

Assurance and policy

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

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

- There remained a high number of concerns raised compared to previous years, which reflected the Trust's positive culture of candour.
- More health and safety concerns had been raised that quarter, which reflected the pressures relating to staffing levels and COVID-19.
- The Safe Space Champions were now well-established and additional recruits would be sought.
- The next report would provide an overview of the 2021/22 year.

EPM referred to page 4 of 5 and noted that lots of cases remained open from "July - September 2021", so asked whether that number of open cases was usual. OGS explained that the higher number of open cases reflected the higher number of contacts in that quarter. OGS also explained the process that was applied to the closure of cases. DH asked for confirmation that any cases forwarded to the People function would remain open on the Freedom to Speak Up (FTSU) register. OGS confirmed that was correct. CL added further context and noted that cases would be kept open from a FTSU perspective to enable contact to be made with the person raising the concern, to check they were satisfied with the outcome.

DM noted that it had previously been acknowledged that increased concerns would arise from positive changes in an organisation's culture, and queried whether the increase in health and safety concerns, which may be related to the safety of others rather than just the individual raising the concern, represented a positive step. CL agreed with DM's assessment.

WW noted that "Health & Safety" could cover a multitude of situations, so asked whether that category was broken down further for the individual departments, and also asked whether the concerns that related to specific departments areas were identified, to enable MS or SS to take appropriate action. CL explained that additional categories had been included in the analysis of themes, when compared to the previous report, and noted that weekly meetings were held with the Organisational Development team and Wellbeing Practitioners, which enabled the themes to be explored in more detail. SS also gave assurance that the information was subject to triangulation.

MC then referred back to the time which cases remained open, and stated that she understood that one of the reasons for cases remaining open for a long time was to ensure that the staff member raising the concern had not experienced any detrimental effects. MC also noted that some concerns had been deliberately generalised in the report to protect confidentiality. The points were acknowledged.

Corporate governance

01-15 Response to NHS England/Improvement's "Enhancing board oversight: a new approach to non-executive director champion roles"

DH referred to the submitted report and explained that there had been concern raised among Trust Board Chairs that there were too many areas where Non-Executive Director 'champions' had arisen, which risked undermining the principle of a unitary board. DH continued that a programme of work was therefore undertaken, and that concluded that five Non-Executive Director 'champion' roles should be retained and other roles should be allocated to Trust Board sub-committees. KR then added the following points:

- The Trust had some locally-agreed roles that had been reviewed and allocated to Trust Board sub-committees.
- Work would take place to ensure the Trust Board sub-committees' Terms of Reference and/or forward programmes aligned with the allocation of roles.
- The Trust's revised Standing Orders were scheduled to be approved at the Audit and Governance Committee in March 2022, not February 2022, as had been stated in the submitted report.

01-16 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 Kent and Medway Medical School accommodation project. The requested authority was duly granted.

01-17 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.

NHS Maidstone and Tunbridge Wells NHS Trust

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'
01-10a	Explore whether any lessons could be learned from Cancer Services' performance on the "Climate Survey Responses" metric that could be applied to the other Divisions, to help improve their performance.	Chief People Officer	February 2022	A review of the actions has been undertaken and the measures for success have been built into the communications and engagement plan. Any lessons or actions will be transferred to other Divisional plans where appropriate.
01-10b	Arrange for future versions of the Integrated Performance Report (IPR) to incorporate a metric relating to medically optimised for discharge (MOFD) patients.	Deputy Chief Executive/Chief Finance Officer and Chief Operating Officer	February 2022	The Head of Performance and Business Intelligence is attempting to incorporate a metric in the IPR for month 10.
01-10c	Explain the rationale for the development of the target for the non-elective bed days metric (which was for a monthly average of <550).	Director of Strategy, Planning and Partnerships	February 2022	The target was based on a 10% reduction in average monthly non-elective bed days for 'General & Acute Beds', so ITU, Maternity and other non-relevant activity are excluded from the count

Actions not yet due (and still 'open')

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

[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. The Trust follows the Good Practice Guidance issued by the Department of Health, in particular delegating the decision to appoint to the AAC, evidenced by the signature of the Chair of the AAC and two other Committee members. The delegated appointments made by the AAC since the previous report are shown below.

Date of AAC	Title	First name/s	Surname	Department	Potential / Actual Start date	New or replacement post?
09/02/2022	Consultant Medical Oncologist-Urology	Diletta	Bianchini	Oncology	TBC	Replacement
09/02/2022	Consultant Clinical/Medical and Acute Oncologists	Mohammed	Osman	Oncology	TBC	Replacement

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:

- On Monday 7 February we welcomed Prime Minister Boris Johnson and Chancellor of the Exchequer Rishi Sunak to Maidstone Hospital. The Prime Minister and Chancellor met staff, patients and Macmillan volunteers at the Kent Oncology Centre. They heard about our investment in staff, equipment and patient pathways and the actions we have taken to ensure we continue to meet the national standard for treating cancer patients within 62 days – one of only a handful of hospital trusts in the country to do this and a standard we have achieved for 29 months in a row. Their visit is well deserved recognition of the hard work, innovation and care shown by so many colleagues across cancer, medicine, elective and emergency care. The achievements at MTW in recent years and our ambitions for the future reflect an incredible team effort from colleagues across our organisation and are driven by exceptional people providing outstanding care and I'm so pleased to see this work recognised. I would like to thank everyone across MTW for their help in making these achievements possible and providing such an outstanding level of care to our patients.

- On Monday 31 January, the Secretary of State for Health and Social Care, the Rt Hon Sajid Javid MP, announced that the government is reviewing its policy on vaccination as a condition of employment. A consultation has been launched this week which will look at ending vaccination as a condition of employment in health and all social care settings and subject to the response of this, the government will revoke these regulations. As a result of this we have paused our plans to comply with this requirement while we await guidance from the government about the detail of the changes. Nonetheless, we will continue to support colleagues to access vaccination and make sure they have the information they need. The only activity which continues (as per national guidance) is the requirement for external candidates to be required to receive a vaccine as a condition of offer. This too will form part of the outcome of the live consultation.

- The number of COVID-19 patients being cared for at our hospitals remains quite stable. As mentioned previously, this third wave has been very different from those coming before. Both wave one and wave two saw very rapid increases in COVID-19 admissions followed by a very rapid decline. But this current wave has been steadier and continued longer and we are not anticipating numbers to drop completely in the way they have done in previous waves. This is having a much greater impact at Maidstone Hospital where the vast majority of our COVID-19 patients are currently being looked after, compared to much smaller numbers at Tunbridge Wells Hospital. The difference in COVID patient numbers reflects the current community transmissions rates which are falling more slowly in Maidstone compared to the rest of the region. The ongoing COVID demand has a significant dislocating effect because of operating separate pathways and managing the significant risk of nosocomial infection (spread within the hospitals) especially given how infectious Omicron is, even for people who are fully vaccinated. This is why we are still remaining cautious and although we have discontinued temperature checking at our hospital entrances, we continue to ask all staff, patients and visitors to continue with face masks until further notice. In addition to this, we're also keeping in place other precautions such as distancing, continuing with regular lateral flow testing and encouraging staff to work from home with some visiting restrictions still in place that are reviewed regularly.

- The Gastro-Intestinal pathway at the Trust has seen some big changes over the last year, in part due to the ongoing COVID-19 pandemic but also due to innovation and increased investment. The Trust uses a combination of standard endoscopy, capsule endoscopy, CT virtual colonoscopy and standard CT examinations and is the only endoscopy centre in Kent and Medway currently without a backlog of patients awaiting treatment post COVID-19. This is thanks to the number of nurse-led clinics in operation across the Trust and service provision is

being expanded further with the appointment of four additional nurses. The Trust has introduced a new innovative Lower Gastro-Intestinal 2ww straight to test pathway over the last nine months, and there has been a move away from the use of the faecal occult blood (FOB) test, with the qFIT test now being used with patients to assess the risk of colorectal cancer and guide further investigations as it is a more sensitive and specific test. Recently the Trust has also started treating patients using a new procedure called Transanal Minimally Invasive Surgery (TAMIS) and this is used for complex rectal polyps and early rectal cancers.

The Trust has recently been confirmed as the Endoscopy training hub for Kent and Medway. We have purchased an endoscopy virtual reality simulator that will be used to train more clinical endoscopists and expand service capacity across the region. MTW is currently the only organisation across Kent and Medway taking part in a pilot programme where patients swallow a tiny camera, known as a colon capsule endoscopy, to check for signs of cancer, providing a diagnosis within hours. Since the launch of the programme in June 2021, the Trust has performed 147 colon capsule endoscopies, resulting in almost 100 patients being removed from the cancer pathway. Results from the pilot to date show that MTW is in the top five trusts for number of colon capsule endoscopies carried out since the launch of the programme. The pilot will run for a period of two years with the aim of extending the service in the future to patients outside of the cancer pathway. The use of this less invasive technology has meant that we have been able to reduce the number of patients needing standard endoscopy procedures.

- Here at the Trust, we are determined to be a dementia-friendly hospital, ensuring that all our patients living with dementia receive the best possible care. This month we have been running a communications' campaign to promote the work of our dementia nurse facilitators, dementia champions, and use of the *This is Me* document. This is an easy and practical way of recording who the patient is as a person and helps us deliver person-centred care that is tailored specifically to their needs. Next month we plan to launch a campaign promoting equality in care for autistic patients, further details will be shared in my next report.

- The new infrastructure developments planned at the Trust continue to progress. Work is currently underway to link the new Paediatric Emergency Department (ED) at Tunbridge Wells Hospital with the existing Emergency Department. This interconnection will ensure the full provision of connectivity for the mobilisation and transportation of critically ill paediatric patients into the main hospital in the event of intensive care intervention or surgery being required. The design of the new paediatric ED has been bought about following engagement with ED and paediatric clinicians, managers and other staff across the Trust. The work is due to be completed by the end of March. At Maidstone Hospital, we are increasing our Oncology services with a new modular building providing additional clinic rooms and administration offices. Foundations are now in place and the delivery of the modular building is expected within the next week. The Oncology team are currently working with all staff groups to maximise the use of this new space, such as improving patient pathways, the introduction of super clinics, training and development for KMMS students and clinical trials. Our Community Diagnostic Centre (CDC) continues to offer extended capacity for our patients requiring diagnostic tests such as CT and MRI scans. Work continues apace on the expansion plans for the CDC, to include bone density scans, phlebotomy services and Point of Care Testing services, and also on the regional imaging training academic hub. In terms of our Digestive Diseases Unit the full DDU business case is in development with close working underway between our surgery and medicine divisions.

- The Health and Care Partnership (HCP) is progressing the agreed clinical and professional priorities. Recent developments have included:
  - MTW Emergency Department (ED) and frailty GPs agreeing the process to transfer clinically appropriate patients from MTW ED to the GP Frailty Service which will provide support and care for patients at home.

  - The Children's Integrated Neuro Development Disorder Assessment Clinic opened at Heathside, Coxheath, in January and will run as a multi-disciplinary pilot for six months. The aim is to deliver a more holistic assessment of the child's needs, reducing the number of

individual assessments required which will improve the experience for families and ensure that assessments and interventions happen more quickly.

- The HCP has supported West Kent Primary Care Networks to access the six month Elite Apex Programme that will support GPs to use this system to access their operational data. The elite programme will support practices to make operational changes to assist with demand and capacity management.
- The Maidstone Borough Council led Health Inequalities project has started its community insight and asset mapping which is being delivered by Activmobs. The results of this community engagement work will provide community insights into what actions can be taken to help address obesity and diabetes in the Parkwood and Shepway communities.
- West Kent Primary Care and MTW have started a Respiratory Virtual Ward service providing an integrated pathway (non-COVID) for supported discharge of respiratory patients who will be virtually monitored by West Kent Primary Care nurses with consultant support. A phased launch is proposed for March with the service initially piloting COPD patients, then moving to Asthmatic and Bronchiectasis patient cohorts.
- A West Kent HCP Engagement Working Group started in January which reports into the West Kent HCP Stakeholder Engagement Group. This group aims to ensure that patient and resident engagement is at the heart of the transformation work led by the partnership and that residents/patients co-design new services or service changes with the relevant provider where possible.

- Our wellbeing programme continues with more health and wellbeing services and activities being made available to staff. Our wellbeing lounges are open daily and staffed by our wellbeing lounge coordinators, where staff can drop in for a coffee and a chat, and take a few minutes to recharge. A programme of wellbeing activities in the lounges is also being rolled out. Ear acupuncture sessions are proving to be very popular with staff. Around 20 MTW colleagues have trained as auricular acupuncture practitioners and are offering treatments in their own time to support the wellbeing of others in the Trust. Our MTW wellbeing partners are visiting the wards and departments to offer wellbeing support, working alongside our team of Human Resources business partners and our organisational development consultants. Their focus is to signpost or refer individuals on to appropriate wellbeing services such as the Employee Assistance Programme or the Psychological Occupational Health Team. They also work with our managers to embed wellbeing good practice in their day to day work.
- Networks continue to play a key role in supporting staff across the Trust. Our LGBT+ Network is working on phase 2 of the national NHS Rainbow Badge. This phase is essentially a benchmarking process which will assess NHS organisations for their inclusivity of the LGBT+ community with regards to both patients, service users and staff. The assessment process runs from February to June and following assessment, the Trust will receive a graded award reflecting their current LGBT+ inclusion work (Foundation, Bronze, Silver and Gold), a comprehensive feedback report and action plan to help improve and become more inclusive. Our Cultural and Ethnic Minorities Network (CEMN) is supporting the Equality, Diversity and Inclusion team with the creation of diversity data workshops for Divisions to better understand their Workforce Race Equality Standard (WRES) data, and be supported to create plans to meet the national targets for race equality in NHS Trusts. The CEMN continues to host monthly Q&A sessions with executives at the Trust and other external contacts, helping to create understanding and learning about race. The Disability Network has launched two sub-groups, an Autism Support Network and a Chronic Pain Network. These groups are designed to provide peer support and understanding about health conditions and the kind of support that's available within, and outside, the Trust. The Disability Network has also launched the Staff Health Passport which provides a structure for managers and staff to have supportive conversations about health conditions and adjustments required. Finally, the Trust has also launched its Disability Leave policy, providing staff with disabilities an additional five days of disability related leave per annum.

- Congratulations to the winner of the Trust's Employee of the Month scheme for January, Arabella Waller. Dr Waller is a consultant in Acute Medicine and Rheumatology and won the award for her work with the vaccination campaign and setting up the anti-viral medicines service for vulnerable patients to ensure that patients at highest risk in the community were able to access COVID-19 treatments. On behalf of the Trust Board I would like to say thank you to Arabella for her fantastic work to help support our colleagues and patients.

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

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

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

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from Quality Committee, 09/02/22 Committee Chair (Non-Exec. Director)

The Quality Committee met (virtually, via webconference) on 9th February 2022 (a Quality Committee 'deep dive' meeting).

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

- The **minutes of the last meeting** were approved and it was agreed that the Medical Director should provide an update to the August 2022 Quality Committee 'deep dive' meeting regarding the proposed process for the review of the governance and assurance arrangements in relation to system working.
- The **progress with previous actions** was reviewed.
- The Programme Director for EPR (Sunrise) and Digital Transformation; Chief Clinical Information Officer (CCIO); and Medical Director attended for a comprehensive **review of the decision-making process for 'clinical design' within the Trust's Digital Transformation programme** wherein the Committee acknowledged the Trust's maturing Digital Transformation programme and associated processes, and the importance of feedback to ensure quality improvements within the Trust's Digital Transformation Programme was emphasised.
- The Director of Strategy, Planning and Partnerships; and the Business Intelligence Business Partner for Acute Medicine & Emergency Flow attended for a **review of the health inequalities and equality of access to services on patient outcomes** (including a brief overview of the lessons learned from patients with learning disabilities)**.** The presentation provided a comprehensive overview of the impact of population demographics on patient outcomes and the associated considerations which were required when interpreting the Trust's population data (i.e. the a-typical population demographic within the Kent and Medway Integrated Care System) and it was agreed that the Assistant Trust Secretary should schedule a "further review of the health inequalities and equality of access to services on patient outcomes (incl. the approach by which the feedback received would be used to inform service developments)" item at the August 2022 Quality Committee 'deep dive' meeting.
- The Trust Lawyer attended for a **review of the lessons learned from adverse outcomes reported to Legal Services** wherein it was agreed the Trust Lawyer should investigate whether the actions implemented in response to the Maternity Services Clinical Negligence Scheme for Trusts (CNST) incentive scheme could be utilised to reduce CNST claims received within other service areas. It was also agreed the Trust Lawyer should liaise with the Director of Quality Governance and Medical Director to provide Committee members with benchmarking data for Clinical Negligence Scheme for Trusts (CNST) claims against neighbouring, and Care Quality Commission 'outstanding' rated, Trusts.
- A discussion was held on the **items that should be scheduled for scrutiny at future Quality Committee 'deep dive' meetings**, wherein it was agreed that the Assistant Trust Secretary should reschedule the "Further review of the Quality and Clinical Governance issues associated with the implementation of the Electronic Patient Record" item from the June 2022 'Quality Committee 'Deep Dive' meeting to the October 2022 Quality Committee 'Deep Dive' meeting.

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

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

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

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

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

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the People and Organisational Development Committee, 18/02/22	**Committee Chair (Non-Exec. Director)**

The People and Organisational Development Committee met (virtually, via webconference) on 18th February 2022 (a 'deep dive' meeting).

The key matters considered at the meeting were as follows:

- The **actions from previous 'deep dive' meetings** were reviewed and it was agreed that the Trust Secretary should liaise with the Chief People Officer and Deputy Chief People Officer, People and Systems to schedule an "Update on the development of Human Resources Business Partners (incl. the approach for an aligned Business Partnership model, encompassing Business Partners from the Trust's other Corporate functions)" item at a future Committee meeting.
- The Deputy Chief Executive/Chief Finance Officer and Chief People Officer presented a **review of the proposed reporting arrangements for the Strategy Deployment process and the 'Business as Usual' improvement work within the People and Culture Function**, and the intended approach was supported. It was also agreed that a "Strategy Deployment Development - The People Strategic Theme" report would be submitted to the Committee's meeting in May 2022.
- The Chief People Officer reported on **the implications of NHSE/I's "The Future of NHS Human Resources and Organisational Development" report**, and it was agreed that an update on the implementation of the actions arising from the report should be submitted to the Committee's meeting in May 2022. It was also agreed that the Chief People Officer should consider how the Trust Board should be informed of the implications of the NHSE/I report.
- An early **draft of the People and Culture Strategy** was reviewed, which included a summary of the findings from the stakeholder engagement. The further work required to develop the Strategy was acknowledged, but the quality of the work undertaken to date, and the content of the draft, was commended. It was confirmed that the next steps would involve the draft Strategy being considered by the Executive Team Meeting (ETM), before returning to the People and Organisational Development Committee for a further review, and then being submitted to the Trust Board, for approval. It was however also agreed that the two Co-Chairs of the Joint Consultative Forum Committee should liaise to consider and recommend the methods the Chief People Officer could deploy to engage effectively with all colleagues across the Trust on the draft Strategy.
- The Chief Nurse reported on the outcome of the comprehensive **assessment of the Staffing Assurance framework for winter 2021 preparedness** that had been issued by NHSE/I in November 2021, and it was agreed to schedule an update on the work at the Committee's meeting in September 2022, for the committee to seek assurance on the actions.
- The Committee conducted an **evaluation of the meeting** which confirmed that members feel the Committee is operating effectively and posing the appropriate questions and challenge to the subjects it considered.

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

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

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

NHS Maidstone and Tunbridge Wells NHS Trust

To approve revised Terms of Reference for the Remuneration and Appointments Committee (annual review)	Trust Secretary / Committee Chair (Chair of the Trust Board)

The annual review of the Remuneration and Appointments Committee's Terms of Reference is overdue, as the Trust Board last approved the Terms of Reference in November 2020. The review has been awaiting the scheduling of the Remuneration and Appointments Committee's next meeting, but as no future meetings are currently scheduled, or planned to be scheduled, it has been agreed that the revised Terms of Reference should be submitted directly to the Trust Board, for approval.

The Terms of Reference have therefore been reviewed and two changes are proposed, which are shown as 'tracked' on the following pages. These are both 'housekeeping' changes.

The Trust Board is asked to approve the changes.

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

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
Approval of the revised Terms of Reference to the Remuneration and Appointments Committee

[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

REMUNERATION AND APPOINTMENTS COMMITTEE

TERMS OF REFERENCE

Maidstone and Tunbridge Wells NHS Trust

1. Purpose

In accordance with the Code of Conduct and Code of Accountability[2], a Remuneration and Appointments Committee is constituted by the Trust Board.

2. Membership

- The Chair of the Trust Board (Chair of Committee)
- All Non-Executive Directors

The Vice Chair of the Committee will be the Vice Chair of the Trust Board.

Members are expected to attend all relevant meetings.

3. Quorum

The Committee shall be quorate when the Chair and two Non-Executive Directors are in attendance.

4. Attendance

The following are invited to attend each main meeting:

- Chief Executive
- Chief People Officer~~Director of Workforce~~
- Associate Non-Executive Directors

Other staff may be invited to attend, to meet the Committee's purpose and duties.

5. Frequency of Meetings

Meetings will be scheduled according to need, but there will be a minimum of one meeting per year.

6. Duties

6.1 To review, on behalf of the Trust Board, the appointment of members of the Executive Team, to ensure such appointments have been undertaken in accordance with Trust Policies.

6.2 To review, on behalf of the Trust Board as required, the remuneration, allowances and terms of service of members of the Executive Team, to ensure that they are fairly rewarded for their individual contribution to the organisation; and by having proper regard to whether such remuneration is justified as reasonable.

6.3 To review, with the Chief Executive, the performance of members of the Executive Team.

6.4 To oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments, taking account of the Trust's Standing Financial Instructions and~~such~~ national guidance, as appropriate. Any non-contractual payment to a staff member must be first reviewed and approved by the Committee.

6.5 To consider and approve, on behalf of the Trust Board, proposals on issues which represent significant change e.g. "Agenda for Change" implementation, Consultant contract/incentive scheme[3].

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[2] Department of Health, 1994 (and subsequent revisions)

[3] The Committee will not consider matters relating to individual posts covered under the Agenda for Change national framework, or matters relating to individual medical staff

7. Parent Committee and reporting procedure

The Remuneration and Appointments Committee is a sub-committee of the Trust Board.

The Chair of the Remuneration and Appointments Committee will determine the extent (and format) to which the detailed activities of the Committee are reported to the Trust Board.

8. Sub-committees and reporting procedure

The Remuneration and Appointments Committee has no sub-committees, but may establish fixed-term working groups, as required, to support the Committee in meeting the duties listed in these Terms of Reference

9. Administration

The minutes of the Committee will be formally recorded and presented to the following meeting for approval and review of actions.

The Committee will be serviced by administrative support from the Trust Secretary.

10. Emergency powers and urgent decisions

The powers and authority of the Remuneration and Appointments Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted the Committee's Vice Chair or the Chair of the Audit and Governance Committee. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Committee, for formal ratification.

11. Review of Terms of Reference

These Terms of Reference will be agreed by the Remuneration and Appointments Committee and approved by the Trust Board. They will be reviewed annually or sooner if there is a significant change in the arrangements

History

- Revised Terms of Reference agreed by the Remuneration Committee, 24/06/15
- Revised Terms of Reference approved by the Trust Board, 22/07/15
- Revised Terms of Reference agreed by the Remuneration and Appointments Committee, 25/01/17
- Revised Terms of Reference approved by the Trust Board, 22/02/17
- Revised Terms of Reference agreed by the Remuneration and Appointments Committee, 23/01/18
- Revised Terms of Reference approved by the Trust Board, 01/03/18
- Revised Terms of Reference agreed by the Remuneration and Appointments Committee, 29/03/18 (to list Chief Executive among those invited to attend each meeting, and note the change in secretariat function)
- Revised Terms of Reference approved by the Trust Board, 26/04/18
- Revised Terms of Reference agreed by the Remuneration and Appointments Committee, 19/12/19
- Revised Terms of Reference approved by the Trust Board, 30/01/20
- Revised Terms of Reference agreed by the Remuneration and Appointments Committee, 19/11/20
- Revised Terms of Reference approved by the Trust Board, 26/11/20
- Revised Terms of Reference approved by the Trust Board, 24/02/22

NHS
Maidstone and Tunbridge Wells NHS Trust

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

The IPR for month 10, 2021/22, is enclosed, along with the monthly finance report and the latest 'planned vs actual' nurse staffing data.

Which Committees have reviewed the information prior to Board submission?
Finance and Performance Committee, 22/02/22 (IPR)

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

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report

January 2022

MTW
exceptional people, outstanding care

Contents

Appendices

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

Key to KPI Variation and Assurance Icons

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

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

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

Maidstone and Tunbridge Wells NHS Trust

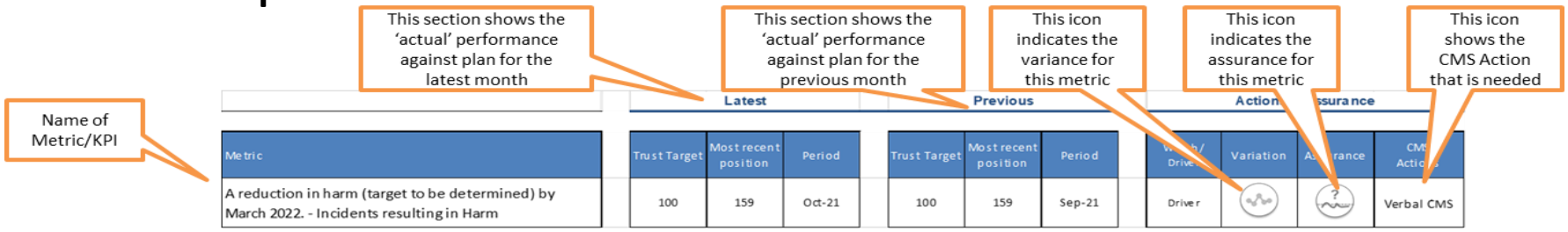
Escalation Rules:

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

Escalation Pages:

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

Scorecards explained



Further Reading / other resources

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

MTW exceptional people, outstanding care

Executive Summary

Executive Summary

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

The rate of inpatient falls has returned to common cause variation in January. This indicator has not achieved the target for more than six months and has therefore been escalated as have both cases of C.Difficiile and Hospital on-set of COVID, which have also not achieved the target for more than six months.

Safe Staffing levels have not achieved the target for more than six months and have been escalated, but significant Recruitment and Retention activity is taking place to address this. The programme of work around the NHS Mandatory Vaccination is currently on pause pending consultation.

The Trust continues to achieve both the National Cancer 62 Day Standard and the 2 Week Wait (2WW) Standard, reporting 86.7% and 94.7% respectively, however, achievement of the these standards continues to remain increasingly challenging with the continued high number of 2WW referrals and increasing 62 Day Backlog .

A&E 4hr performance remains in special cause variation of a concerning nature at 83.9% and has not achieved the target for more than six months. However, the Trust's performance remains one of the highest both Regionally and Nationally.

RTT performance and 52 week breaches are now measured on the trajectories set during business planning and as such are performing well, falling within hit and miss and passing the targets respectively. Activity levels (including activity being undertaken by the Independent Sector) have remained slightly below plan for the last six months with January currently showing 86.4% of 19/20 levels for Elective Activity and 95% for Total Outpatients. The high level of non-elective emergency admissions as well as the high level of elective activity being undertaken is therefore putting pressure on the bed capacity across with Trust.

Escalations by Strategic Theme:

People:
- Climate Survey Responses
- Vacancy Rate
- Sickness Rate

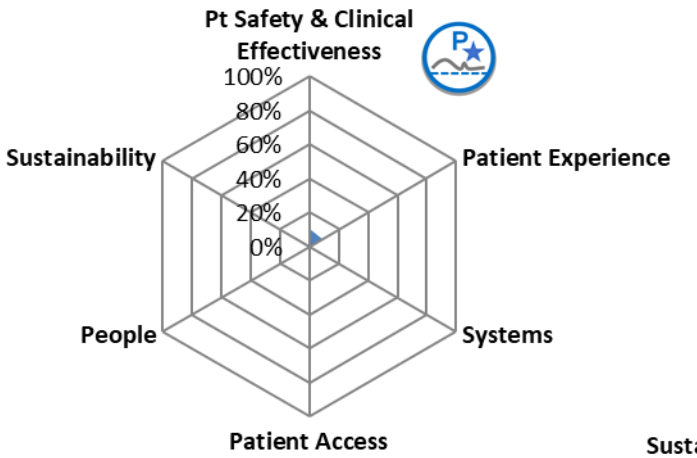
Patient Safety & Clinical Effectiveness:
- Falls Rate
- Safe Staffing
- Incidents Resulting in Harm
- Infection Control

Patient Access:
- Diagnostics <6 weeks
- A&E Performance
- Outpatient Calls answered <1 minute
- Outpatient Clinic Utilisation
- Ambulance Handovers >30 minutes
- Super-Stranded Patients
- % Emergency Admissions to Assessment Areas
- Ensuring Activity Levels Match those Pre-Covid – Inpatients, & Outpatients

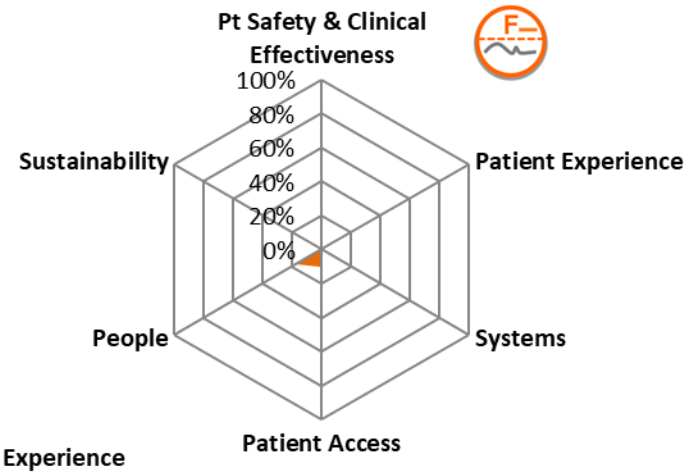
Patient Experience:
- Friends & Family Response Rates
- Friends & Family % Positive Rates
- Complaints

Assurance Radar Charts by Strategic Theme

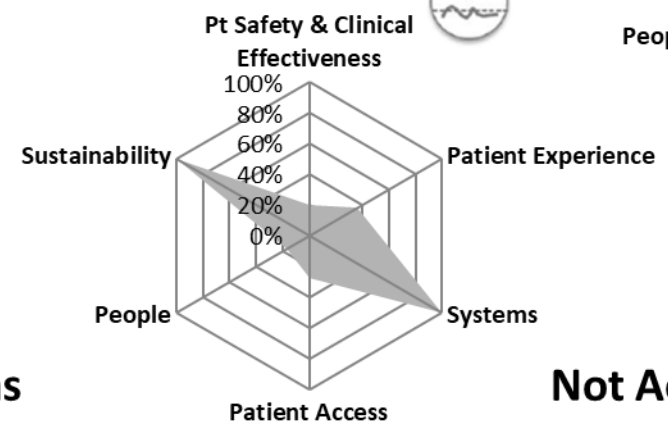
Consistently Passing



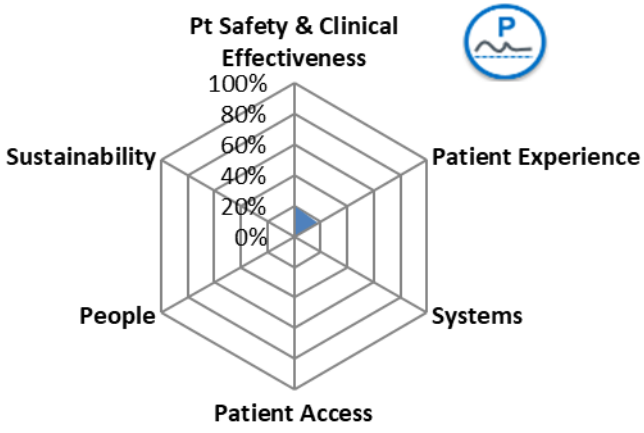
Consistently Failing



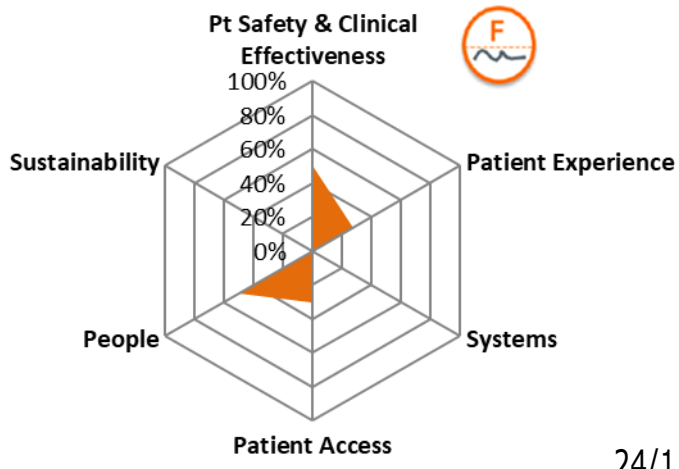
Hit and Miss



Achieved Target > 6 months



Not Achieved Target > 6 months



Matrix Summary

January 2022		Assurance				
		Pass★	Pass	Hit and Miss	Fail	Fail -
Variance	Special Cause - Improvement	Statutory and Mandatory Training	RTT >52 wk Waiters Flow: % of Emergency Admissions that are zero LOS (SDEC)	By April 2022 we will achieve the RTT standard	Appraisal Completeness	Transformation: CAU Calls answered <1 minute
	Common Cause	0	FFT positive response: Inpatients, FFT positive response rate: Matenity, Activity levels match those pre-Covid - CT Scans, Number of New Sis Cancer 62 Day Standard	FFT positive response rate A&E, FFT positive response rate: Outpatients, Delivery of financial plan,including CIP, Activity levels match those pre-Covid - Follow Up OP, MRI, NOUS, Reduce average non-elective bed days relating to patients with high and very high AEC conditions by 10%, Reduce Agency Spend - £000, IC - Number of Hospital acquired MRSA, Never Events, Complaints Rate, % complaints responded to within target, Access to Diagnostics (<6weeks standard), Capital Expenditure (£k)	Reduction in Incidents causing Harm, Reduction in slips, trips and falls Hospital Acquired Covid, Activity levels match those pre-Covid - Elective, Activity levels match those pre-Covid - OP New, Increase FFT response rates: Inpatients, Safe Staffing Levels, Rate of Hospital C.Difficile, Sickness Absence, Flow: Super Stranded Patients, Flow: % of Emergency Admissions into Assessment Areas	Vacancy Rate, Transformation: % OP Clinics Utilised (slots)
	Special Cause - Concern	Standardised Mortality HSMR % VTE Risk Assessment	0	% of staff that "Recommended MTW as a good place to work" taken from Quarterly Climate Survey, Reduction in non-elective bed days, Cash Balance (£k)	Increase Climate Survey response rates, Increase FFT response rates: Maternity, Increase FFT response rates: Outpatients, A&E 4 hr Performance, Flow: Ambulance Handover Delays >30mins	FFT Response Rate: A&E

Strategic Theme: People

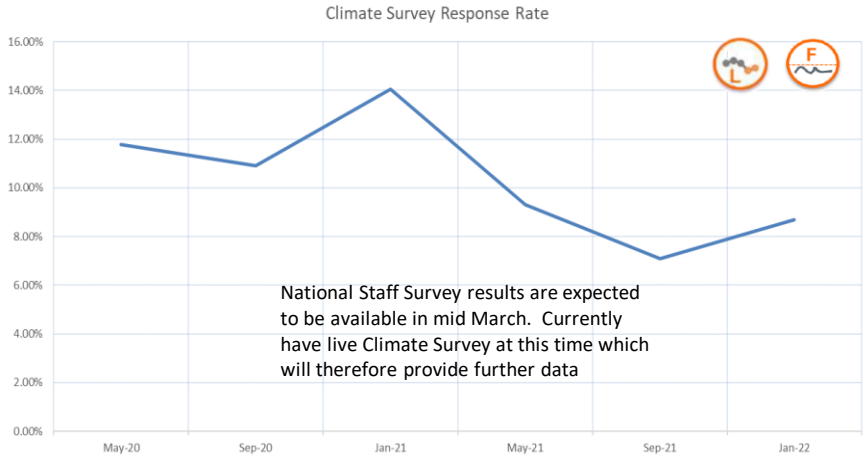
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Well Led	% of staff that "Recommended MTW as a good place to work" taken from Quarterly Climate Surveys	80%	64.4%	Jan-22	80%	63.8%	Sep-21	Driver			Verbal CMS
Breakthrough Objectives	Well Led	Increase Climate Survey response rates to provide a larger sample base to be able to assess those that recommend MTW as a place to work.	25%	8.70%	Jan-22	25%	7.08%	Sep-21	Driver			Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Well Led	Vacancy Rate	9.0%	12.7%	Jan-22	9.0%	13.0%	Dec-21	Driver			Escalation
	Well Led	Sickness Absence	3.3%	4.6%	Dec-21	3.3%	4.6%	Nov-21	Driver			Escalation
	Well Led	Appraisal Completeness	95.0%	89.8%	Jan-22	95.0%	89.3%	Dec-21	Driver			Escalation
	Well Led	Statutory and Mandatory Training	85.0%	91.2%	Jan-22	85.0%	90.9%	Dec-21	Driver			Note Performance

Breakthrough Objective: Counter Measure Summary

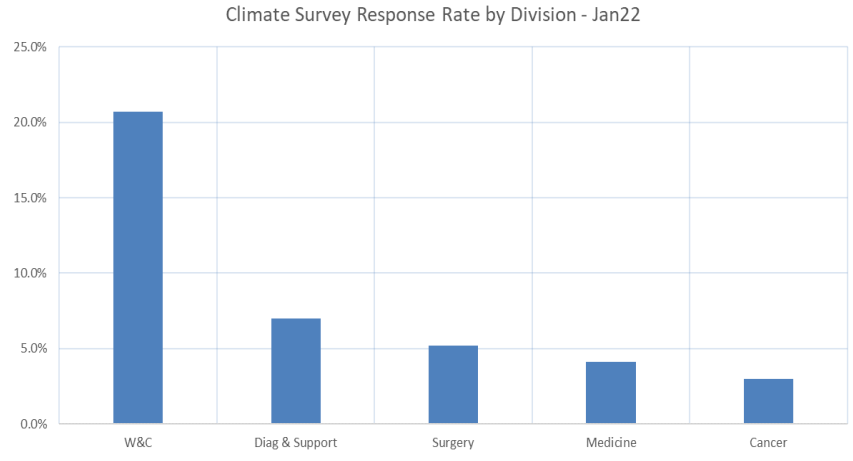
Metric Name – Increase Climate Survey Response to provide a larger sample base

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

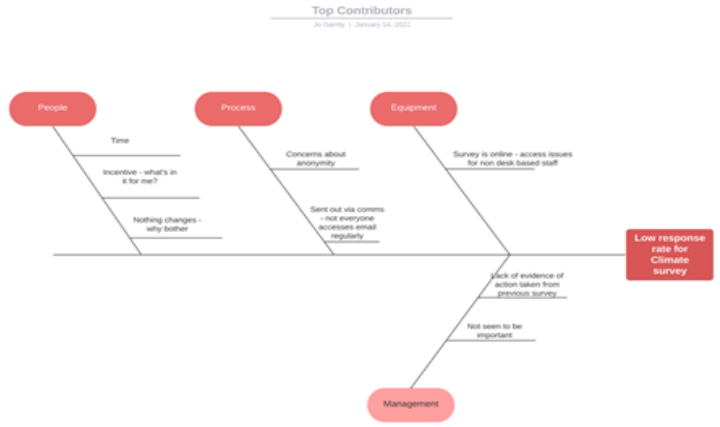
1. Historic Trend Data



2. Stratified Data



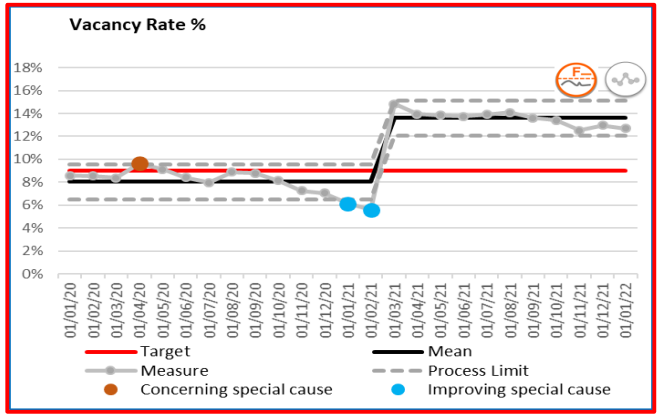
3. Top Contributors



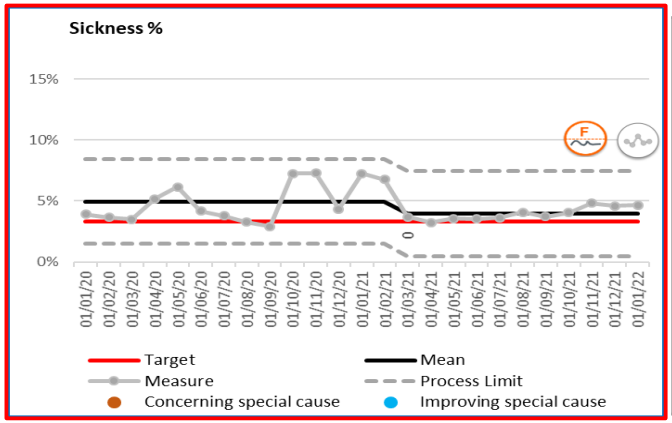
4. Action Plan

Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
		Introduction of QR Code to enable staff alternative method of responding Promotion of QR code in wellbeing lounges and encouragement to complete by coordinators plus promotion by wellbeing team Introduction of incentive (2x £50 vouchers) – prize draw for all who respond	JG	Complete
		You said We did – Trust wide communications	JG/Comms	Ongoing
		You said We Did – Divisional comms	JG/Divisional Leads	Ongoing
		Undertake "Lessons Learned" analysis from the W&C Division to share good practice for other Divisions	JG/Division	End of February 22

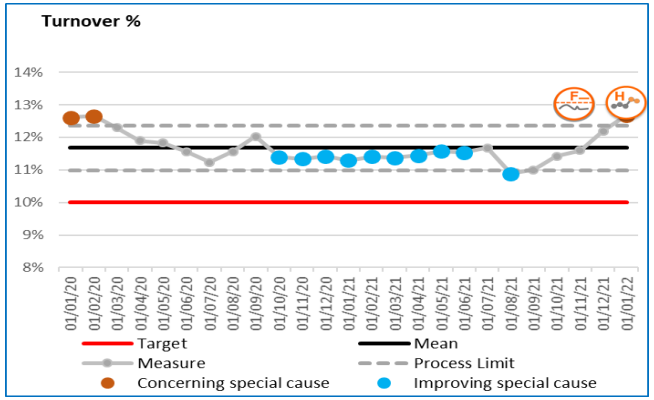
People – Workforce: CQC: Well-Led



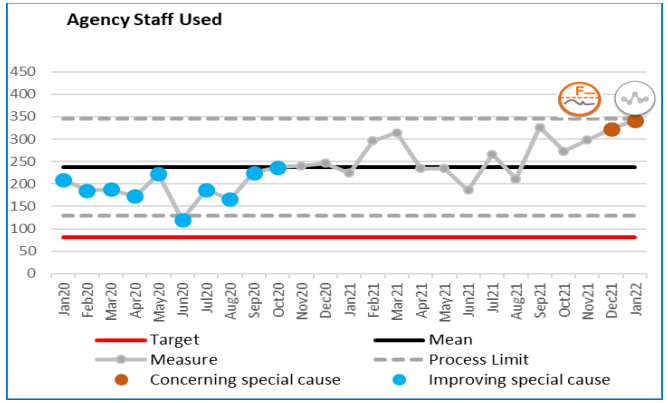
Jan-22
12.7%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and consistently failing the target
Max Limit (Internal)
9%
Business Rule
Full Escalation



Dec-21
4.6%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and not achieving the target for > 6 months
Max Target (Internal)
3.3%
Business Rule
Full Escalation as not achieving the target > 6 months



Jan-22
12.7%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of a concerning nature and is consistently failing the target
Max Limit (Internal)
10%
Business Rule
For Information as linked to Vacancy Rate



Jan-22
342
Variance / Assurance
Metric is currently experiencing Common Cause Variation consistently failing the target
Target (Internal)
81
Business Rule
For Information as linked to Vacancy Rate

Summary:

Vacancy Rate % - With a step change after the beginning of 2021/22, this metric is experiencing Common Cause Variation, but is consistently failing the target

Sickness % - With a step change after wave 2 of Covid, this metric is experiencing Common Cause Variation and variable achievement of the target and has failed the target for more than six months

Turnover: Shown for information as linked to Vacancy Rate and is consistently failing the target

Agency Staff Used: Shown for information as linked to Vacancy Rate and is consistently failing the target.

Actions:

Vacancy Rate: increased use of marketing for attraction purposes, continued use of agency-led campaigns (e.g. Oncology) resulting in positive outcomes amid the background of continuing higher levels of recruitment across the trust.

Sickness: Close monitoring of covid absence shows a reduction in this reason for absence, mirroring the national picture. If this continues, expectation sickness levels will return to more normal for the time of year for February.

Turnover: interventions beginning to be put in place e.g. welfare support, and a retention lead now to be recruited following the approval of the business case for this

Assurance & Timescales for Improvement:

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

Sickness % - Seasonal increase and effect of omicron relate to this metric. Omicron related in particular expected to decrease in line with national levels into February.

Lead Recruitment and Retention matron has commenced which will support the Recruitment and Nursing teams in reducing vacancies and turnover
NHSI funding has been approved to support 140 international nurses to commence between June-December.
A calendar of Recruitment events for 22/23 is being organised which will include Internal/external events, Education providers and PR events for a range of staff groups.
Kick start scheme for MTW is currently being advertised in connection with DWP.

Strategic Theme: Patient Safety & Clinical Effectiveness

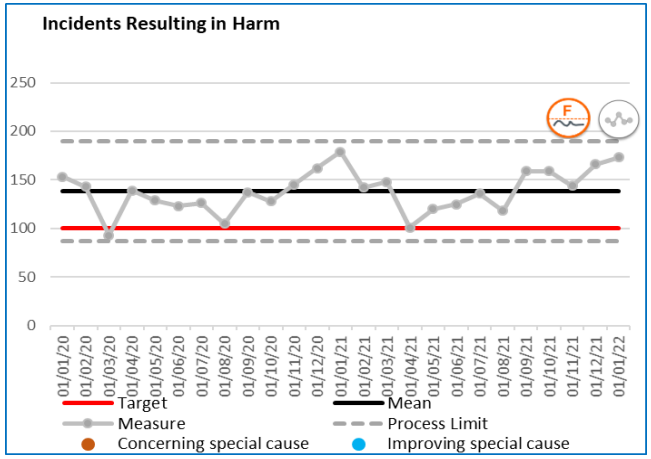
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Safe	A reduction in harm (target to be determined) by March 2022. - Incidents resulting in Harm	100	173	Jan-22	100	166	Dec-21	Driver		F	Full CMS
Breakthrough Objectives	Safe	Reduction in slips, trips and falls (Rate per 1,000 Occupied Beddays)	6.0	9.1	Jan-22	6.0	10.4	Dec-21	Driver		F	Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Safe	Number of New SIs in month	11	10	Jan-22	11	1	Dec-21	Driver		P	Note Performance
	Safe	Standardised Mortality HSMR	100.0	99.9	Nov-21	100.0	94.1	Oct-21	Driver	H	P	Verbal CMS
	Safe	Never Events	0	0	Jan-22	0	0	Dec-21	Driver		?	Verbal CMS
	Safe	Safe Staffing Levels	93.5%	90.3%	Jan-22	93.5%	86.4%	Dec-21	Driver		F	Escalation
	Safe	Infection Control - Hospital Acquired Covid	0	19	Jan-22	0	20	Dec-21	Driver		F	Escalation
	Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays	22.7	30.0	Jan-22	22.7	42.1	Dec-21	Driver		F	Escalation
	Safe	IC - Number of Hospital acquired MRSA	0.0	0	Jan-22	0	1	Dec-21	Driver		?	Verbal CMS

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

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

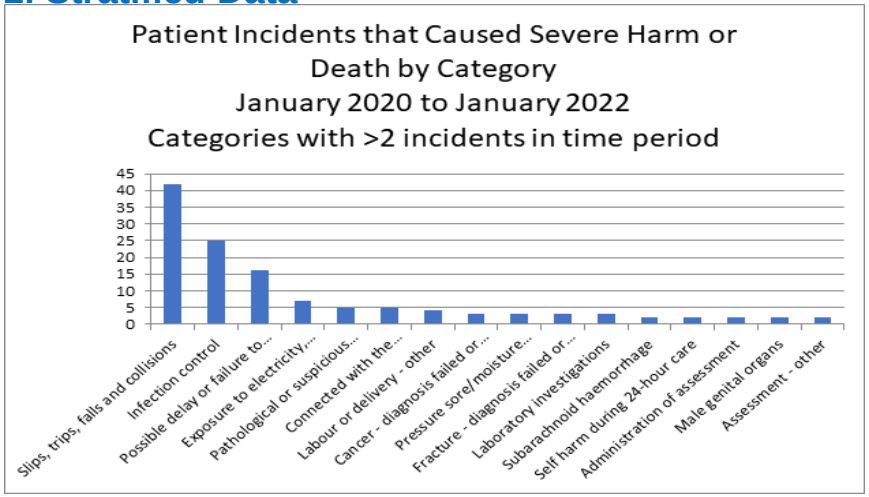
Owner: Peter Maskell
Metric: Incidents resulting in harm
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data

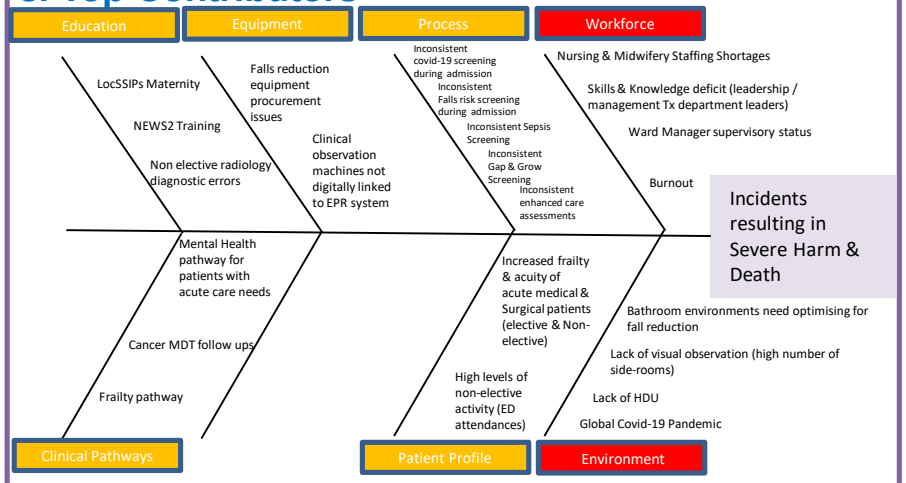


Jan-22
173
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has not achieved the target for more than 6 months
Max Target (Internal)
100
Business Rule
Full Escalation as Hit or Miss > 6 months

2. Stratified Data



3. Top Contributors



4. Action Plan

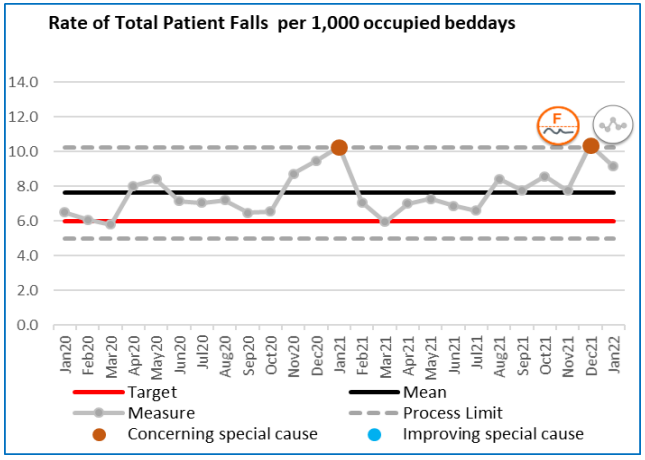
Contributor	Solution / Countermeasure	Owner	Due by?
Environment	Trust wide Falls QI workstream	Medical Director & Deputy CNO	Launched and Ongoing
	Options Appraisal HDU		
Workforce	Safer Staffing Review (drive to 95% fill rate substantive staff & assurance safe staffing models in place)	CNO	Sept 2022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

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

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

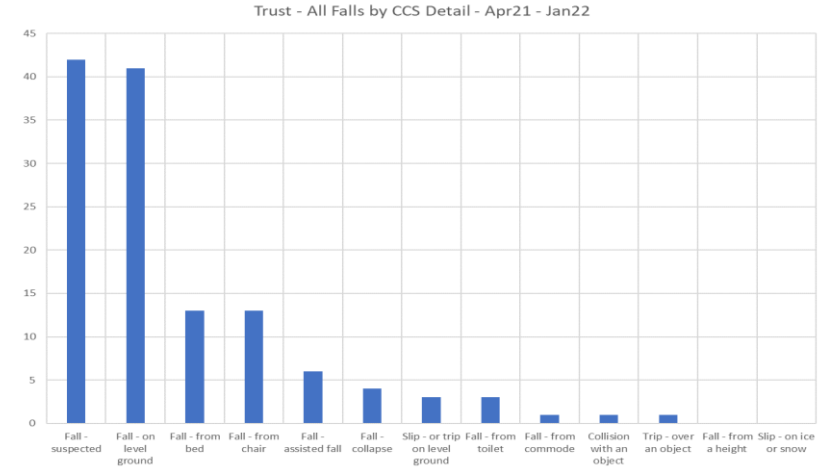
Owner: Peter Maskell
Metric: Falls Rate per 1,000 Occupied Beddays
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data

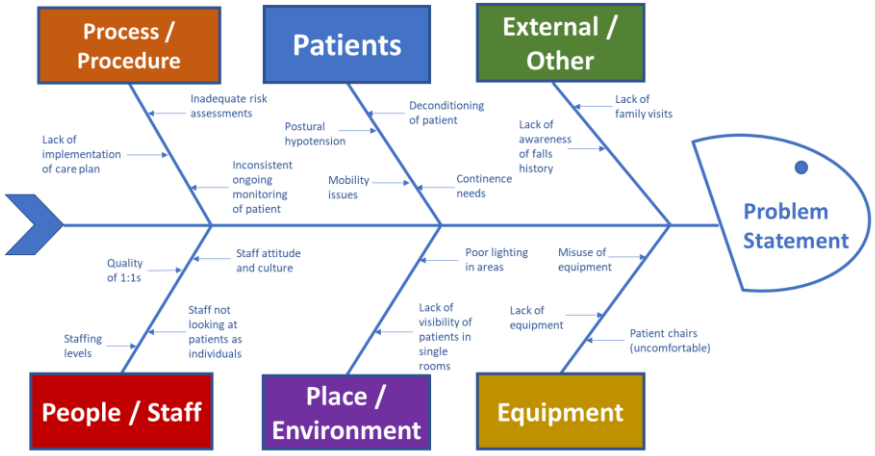


Jan-22
9.15
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has not achieved the target for more than 6 months
Max Target (Internal)
6.0
Business Rule
Full Escalation as not achieved target for > 6 months

2. Stratified Data



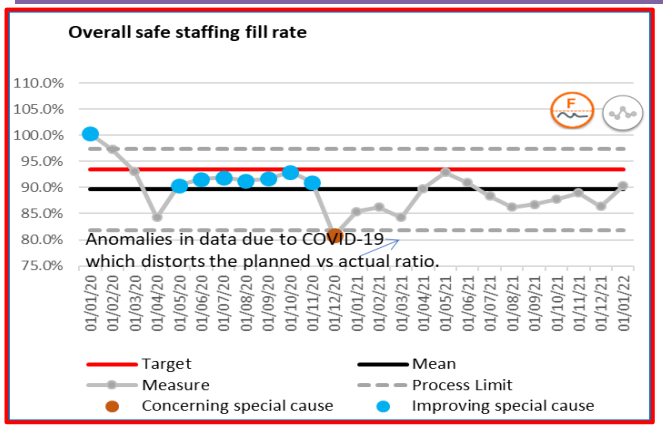
3. Top Contributors



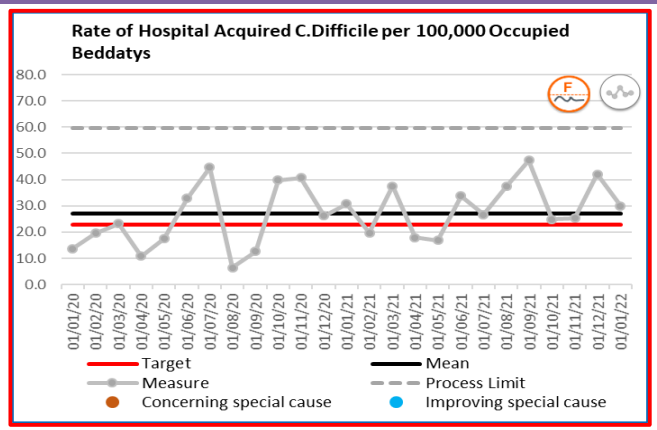
4. Action Plan

Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
Equipment-lack of / faulty / incorrect use	To be Confirmed	Ward equipment audit plan being drawn up. Audit to be undertaken initially on 6 focus wards with high falls.	Falls Working group A	w/c 28/02/22
Processes-assessment	assessment not specific to ED	ED specific assessment documents being drawn up. Identification of patients at risk of falls through the 'Think Yellow' initiative.	Lead Nurse for Falls prevention	w/c 28/02/22
Processes-dissemination of learning and feedback	method of sharing learning not always accessible to all staff	Explore, identify options for best way to disseminate learning to ward staff from falls and SI.	Patient Safety team/ Working group B	w/c 21/02/22
Staff/ Patients-staffing reduced as planned / required staffing numbers not able to be met	Shifts unfilled due to Vacancies and staff sickness.	Explore the use of One Team Runners to support wards with non clinical tasks.	Falls Working Group C	w/c 28/02/22

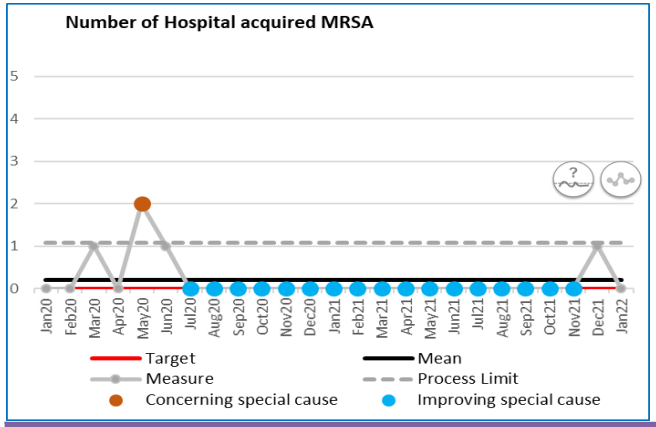
Patient Safety and Clinical Effectiveness: CQC: Safe (Hit & Miss > 6months)



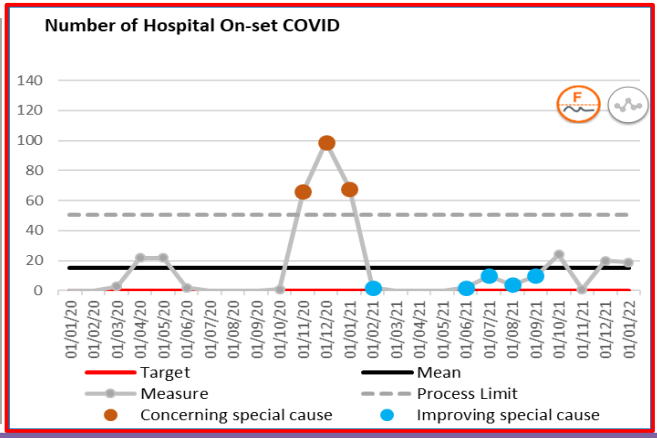
Jan-22
90.3%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has not achieved the target for >6months
Target (Internal)
93.3%
Business Rule
Full Escalation as has not achieved the target for > 6 months



Jan-22
30.0
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has not achieved the target for >6months
Max Target (Internal)
22.7
Business Rule
Full Escalation as has not achieved the target for > 6 months



Jan-22
0
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Max Target
0
Business Rule
For Info Only



Jan-22
19
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has not achieved the target for >6 months
Max Target (Intern
0
Business Rule
Full Escalation as has not achieved the target for > 6 months

Summary:

Safe Staffing Fill Rate: The level reported continues to experience common cause variation and has been experiencing variable achievement of the standard for more than six months.

Rate of C.Difficile: continues to experience common cause variation but has not achieved the target for more than six months.

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

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

Actions:

Safe Staffing Fill Rate: Daily staffing huddles review nursing and midwifery rosters. This enables forward planning, risk identification and action planning on projected fill rates. The temporary staffing team continue to attend morning site meetings. The Matrons afternoon staffing huddle is facilitated by Bank team and is further supported by the Senior corporate nursing team. Daily senior nurse staffing huddle is ongoing to provide oversight for areas of concern. A deep dive into fill and cancellation of agency shifts is being undertaken by the temporary staffing team. This aims to give insight to agency usage and the evidencing of shift cancellation at late notice. Head of Nursing for Safe Staffing has now been recruited and will commence on the 1st March. Retention Committee, chaired by the Chief Nurse is currently in implementation stage. This will focus specifically on Nursing, Midwifery and Clinical Support Workers (CSWs).

Infection Control: The Trust has seen an increase in numbers of Trust attributable C.Difficile cases, a large proportion of those cases were deemed to be unavoidable on RCA, those cases that were deemed to be avoidable were largely due to inappropriate antimicrobial prescribing which has been feedback to teams. The infection prevention team have led Trust wide incidence meetings in relation to the increase in C.Difficile and identified actions for improvement which have been worked on by all divisions.

Nationally there has been an increase in C.Difficile infections which is also being seen in the South East region.

The Trust is experiencing a number of Covid outbreaks which has seen a fairly high transmission rate in bays where a Covid positive patient has been identified.

Assurance & Timescales for Improvement:

Safe Staffing Fill Rate: Regular staffing huddles with Divisional leads and Staff Bank review substantive and temporary staffing requirements across all areas. All staffing levels are reviewed on a shift by shift basis, with oversight and appropriate redeployment monitored by the Senior Nurse Leadership Team. Daily BI staffing data for 14 days sent to all DDNQ's, senior corporate nursing team, temporary staffing team and Flow team for review. Daily senior nurse staffing huddle continues to provide oversight for areas of concern. Incentive package revised and focus remains on the TWH site and high risk areas (Escalation, ED, Maternity, ITU and Theatres). The Trust continues to implement SafeCare and now has 15 units live with 7 in the implementation stages. SafeCare walk the floor sessions have been implemented to provide support for clinical areas with data entry and effective rostering. SafeCare project has been mapped to ensure all inpatient wards are live by April 2022. Retention and Recruitment Matron is now in post and is working collaboratively with clinical teams and Human Resources to ensure recruitment and retention activity moves at pace.

Infection Control: The Infection prevention team will continue to monitor and escalate where infection rates are rising, actions taken had seen an improvement in October and November, however with a dip in December. RCA scrutiny will continue for alert organisms including C.difficile.

Covid-19 outbreak management meetings continue to be a high priority in the Trust.

Strategic Theme: Patient Access

			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Responsive	We will ensure no patient waits longer than 52 week for treatment by April 2022	25	2	Jan-22	36	4	Dec-21	Driver			Note Performance
	Responsive	By April 2022 we will achieve the RTT standard	77.7%	71.0%	Jan-22	76.7%	71.7%	Dec-21	Driver			Note Performance
Breakthrough Objectives	Responsive	Ensure activity levels for theatres match those pre-Covid - Total Elective	100.0%	86.4%	Jan-22	100.0%	93.3%	Dec-21	Driver			Full CMS
	Responsive	Ensure activity levels for outpatients match those pre-Covid - First Outpatients	100.0%	87.0%	Jan-22	100.0%	82.2%	Dec-21	Driver			Full CMS
	Responsive	Ensure activity levels for outpatients match those pre-Covid - Follow Up Outpatients	100%	99%	Jan-22	100%	104%	Dec-21	Driver			Verbal CMS
	Responsive	Ensure activity levels for diagnostics match those pre-Covid - MRI	100%	94%	Jan-22	100%	100%	Dec-21	Driver			Verbal CMS
	Responsive	Ensure activity levels for diagnostics match those pre-Covid - CT	100%	113%	Jan-22	100%	118%	Dec-21	Driver			Note Performance
	Responsive	Ensure activity levels for diagnostics match those pre-Covid - NOUS	100%	94%	Jan-22	100%	95%	Dec-21	Driver			Verbal CMS

Strategic Theme: Patient Access; continued

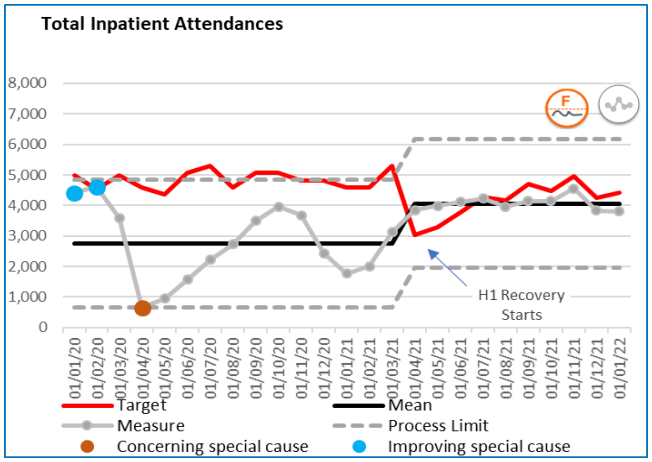
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Constitutional Standards and Key Metrics (not in SDR)	Effective	Transformation: % OP Clinics Utilised (slots)	85.0%	51.5%	Jan-22	85.0%	49.5%	Dec-21	Driver			Escalation
	Responsive	Access to Diagnostics (<6weeks standard)	74.6%	68.6%	Jan-22	73.7%	60.8%	Dec-21	Driver			Verbal CMS
	Responsive	A&E 4 hr Performance	85.0%	83.9%	Jan-22	86.0%	81.1%	Dec-21	Driver			Escalation
	Responsive	Cancer - 2 Week Wait	93.0%	94.7%	Dec-21	93.0%	94.3%	Nov-21	Driver			Note Performance
	Responsive	Cancer - 62 Day	85.0%	86.7%	Dec-21	85.0%	85.9%	Dec-21	Driver			Note Performance
	Effective	Transformation: % of Patients Discharged to a PIFU Pathways	1.50%	2.69%	Jan-22	1.50%	2.15%	Dec-21	Driver	No SPC	No SPC	
	Effective	Transformation: CAU Calls answered <1 minute	90.0%	59.4%	Jan-22	90.0%	67.2%	Dec-21	Driver			Escalation
	Effective	Flow: Ambulance Handover Delays >30mins	7.0%	7.8%	Jan-22	7.0%	12.1%	Dec-21	Driver			Escalation
	Effective	Flow: Super Stranded Patients	80	102	Jan-22	80	114	Dec-21	Driver			Escalation
	Effective	Flow: % of Emergency Admissions that are zero LOS (SDEC)	35.0%	43.5%	Jan-22	35.0%	40.2%	Dec-21	Driver			Note Performance
	Effective	Flow: % of Emergency Admissions into Assessment Areas	65.0%	59.9%	Jan-22	65.0%	58.7%	Dec-21	Driver			Escalation
	Effective	Patients not meeting the criteria to reside (MFFD)	TBC	121	Jan-22	TBC	111	Dec-21	Driver	No SPC	No SPC	
	Effective	Bed Days not meeting the criteria to reside (MFFD)	TBC	1102	Jan-22	TBC	911	Dec-21	Driver	No SPC	No SPC	

Breakthrough Objective: Counter Measure Summary

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

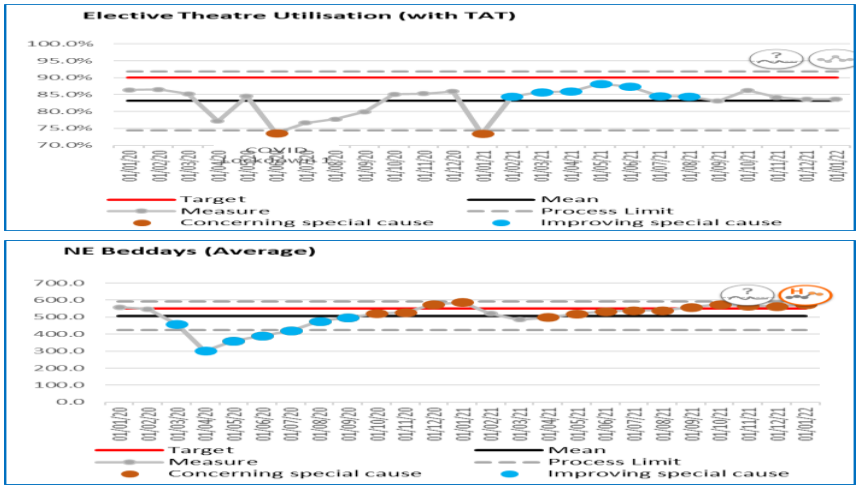
Owner: Sean Briggs
Metric: Elective Activity: Total Elective
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Jan-22
3806
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4406
Target Achievement
Metric has not achieved the target for >6 months

2. Stratified Data



3. Top Contributors

- A3 thinking to be completed – February 22
- Currently have actions in place to monitor activity.
- Data gathering commenced.

4. Action Plan

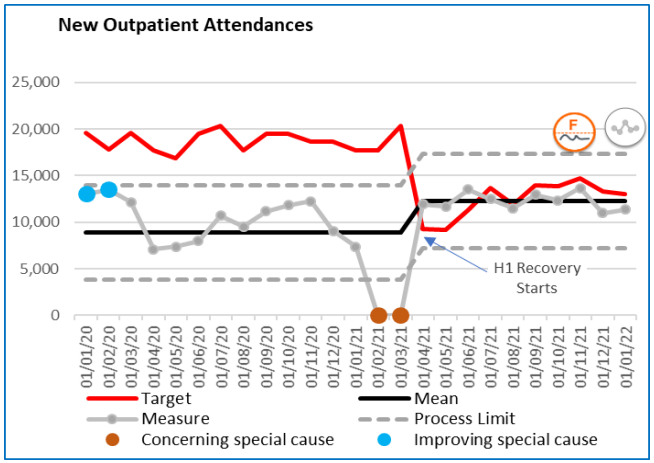
Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
Internal activity below plan	Closure of 1 theatre at TW due to staffing and increase in NEL demand.	Activity monitored weekly and day case activity increased. Theatre will re-open in line with Covid reduction	TS/DR	In progress
Outsource activity below plan	Lack of staff and capacity	Activity monitored weekly. Calls scheduled with IS Directors 17/01/22 – capacity made available, activity improving	SD/DR	In progress
Theatre utilization	Theatres not utilized to 85% trajectory without TAT	Monitored weekly at Directorate PTL Monitored monthly at TUB	GM's/PM	In progress
Cancelled operations	Increase in cancellations due to processes not being followed correctly	Cancellation to be monitored at weekly Directorate PTL's. Weekly monitoring at theatre scheduling meeting	GM's/JS	In progress

Breakthrough Objective: Counter Measure Summary

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

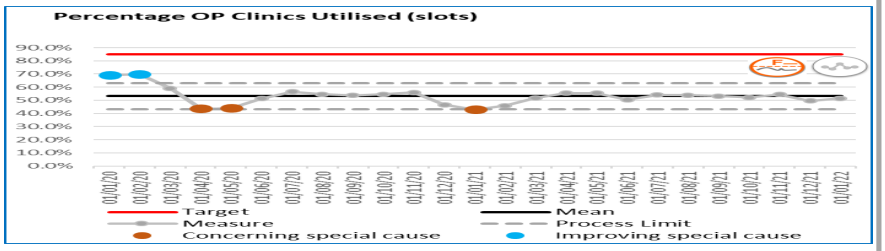
Owner: Sean Briggs
Metric: Elective Activity: New Outpatients
Desired Trend: 7 consecutive data points above the mean

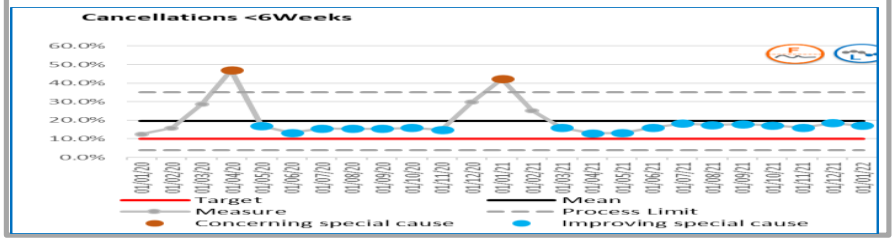
1. Historic Trend Data



Jan-22
11,368
Variance Type
Metric is currently experiencing Common Cause Variation
Target
13,070
Target Achievement
Metric has not achieved the target for >6 months

2. Stratified Data





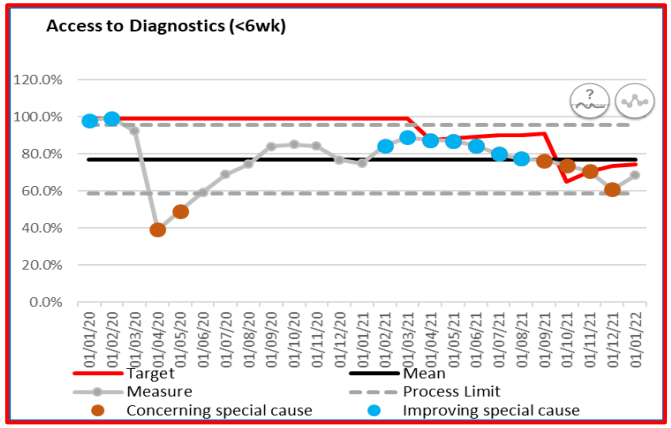
3. Top Contributors

- A3 thinking to be completed – February 22
- Currently have actions in place to monitor activity
- Data gathering commenced.

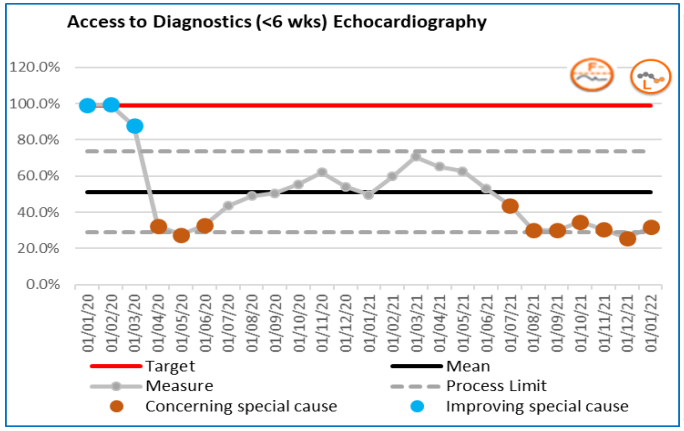
4. Action Plan

Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
Internal activity below plan	Clinics not cancelled with 6 weeks notice if specialty cant utilise	Activity monitored weekly. Weekly OPA scheduling meeting. Monitored weekly at Directorate PTL	GM's	In progress
Outsource activity below plan	Lack of staff and capacity	Activity monitored weekly. Calls scheduled with IS Directors 17/01/22 – capacity identified.	Director of Operations Surgery	In progress
OPA utilisation	Clinics not utilized to 90% trajectory	Monitored weekly at Directorate PTL	General Manager's /OPA team	In progress

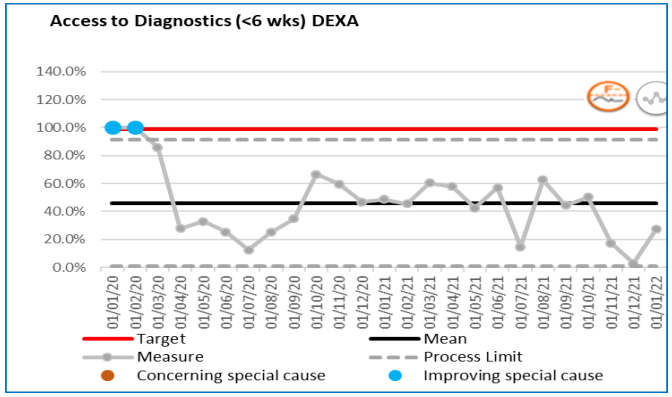
Patient Access – Diagnostics Waiting Times: CQC Responsive



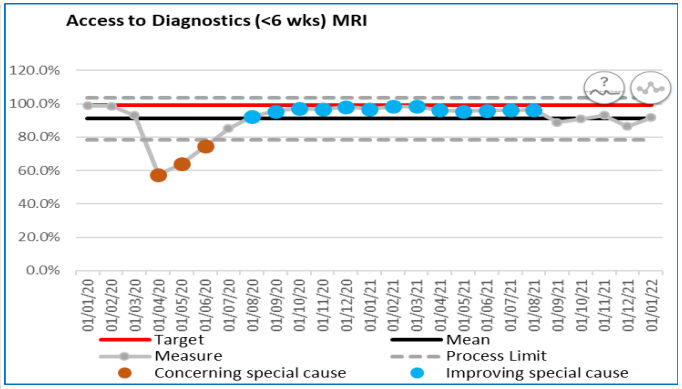
Jan-22
68.6%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Max Limit (Internal)
74.6%
Business Rule
Full Escalation as Hit or Miss > 6 months



Jan-22
31.7%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of a concerning nature and consistently failing the target
Max Limit (Internal)
99%
Business Rule
For Information as Contributor to Overall



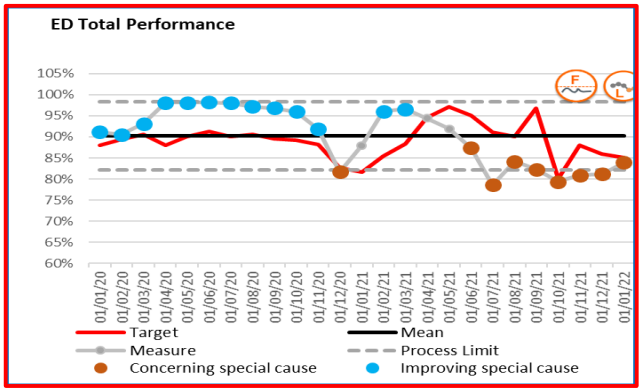
Jan-22
27.2%
Variance / Assurance
Metric is currently experiencing special cause variation of a concerning nature and consistently failing the target
Max Limit (Internal)
99%
Business Rule
For Information as Contributor to Overall



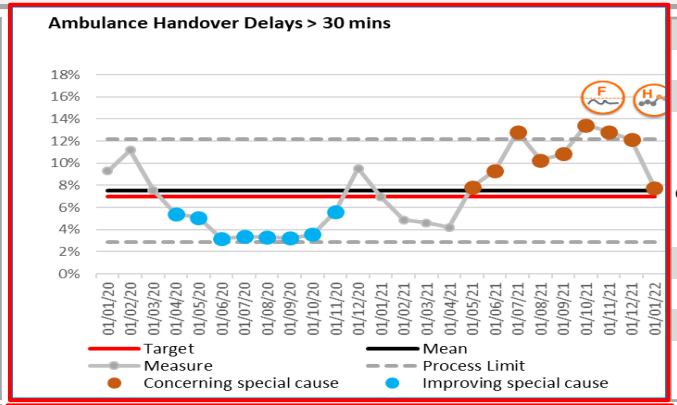
Jan-22
91.7%
Variance / Assurance
Metric is currently experiencing common cause variation and variable achievement of the target
Max Limit (Internal)
99%
Business Rule
For Information as Contributor to Overall

Summary:	Actions:	Assurance & Timescales for Improvement:
Diagnostic Waiting Times: Overall performance is now experiencing common cause variation and variable achievement of the target. This three biggest contributors to this are Echocardiography, DEXA and MRI. **MRI:** is experiencing common cause variation and variable achievement. **Echocardiography:** is experiencing special cause variation of a concerning nature and consistently failing the target largely due to staffing shortages **DEXA:** is in special cause variation of a concerning nature and consistently failing the target largely due to a lack of capacity.	**Echocardiography:** The cardiology team have implemented an improvement plan. **DEXA:** New DEXA in place at TWH and initial activity undertaken but not yet plotted through on trajectory (work in progress). Additional outsourcing agreement with Medway agreed and plotted through. **MRI:** proposal for a second mobile MRI scanner is being developed.	**Echocardiography:** Insourcing has commenced to support the internal recovery plan. Plan is monitored weekly with DCOO. **DEXA:** continues to be outsourced to various providers to maximise capacity which is being supported by an internal recovery plan. Revised operational structure has been implemented. Recovery plan is monitored weekly with DCOO. **MRI:** MRI progress is limited by staffing supply. Procurement process for Managed MRI has been completed and the FBC although approved but the Trust processes, is outstanding with NHSE/I for review. Limited progress can be made until this FBC is approved and contract awarded

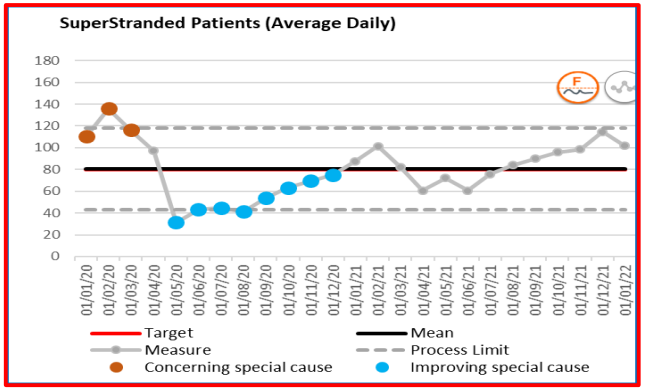
Patient Access – Hospital Flow: CQC: Responsive



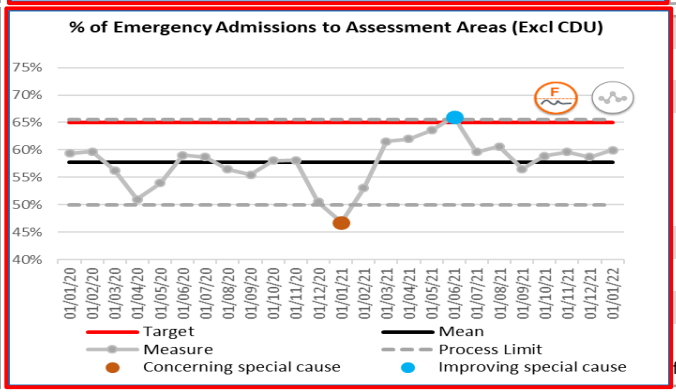
Jan-22
83.9%
Variance / Assurance
Metric is currently experiencing Special Cause variation of a concerning nature and has failed the target for >6 months
Target (Internal)
85%
Business Rule
Full Escalation as Hit or Miss > 6 months



Jan-22
8%
Variance / Assurance
Metric is currently experiencing Special Cause variation of a concerning nature and has failed the target for >6 months
Mas Limit (Internal)
7%
Business Rule
Full Escalation as Hit or Miss > 6 months



Jan-22
102
Variance / Assurance
Metric is currently experiencing Common cause variation and has failed the target for >6 months
Max Limit (Internal)
80
Business Rule
Full Escalation as has failed target for >6 months



Jan-22
59.9%
Variance / Assurance
Metric is currently experiencing Common Cause variation and has failed the target for >6 months
Target
65%
Business Rule
Full Escalation as has failed target for >6 months

Summary:

ED 4hr performance (inc MIU): This indicator continues to experience special cause variation of a concerning nature and has been failed the target for more than six months

Ambulance Handover Delays of >30 minutes is experiencing special cause variation of a concerning nature and has failed the target for more than six months

Super Stranded Patients: is experiencing common cause variation and has failed the target for more than six months

% of Emergency Admissions to Assessment Areas: is experiencing common cause variation but has failed the target for >6 months. SAU emergency admission rates have reduced due to site escalation restricting flow and lack of ability to open 24hours due to staffing constraints. Performance varies depending on escalation and complexity of patients in A&E.

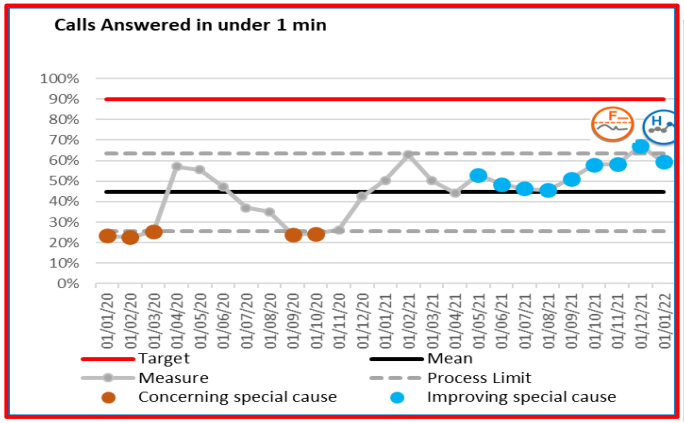
Actions:

ED 4hr performance (inc MIU): The trust has maintained a strong position regionally and nationally and are working on a trajectory to get us to 95% in March. Improved work in SDEC areas will support sustained improvement.
Ambulance handover delays: Work required to embed process for pin entry (currently single point of failure if staff are sick). Looking to have a more robust plan in place. Ambulance handovers undergoing an A3 approach to be really clear of root cause. Reporting of ambulance delays 4 times daily with same day validation.
Super-Stranded Patients : Performance improved this month but this has not been maintained. The main discharge block is domiciliary care for LT packages of care. Slow down in nursing home admissions caused by covid.
% of Emergency Admissions to Assessment Areas: 4 suitable candidates arranged for interview in January in order to resume 24/7 opening hours. 3 x ACP's are training to help improve flow and length of stay.

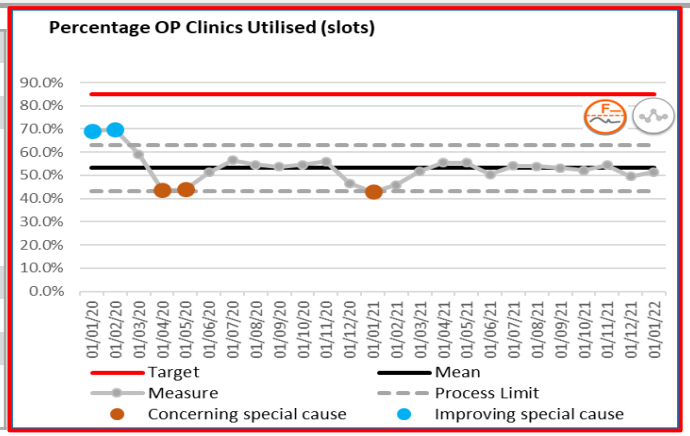
Assurance & Timescales for Improvement:

ED 4hr performance (inc MIU): Continued improvement monthly – internal target of 85% performance in January remains achievable. Although as we deescalate this will add a level of risk. Continue with ED improvement huddles
Ambulance handovers delays: Improvements expected in February. Divisional weekly performance meeting in place
Super stranded patients:
Monthly MADE events to bring an MDT approach. Improved understanding of pathways and introduction of resource packages.
% of Emergency Admissions to Assessment Areas: Follow up clinics will be removed from the department by the end of January 2022 therefore allowing dedicated SDEC capacity between 9-1 daily. Ongoing recruitment programme and introduction of the Physicians Associate role to pull from A&E so patients are not placed in a ward beds before being assessed by the SAU team

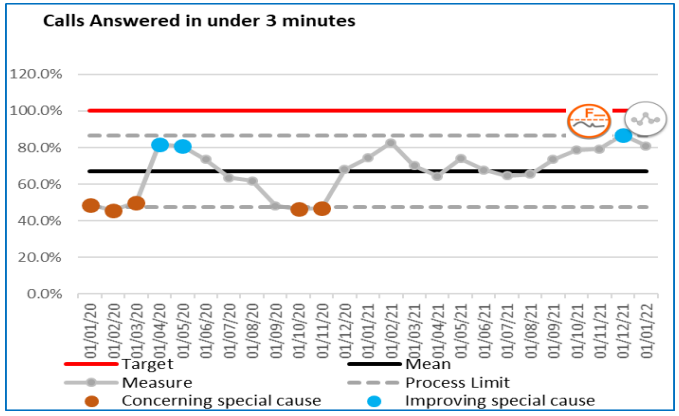
Patient Access – Transformation: Outpatients: CQC: Responsive



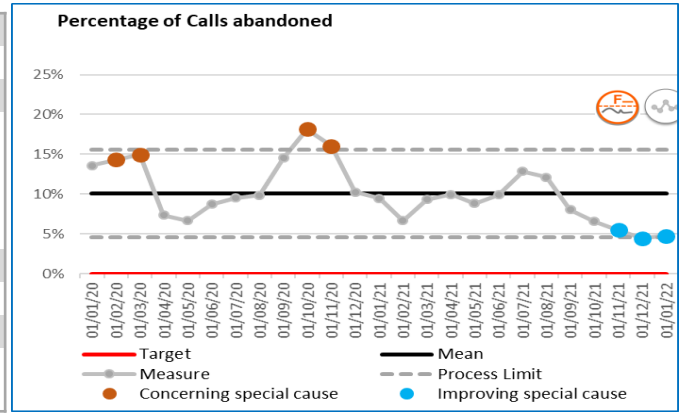
Jan-22
59.4%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target
Target (Internal)
90%
Business Rule
Full Escalation



Jan-22
51.5%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and consistently failing the target
Target (Internal)
85%
Business Rule
Full Escalation



Jan-22
80.9%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and consistently failing the target
Target (Internal)
100%
Business Rule
For Information as linked to Calls <1min



Jan-22
4.8%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and consistently failing the target
Target (Internal)
0%
Business Rule
For Information as linked to Calls <1min

Summary:

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

Outpatient Utilisation: This indicator is now experiencing common cause variation but continues to consistently fail the target

Actions:

Calls Answered: Currently investigating spacing options in which to house call operatives for the outpatient communication centre pilot which will improve this. Continuous monitoring of the CAU's has helped to flag any long waiters.

Outpatient Utilisation: The Clinical System Development Managers have reviewed over 99% of the clinic templates on Allscripts, this includes viewing the individual micro session templates and removing any historic clinics that are no longer required to ensure that utilisation is a true reflection. Once complete the utilisation figures will be correct to do further analysis on how to improve this.

Assurance & Timescales for Improvement:

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

Outpatient Utilisation: Specialty clinic templates are being reviewed to ensure that all templates are correct and have received GM and CD sign off. Further analysis of utilisation is being completed to understand reasonings.

Strategic Theme: Patient Experience

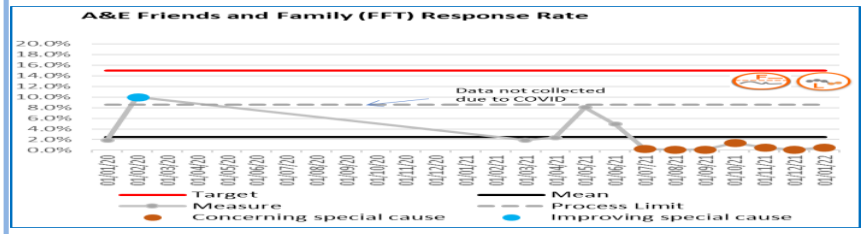
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Caring	Maintain the National FFT positive response rate. Inpatients	95.0%	96.8%	Jan-22	95.0%	98.3%	Dec-21	Driver		P	Note Performance
	Caring	Maintain the National FFT positive response rate. A&E	87.0%	98.7%	Jan-22	87.0%	100.0%	Dec-21	Driver		?	Verbal CMS
	Caring	Maintain the National FFT positive response rate. Maternity	95.0%	100.0%	Jan-22	95.0%	100.0%	Dec-21	Driver		P	Note Performance
	Caring	Maintain the National FFT positive response rate. Outpatients	84.0%	84.9%	Jan-22	84.0%	84.0%	Dec-21	Driver		?	Verbal CMS
Breakthrough Objectives	Caring	Implementation of the Always events which will include a focus on seeing an Increase in response rates across all our FFT domains to meet the national target : Inpatients	25.0%	12.3%	Jan-22	25.0%	8.2%	Dec-21	Driver		F	Full CMS
	Caring	Implementation of the Always events which will include a focus on seeing an Increase in response rates across all our FFT domains to meet the national target A&E	15.0%	0.5%	Jan-22	15.0%	0.1%	Dec-21	Driver	L	F	Full CMS
	Caring	Increase response rates across all our FFT domains to meet the national target: Maternity	25.0%	8.4%	Jan-22	25.0%	2.8%	Dec-21	Driver	L	F	Full CMS
	Caring	Increase response rates across all our FFT domains to meet the national target: Outpatients	20.0%	15.4%	Jan-22	20.0%	15.3%	Dec-21	Driver	L	F	Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Caring	Complaints Rate	3.9	2.3	Jan-22	3.9	1.9	Dec-21	Driver		?	Verbal CMS
	Caring	% complaints responded to within target	75.0%	72.7%	Jan-22	75.0%	85.1%	Dec-21	Driver		?	Verbal CMS
	Caring	% VTE Risk Assessment (one month behind)	95.0%	95.8%	Dec-21	95.0%	96.3%	Nov-21	Driver	L	P	Verbal CMS

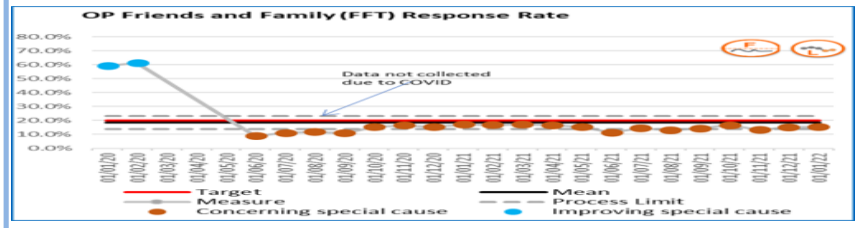
Breakthrough Objective: Counter Measure Summary

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

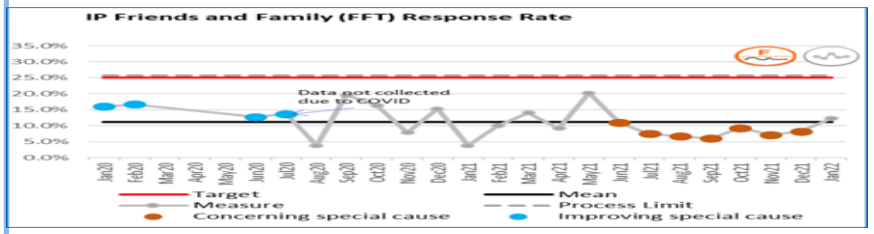
Owner: Joanna Haworth
Metric: FFT Response Rate – A&E, OP, IP, Mat
Desired Trend: 7 consecutive data points above the mean

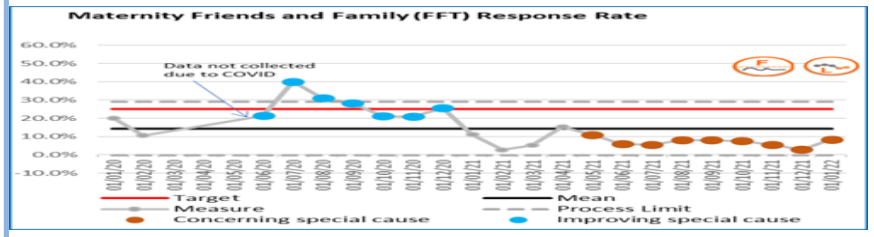
1. Historic Trend Data



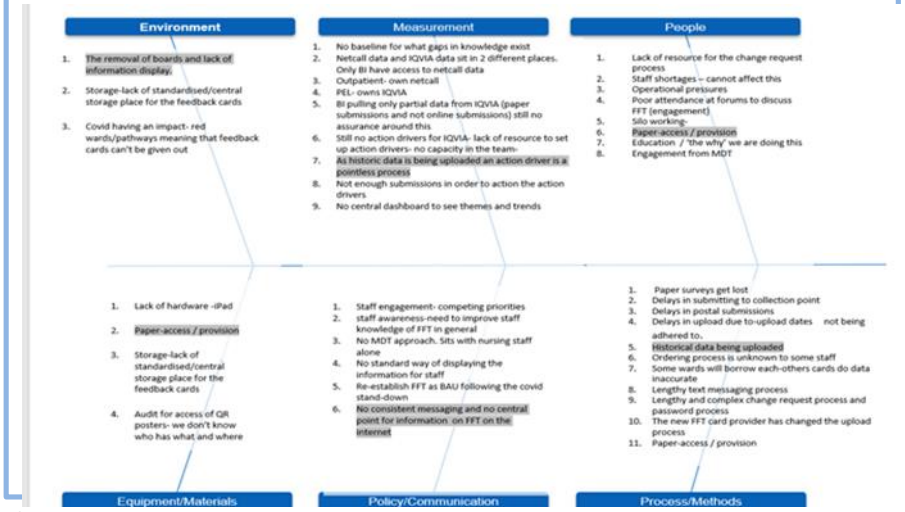


1. Historic Trend Data





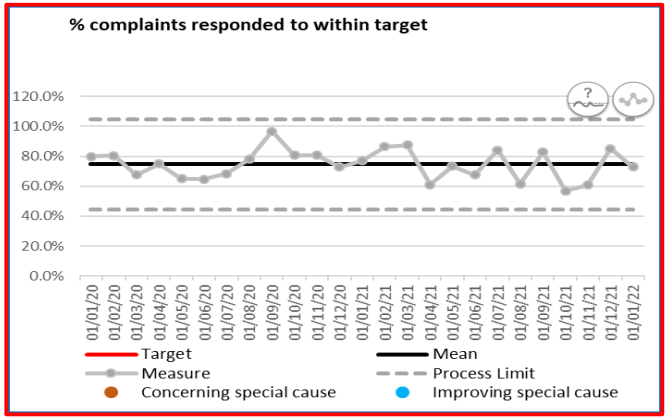
3. Top Contributors



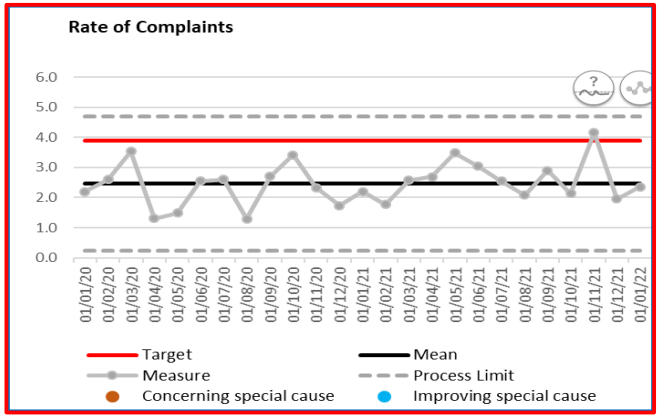
4. Action Plan

Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
Fully understand root causes of engagement and FFT contribution	6 contributors found	Complete the A3 process across all areas to identify root causes & countermeasures	NL/CM/ NH/LB	21/02/22
Staff unaware of how to order / access surveys / feedback	No central point of information on intranet	Work with comms to set up central information page	NL	28/02/22
Lack of engagement for the FFT process	Staff pressures / covid issues	To request feedback from leads / staff to understand their root causes	NL	28/02/22

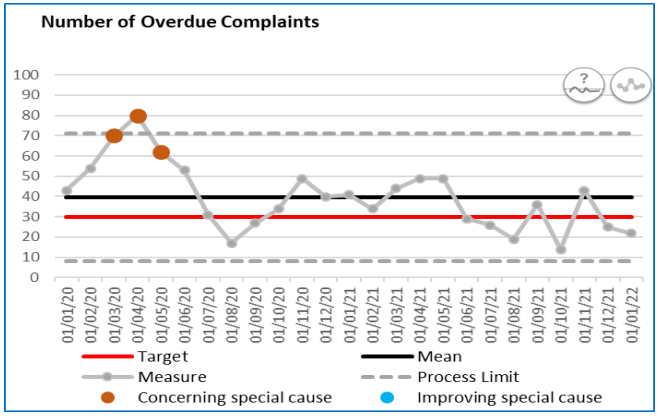
Patient Experience: CQC: Caring (Hit or Miss >6 months)



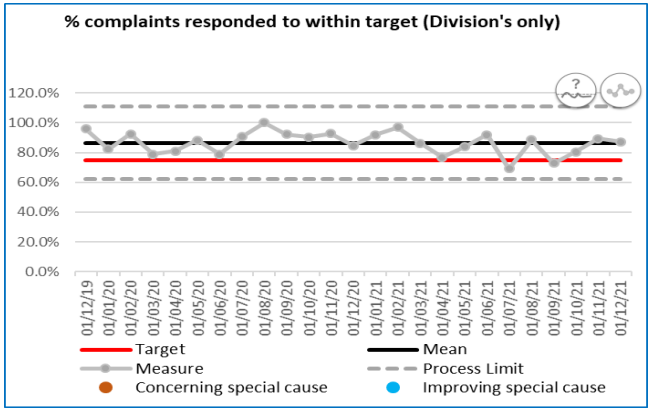
Jan-22
72.7%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Target (Internal)
75%
Business Rule
Full Escalation as Hit or Miss > 6 months



Jan-22
2.35
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Max Limit (Internal)
3.9
Business Rule
Full Escalation as Hit or Miss > 6 months



Jan-22
25
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Max Limit (Internal)
30
Business Rule
For Information as linked to % Complaint Responded



Jan-22
87.3%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Max Limit (Internal)
75%
Business Rule
For Information as linked to % Complaint Responded

Summary:

% Complaints responded to within Target: this indicator continues to experience common cause variation, but has been experiencing variable achievement of the target (Hit & Miss) for more than six months.

Rate of Complaints: This indicator is experiencing common cause variation, but has been experiencing variable achievement of the target (Hit & Miss) for more than six months.

Actions:

% Complaints responded to within Target:

- Director of Quality Governance to explore pathway for signing complaints with Chief Nurse to reduce delays in process
- Regular meetings with divisional teams to monitor progress on all open complaints
- The staffing challenges that have recently been experience are resolving with new staff starting in Jan 22. This will support clearing the backlog of complaints currently sat with the complaint team and improve overall performance

Assurance & Timescales for Improvement:

% Complaints responded to within Target:

- Interim complaints performance (unvalidated) reported to Director of Quality Governance and Chief Nurse mid-month for early escalation
- Due to ongoing recruitment and vacancies in the wider team, and training of new starter, target for February may not be achieved
- An improvement plan is being developed to address current performance and ensure the target is met.

Strategic Theme: Systems

			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Effective	The target is to reduce non-elective bed days to a monthly average of <550 an approx. 10% reduction).	550	573	Jan-22	550	563	Dec-21	Driver			Verbal CMS
Breakthrough Objectives	Effective	The target is to reduce the average non-elective bed days relating to patients with high and very high AEC conditions by 10%	3.90	3.99	Nov-21	3.90	3.94	Oct-21	Driver			Verbal CMS

Strategic Theme: Sustainability

			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Well Led	Delivery of financial plan, including operational delivery of capital investment plan.	0	15	Jan-22	0	7	Dec-21	Driver			Note Performance
Breakthrough Objectives	Well Led	Reduce the amount of money the Trusts spends on premium workforce spend from c.£48m to target level by April 2022: Monthly Agency Spend - £000	1333	2396	Jan-22	1333	2502	Dec-21	Driver			Verbal CMS
Constitutional Standards and Key Metrics (not in SDR)	Well Led	CIP	483	214	Jan-22	483	228	Dec-21	Driver	No SPC	No SPC	
	Well Led	Cash Balance (£k)	25192	22295	Jan-22	25192	32729	Dec-21	Driver			Verbal CMS
	Well Led	Capital Expenditure (£k)	898	2551	Jan-22	898	804	Dec-21	Driver			Verbal CMS

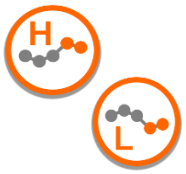
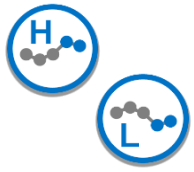
NHS
Maidstone and Tunbridge Wells NHS Trust

Appendices

MTW
exceptional people, outstanding care

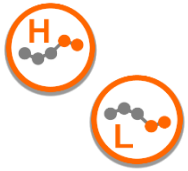
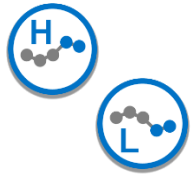
SDR Business Rules Driven by the SPC Icons

Assurance: Failing

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

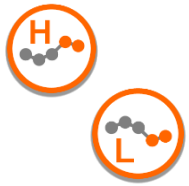
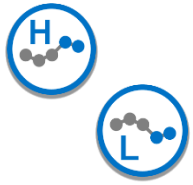
SDR Business Rules Driven by the SPC Icons

Assurance: Hit & Miss

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

SDR Business Rules Driven by the SPC Icons

Assurance: Passing

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

Passing, Failing and Hit & Miss Examples

Metrics that consistently **pass** have:

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

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

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

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

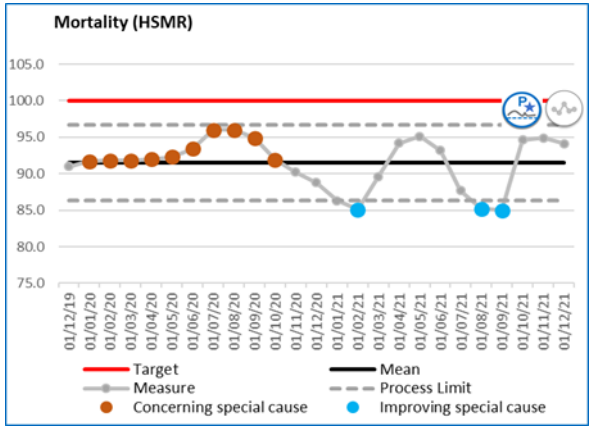
The **target** line **between** the **upper** and **lower** control limit for all metric types

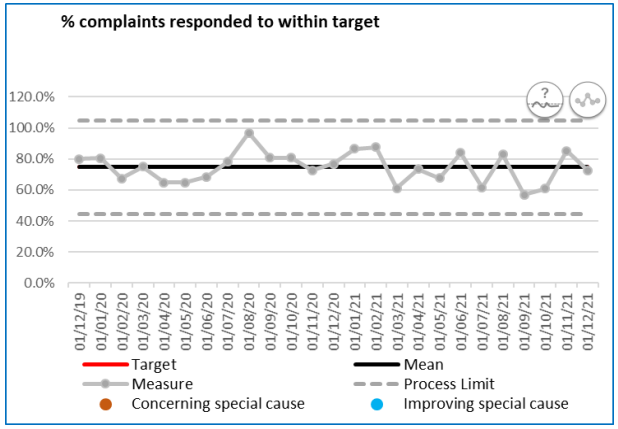
Metrics that consistently **fail** have:

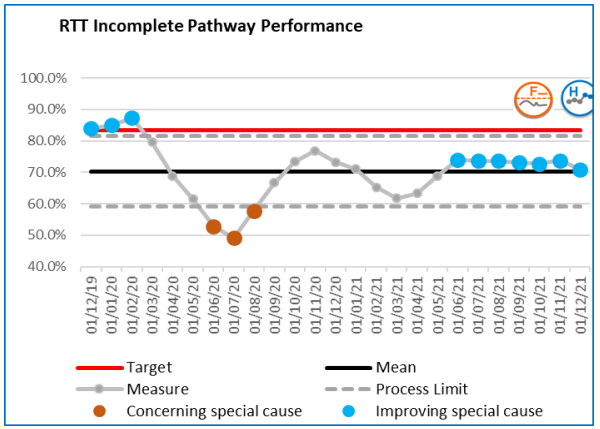
The **lower** control limit **above** the target line for metrics that need to be **below the target**

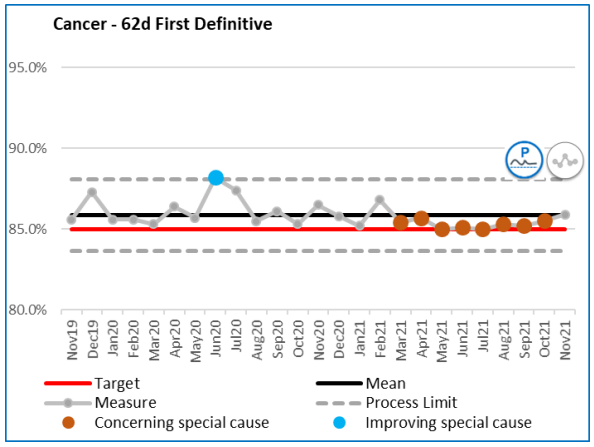
The **upper** control limit **below** the target line for metrics that need to be **above the target**

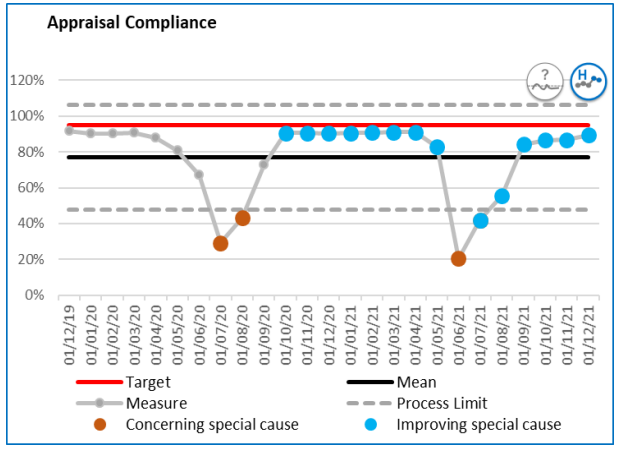
A metric not achieving the target for 6 months or more will be flagged as failing

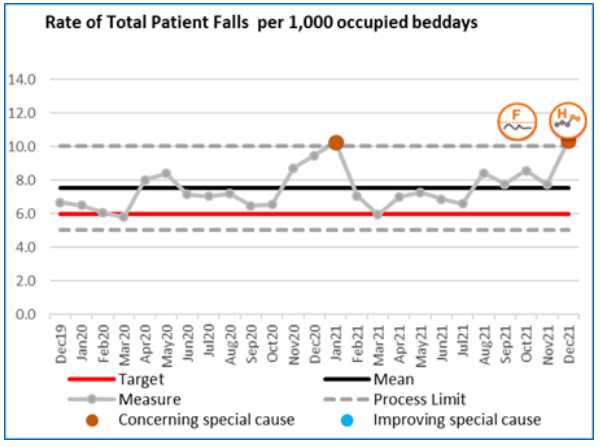












Current and Retired Metrics

Current Metrics

Domain	Metric
Caring	Complaints Rate
Caring	% complaints responded to within target
Caring	% VTE Risk Assessment
Caring	Maintain the National FFT positive response rate. Inpatients
Caring	Maintain the National FFT positive response rate. A&E
Caring	Maintain the National FFT positive response rate. Maternity
Caring	Maintain the National FFT positive response rate. Outpatients
Caring	Implementation of the Always events which will include a focus on seeing an Increase in response rates across all our FFT domains to meet the national target : Inpatients
Caring	Implementation of the Always events which will include a focus on seeing an Increase in response rates across all our FFT domains to meet the national target A&E
Caring	Increase response rates across all our FFT domains to meet the national target: Maternity
Caring	Increase response rates across all our FFT domains to meet the national target: Outpatients
Effective	Transformation: % of Patients Discharged to a PIFU Pathways
Effective	Transformation: CAU Calls answered <1 minute
Effective	Transformation: % OP Clinics Utilised (slots)
Effective	Flow: Ambulance Handover Delays >30mins
Effective	Flow: Super Stranded Patients
Effective	Flow: % of Emergency Admissions into Assessment Areas
Effective	Flow: % of Emergency Admissions that are zero LOS (SDEC)
Effective	The target is to reduce non-elective bed days to a monthly average of <550 an approx. 10% reduction).
Effective	The target is to reduce the average non-elective bed days relating to patients with high and very high AEC conditions by 10%
Responsive	Emergency A&E 4hr Wait
Responsive	% Diagnostics Tests WTimes <6wks
Responsive	Cancer 62 day wait - First Definitive
Responsive	Cancer 62 day wait -PTL
Responsive	We will ensure no patient waits longer than 52 week for treatment by April 2022
Responsive	By April 2022 we will achieve the RTT standard
Responsive	Ensure activity levels for theatres match those pre-Covid - Total Elective
Responsive	Ensure activity levels for outpatients match those pre-Covid - First Outpatients
Responsive	Ensure activity levels for outpatients match those pre-Covid - Follow Up Outpatients
Responsive	Ensure activity levels for diagnostics match those pre-Covid - MRI
Responsive	Ensure activity levels for diagnostics match those pre-Covid - CT
Responsive	Ensure activity levels for diagnostics match those pre-Covid - NOUS
Responsive	Ensure activity levels for outpatients match those pre-Covid - Colonoscopy
Responsive	Ensure activity levels for outpatients match those pre-Covid - Flexi Sigmoidoscopy
Responsive	Ensure activity levels for outpatients match those pre-Covid - Gastroscopy

Retired Metrics

Domain	Metric
Caring	Admin and clerical office space in (sqm)
Caring	Energy cost per staff
Caring	Footprint devoted to clinical care vs non clinical care
Caring	Single Sex Accommodation Breaches
Caring	Staff occupancy per m2
Caring	Utilised and unutilised space ratio
Effective	% Total Readmissions
Effective	Average LOS Non-Elective
Effective	Elective Readmissions < 30 Days
Effective	Non-Elective Readmissions <30 days
Effective	OP Follow UP DNAs
Effective	OP New DNAs
Effective	Outpatient Cancellations < 6 weeks
Effective	Outpatient Hospital Cancellation
Effective	Percentage of Calls abandoned
Effective	Percentage of Virtual OP Appointments
Effective	Percentage OP Clinics Utilised (slots)
Effective	Stroke: Best Practice (BPT) Overall %
Effective	Theatre Utilisation
Responsive	28 day Target
Responsive	Average for new appointment
Responsive	Cancer - 31 Day
Responsive	Referrals to ED from NHS 111
Responsive	Size of backlog

Current and Retired Metrics

Current Metrics	
Domain	**Metric**
Safe	Standardised Mortality HSMR
Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays
Safe	IC - Number of Hospital acquired MRSA
Safe	IC- Hospital Acquired Covid
Safe	Number of Never Events
Safe	Number of New SIs in month
Safe	Overall Safe staffing fill rate
Safe	A reduction in harm (target to be determined) by March 2022. - Incidents resulting in Harm
Safe	Reduction in slips, trips and falls (Rate per 1,000 Occupied Beddays)
Well Led	Vacancy Rate (%)
Well Led	Sickness Absence
Well Led	Appraisal Completeness
Well Led	Statutory and Mandatory Training
Well Led	CIP Savings (£k)
Well Led	Cash Balance (£k)
Well Led	Capital Expenditure (£k)
Well Led	% of staff that "Recommended MTW as a good place to work" taken from Quarterly Climate Surveys
Well Led	Delivery of financial plan, including operational delivery of capital investment plan.
Well Led	Increase Climate Survey response rates to provide a larger sample base to be able to assess those that recommend MTW as a place to work.
Well Led	Reduce the amount of money the Trusts spends on premium workforce spend from c.£48m to target level by April 2022: Monthly Agency Spend - £000

Retired Metrics	
Domain	**Metric**
Safe	Infection Control - Rate of Hospital E. Coli Bacteraemia
Safe	Rate of Hospital Acquired Pressure Ulcers per 1,000 admissions
Safe	Sickness Rate - Covid
Well Led	Climate Survey - Percentage of staff who feel able to cope with the demands that are being placed on them at the moment
Well Led	Climate Survey - Percentage of staff who feel fully supported in their role
Well Led	Climate Survey - Percentage of staff who feel the Trust has a genuine concern for their safety and wellbeing
Well Led	Covid Positive - number of patients
Well Led	Elective Spells in London Trusts from West Kent
Well Led	Equality, Diversity and Inclusion reducing inequalities metrics / dashboard
Well Led	Health and Wellbeing: How many calls received
Well Led	Health and Wellbeing: What percentage of Calls related to Mental Health Issues
Well Led	Number of advanced practitioners
Well Led	Number of specialist services
Well Led	Nursing vacancies
Well Led	Percentage of Trust policies within review date
Well Led	Research grants (£)
Well Led	Service contribution by division
Well Led	Staff Friends and Family % recommended care
Well Led	Staff Friends and Family % recommended work
Well Led	Turnover
Well Led	Use of Agency (WTE)
Well Led	Use of Financial Resources

Year to Date Financial Position

- The Trust has generated a year to date surplus of £0.1m which is £0.1m favourable to plan.
- The Trust delivered a breakeven position in January which was on plan.
- In line with NHSE/I guidance additional income (£5.3m) has been included in the position to offset additional costs for PCR swabbing, Rapid testing and vaccination centre. The Trust received £3m to cover the full costs incurred in quarter one and two.
- The key year to date variances is as follows:
  - **Favourable Variances**
    - Non-recurrent benefits / release of contingency (£6.1m)
    - Independent Sector usage (£4.8m),
    - Clinical supplies and drugs (£1.2m) due to lower activity than funded levels
    - Pay underspends (£0.9m
    - Pathology trade income (£0.7m)
    - Elective recovery fund overperformance (£0.6m).
  - **Adverse Variances**
    - Re-phasing of top up and non-recurrent income support (£6.1m)
    - Expenditure incurred relating to Kent and Medway Medical school (£5.8m)
    - CIP slippage to internal target (£2.4m)

Current Months Financial Position

- The key current month variances are as follows:
  - Income overperformed by £0.5m in January. Excluding income overperformance associated with donated assets (offset by technical adjustment) and COVID swabbing (offset by increase in expenditure) the Trust was £0.3m favourable to plan. The main areas favourable to plan were income from patient care activities (£0.2m) associated with additional non-elective growth support and £0.1m overperformance within other operating income mainly associated with overperformance within R&D and pathology trade income.
  - Expenditure budgets overspent by £0.4m. Pay budgets overspent by £1.2m which was partly offset by non-pay underspends (£0.8m). The main pressures in pay (£1.2m) were mainly associated with the increase in bank rates (£0.8m increase in spend between months with only a small increase in wte (7wte)). The main other pressure in month was due to an increase in the level of doubtful debt increased by £0.3m between months (mainly within Pathology and Sexual Health), these pressures were partly offset by £1.3m underspend associated with Independent Sector usage.

Cashflow

- The closing cash balance for January was £22.3m compared to the plan cash balance of £14.5m. The variance is primarily linked to the delay within the capital programme; as business cases have been approved orders are now being raised.
- The capital programme for the year is currently c.£23m; the majority of the capital spend with the cash flow forecast is within the last two months c.£18.2m. The balance sheet is assuming a reduction in capital creditors carried forward from 2020/21 of c£6m to closing creditors for 2021/22 of £2m within the cash flow - therefore the capital cash spend overall in the cash flow is c£27m.
- Also forecast to be paid in March is the PDC dividend £1.4m and repayment of capital loans and interest £0.6m; all of these repayments are made twice a year once in September and again in March.

Capital Position

- The Trust's capital plan agreed with the ICS/STP for 2021/22 was £10.57m comprising of net internal funding £8.9m, PFI lifecycle per Project model of £1.2m and donated assets of £0.4m. The Plan includes;
  - **Estates:** The Backlog schemes include contractual commitments from 20/21 relating to enabling works for CT Simulator, Pharmacy Robot, MRI, Interventional Radiology and Mammography equipment. Development schemes include the Annex Modular Development,

KMMS enabling work, Paeds ED modular build and Oncology Outpatients. The new projects have been funded from a combination of the Backlog capital plan and planned equipment being subsequently funded from National & System resources.
    - **ICT**: The EPR costs relate to contractual commitments. Other ICT schemes include Network upgrades, over-age laptops/PCs, switches, hubs and servers.
    - **Equipment:** The Linac machine was delivered to the Canterbury site at the end of March, this year's costs include ancillary equipment and commissioning. Trustwide equipment has been prioritised and some emergency cases have been approved.

- In addition to the Plan, an Emergency System PDC bid has been agreed with the ICS/STP and made to NHSE/I for £1.9m; this includes £1.1m for Linac enabling and ancillary equipment, as well as funding for additional essential equipment. The ICS has also agreed to finance £411k of Diagnostic Equipment and £669k of Digital Diagnostics for Radiology and Pathology IT from the National Diagnostic Fund, over which they have discretion. The Trust has received confirmation of national NHSE funding for 2 core Linacs (£3.73m) in 21/22, to be delivered by 31st March, Imaging and Endoscopy Academies (£470k), digital maternity fund (£263k) and cyber security (£250k). The national Target Investment Fund (TIF) bids for £2.5m have been approved for schemes including a SPECT CT and Dexa scanner for Radiology, as well as IT equipment including Audio Visual, iPro and Video Consultation Platform. The Trust has also been offered additional capital resource arising from overall K&M capital slippage for a total of £3.2m: this is being used to support £1.2m equipment for the Barn Theatre, £1m for patient monitoring equipment and defibrillators, as well as other various medical and non-medical equipment and IT hardware. £1.032m of this resource is anticipated as additional PDC from a varied MOU with EKHUFT Trust, to enable us to bring forward schemes from 2022/23 on the basis of surrendering the equivalent funding to the system in 2022/23. The remaining system slippage funding is capital resource only, not PDC, so the Trust requires to finance the cash for the investments.
- The forecast outturn including all the additional funds is therefore £23.77m, including donated assets and PFI Lifecycle.
- There are two other national digital funding bids that have been agreed in Month 10: 1) digital maternity fund for £263k and 2) cyber security £250k. The Barn Theatre development at Maidstone to provide additional elective recovery capacity is subject to a full business case being produced, an early version of which has been shared with NHSEI.
- The year to date capital spend is £6.6m compared to the original Plan of £7.2m, prior to the substantial additional funding that has been subsequently agreed from ICS or national sources, most of which has been agreed in the third quarter of the year. The majority of the spend to date relates to: Estates - the completion of the MRI and Interventional Radiology installation, ongoing works to The Annex, KMMS enabling and Paeds ED; Equipment - the completion of the Canterbury Linac and other various equipment; IT - the ongoing EPR project and hardware devices.
- The outturn delivery of capital schemes has been risk rated using the RAG rating system. Most schemes are anticipated to deliver by year-end, but there are some areas, particularly relating to Estates projects and final quarter National/System funding, where there are risks on delivery. These are noted in the Capital Programme tab narrative.

Year and Forecast

- The Trust is forecasting to deliver the planned breakeven position however the Trust has the following key risk:
    - The forecast assumes the lease for the Kent and Medway Medical School will be agreed which will result in expenditure incurred to be recharged to the lessor therefore improving the financial position.

Maidstone and Tunbridge Wells NHS Trust

Finance Report

Month 10
2021/22

Maidstone and Tunbridge Wells NHS Trust

Trust Board - Finance Report for January 2022

Contents

1. Dashboard

January 2021/22

	Current Month			Year to Date			Annual Forecast / Plan		
	Actual £m	*Plan* £m	*Variance* £m	*Actual* £m	*Plan* £m	*Variance* £m	*Forecast* £m	*Plan* £m	*Variance* £m
Income	52.4	51.9	0.5	502.4	508.8	(6.4)	605.3	612.0	(6.8)
Expenditure	(49.4)	(49.0)	(0.4)	(474.9)	(481.5)	6.6	(572.3)	(579.0)	6.8
EBITDA (Income less Expenditure)	2.9	2.9	0.1	27.5	27.2	0.2	33.0	33.0	0.0
Financing Costs	(2.8)	(2.8)	0.0	(27.7)	(27.8)	0.1	(34.2)	(34.2)	0.0
Technical Adjustments	(0.1)	(0.0)	(0.1)	0.3	0.6	(0.3)	1.2	1.2	(0.0)
Net Surplus / Deficit (Incl Top Up funding support)	**0.0**	**(0.0)**	**0.0**	**0.1**	**(0.0)**	**0.1**	**0.0**	**(0.0)**	**0.0**
Cash Balance	22.3	25.2	(2.9)	22.3	25.2	(2.9)	1.5	1.5	0.0
Capital Expenditure (Incl Donated Assets)	2.6	0.9	(1.7)	6.6	8.1	(1.5)	1.6	23.4	21.8

Summary Current Month:

- The Trust was on plan generating a breakeven position.
- Income overperformed by £0.5m in January. Excluding income overperformance associated with donated assets (offset by technical adjustment) and COVID swabbing (offset by increase in expenditure) the Trust was £0.3m favourable to plan. The main areas favourable to plan were income from patient care activities (£0.2m) associated with additional non elective growth support and £0.1m overperformance within other operating income mainly associated with overperformance within R&D and pathology trade income.
- Expenditure budgets overspent by £0.4m. Pay budgets overspent by £1.2m which was partly offset by non pay underspends (£0.8m). The main pressures in pay (£1.2m) were mainly associated with the increase in bank rates (£0.8m increase in spend between months with only a small increase in wte (7wte)). The main other pressure in month was due to a increase in the level of doubtful debt increased by £0.3m between months (mainly within Pathology and Sexual Health), these pressures were partly offset by £1.3m underspend associated with Independent Sector usage.
- In line with NHSE/I guidance additional income (£0.6m) has been included in the month 10 position to offset additional costs for PCR swabbing, Rapid testing and vaccination centre.

Year to date overview:

- The Trust is £0.1m favourable to plan generating a Surplus of £0.1m.
- The Trusts key variances to the plan are:

Favourable Variances:

- Non recurrent benefits / release of contingency (£6.1m), Independent Sector usage (£4.8m), Pay underspends (£0.9m), underspends within clinical supplies and drugs (£1.2m) due to lower activity than funded levels, Elective recovery fund (£0.6m) and Pathology trade income overperformance (£0.7m).

Adverse Variances:

- Rephasing of top up and non recurrent income support (£6.1m), expenditure incurred relating to Kent and Medway Medical school (£5.8m) and CIP slippage to internal plan (£2.4m) .
- In line with NHSE/I guidance additional income (£5.3m) has been included in the position to offset additional costs for PCR swabbing, Rapid testing and vaccination centre. The Trust received the funding in full for quarter 1 and 2 (£3.1m) and is expected to receive the outstanding amount in full.

CIP (Savings)

- The Trust has a external (NHSE/I) savings target for 2021/22 of £3.7m which consists of £0.8m in H1 (April to September) and £2.9m in H2 (October to March 22).
- Year to date the Trust has identified savings of £2.1m which is £0.6m adverse to plan.

2. COVID 19 Expenditure and Income Impact

2021/22 Summary of Cost Reimbursement

Expenditure

Breakdown by Allowable Cost Type	£000s
Segregation of patient pathways	5,569
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	477
Backfill for higher sickness absence	2,064
Remote working for non-patient activities	18
Existing workforce additional shifts to meet increased demand	97
PPE associated costs	12
Additional Sick pay at full pay for all staff policy - full pay for COVID-related staff absence	16
Other -Not detailed on NHSI return	1,067
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	3,180
Long COVID	743
Total 'In Envelope'	**13,243**
COVID-19 virus testing- rt-PCR virus testing	4,693
COVID-19 - Vaccination Programme - Provider/ Hospital hubs	82
COVID-19 virus testing - Rapid / point of care testing	483
COVID-19 virus testing (NHS laboratories)	0
NIHR SIREN testing - research staff costs	11
NIHR SIREN testing - antibody testing only	7
COVID-19 - International quarantine costs	8
Total 'Out of Enevelope'	**5,284**
Total Expenditure (£000s):	**18,527**

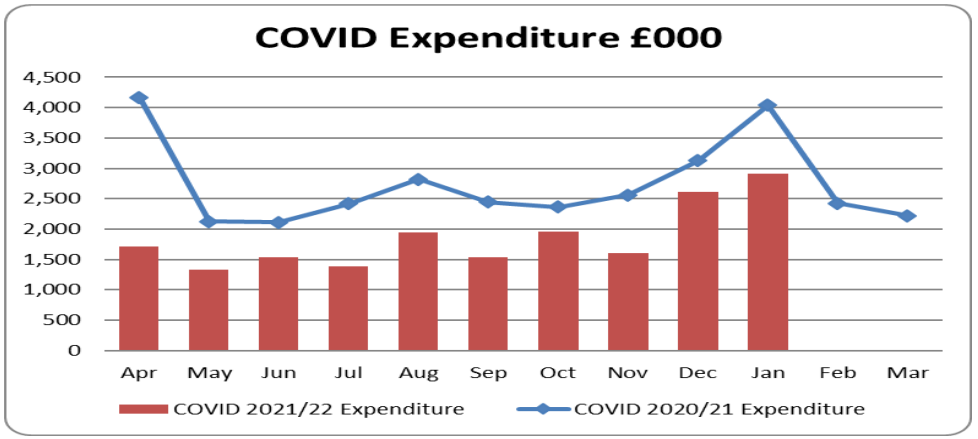
Income

Free staff car parking	474
Catering - Income loss	23
Total Income	**497**
Grand Total (£000s):	**19,024**

Commentary:
The Trust has identified the year to date financial impact relating to COVID to be £19m.

The main cost includes costs associated with virus testing , staff welfare such as providing meals, additional shifts required in ED to support patient flow and escalation of Edith Cavell and Peale Wards and the expansion of ITU. The increase in spend in December is due to the increase in bank and agency staff to cover sickness / isolation

The Trust has included £5.3m income in the position to offset the costs for 'Out of envelope' which include COVID swabbing , rapid testing and vaccination programme. NHSE/I has paid in full the costs identified relating to quarter 1 and 2, the remainder is expected to be confirmed over the next few months.



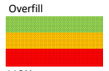
Jan-22		DAY				NIGHT				TEMPORARY STAFFING		Bank / Agency Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand Unfilled -RM/N (number of shifts)	Overall Care Hours per pt day	Nurse Sensitive Indicators				Financial review		
Hospital Site name	Health Roster Name	Average fill rate 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					FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Stroke Unit (M) - NK551	81.0%	115.4%	-	100.0%	97.2%	133.6%	-	100.0%	36.9%	19.4%	342	22.54	128	6.6	11.9%	71.4%	14	4	275,288	290,317	(15,029)
MAIDSTONE	Cornwallis (M) - NS959	73.7%	70.9%	-	100.0%	102.5%	166.9%	-	-	57.5%	33.6%	158	11.19	43	6.1	0.0%	0.0%	2	0	0	95,764	(95,764)
MAIDSTONE	Culpepper Ward (M) - NS551	123.9%	75.4%	-	-	143.1%	174.3%	-	-	60.0%	37.6%	108	7.73	33	5.9	13.5%	100.0%	3	0	111,333	121,723	(10,390)
MAIDSTONE	John Day Respiratory Ward (M) - NT151	91.2%	101.9%	-	-	97.1%	145.2%	-	-	38.8%	29.2%	196	13.12	82	6.0	6.7%	100.0%	3	0	145,571	166,594	(21,023)
MAIDSTONE	Intensive Care (M) - NA251	116.2%	120.2%	-	-	88.3%	95.2%	-	-	15.6%	1.0%	150	9.19	44	46.4	500.0%	100.0%	0	0	252,851	235,683	17,168
MAIDSTONE	Pye Oliver (Medical) - NK259	96.4%	90.1%	-	-	115.1%	108.6%	-	-	35.4%	45.2%	152	9.66	31	6.2	81.4%	82.9%	5	4	123,301	145,422	(22,121)
MAIDSTONE	Whatman Ward - NK959	81.1%	107.7%	-	-	109.9%	216.1%	-	-	73.5%	47.7%	232	16.73	80	6.3	4.0%	100.0%	6	1	91,695	127,652	(35,957)
MAIDSTONE	Lord North Ward (M) - NF651	78.6%	90.0%	-	100.0%	83.8%	100.0%	-	-	8.8%	7.1%	52	3.87	26	9.4	26.7%	100.0%	1	0	112,255	101,049	11,206
MAIDSTONE	Mercer Ward (M) - NJ251	80.4%	79.1%	-	100.0%	107.7%	109.7%	-	-	35.0%	37.7%	130	9.16	38	5.7	4.3%	100.0%	4	0	109,816	118,585	(8,769)
MAIDSTONE	Edith Cavell - NS459	94.5%	85.3%	-	100.0%	93.7%	91.9%	-	-	44.9%	26.7%	125	8.85	35	6.3	14.3%	100.0%	7	1	118,411	102,585	15,826
MAIDSTONE	Acute Medical Unit (M) - NG551	91.0%	92.4%	-	-	129.3%	225.8%	-	-	34.4%	26.1%	158	11.06	67	9.5	0.0%	100.0%	3	0	163,153	168,485	(5,332)
TWH	Ward 22 (TW) - NG332	83.7%	89.4%	-	-	160.2%	99.9%	-	-	60.5%	51.4%	330	23.91	148	6.2	20.5%	77.8%	13	0	130,587	160,009	(29,422)
TWH	Coronary Care Unit (TW) - NP301	76.4%	75.7%	-	-	75.1%	-	-	-	30.0%	21.3%	108	6.57	66	10.5	128.0%	96.9%	0	0	69,560	63,768	5,792
TWH	Ward 33 (Gynae) (TW) - ND302	89.7%	83.9%	-	-	85.9%	96.0%	-	-	34.4%	3.0%	81	5.24	27	5.9	42.2%	100.0%	0	0	114,771	115,026	(255)
TWH	Intensive Care (TW) - NA201	105.4%	95.8%	-	-	99.2%	100.0%	-	-	15.2%	0.0%	162	10.71	16	36.8	50.0%	100.0%	1	1	383,197	368,338	14,859
TWH	Acute Medical Unit (TW) - NA901	80.9%	50.6%	-	100.0%	79.4%	75.8%	-	100.0%	20.9%	24.1%	233	17.31	150	7.9	2.4%	100.0%	12	0	218,161	203,451	14,710
TWH	Surgical Assessment Unit (TW) - NE701	92.9%	144.0%	-	-	24.2%	41.6%	-	-	24.5%	17.9%	89	6.39	53	32.2	3.7%	100.0%	0	0	71,341	52,625	18,716
TWH	Ward 32 (TW) - NG130	86.5%	67.1%	-	100.0%	69.4%	91.3%	-	100.0%	22.1%	21.4%	112	7.79	53	7.8	37.2%	100.0%	5	0	141,037	114,309	26,728
TWH	Ward 10 (TW) - NG131	94.8%	94.0%	-	100.0%	88.9%	173.8%	-	100.0%	62.8%	38.5%	265	17.56	102	6.4	0.0%	0.0%	6	0	137,398	159,576	(22,178)
TWH	Ward 11 (TW) Winter Escalation 2019 - NG144	68.2%	78.1%	-	100.0%	104.4%	106.5%	-	-	74.1%	27.9%	272	17.70	98	5.6	0.0%	0.0%	18	0	0	129,507	(129,507)
TWH	Ward 12 (TW) - NG132	78.8%	99.6%	-	100.0%	107.6%	91.7%	-	-	40.1%	29.0%	211	12.99	108	6.0	0.0%	0.0%	11	1	139,447	151,354	(11,907)
TWH	Ward 20 (TW) - NG230	85.4%	102.4%	-	-	149.5%	110.4%	-	-	39.2%	37.4%	234	16.25	111	7.6	0.0%	0.0%	13	1	185,628	182,866	2,762
TWH	Ward 21 (TW) - NG231	76.4%	111.6%	-	100.0%	87.1%	114.5%	-	-	29.9%	31.3%	181	12.01	102	6.6	6.0%	100.0%	7	0	147,063	139,112	7,951
TWH	Ward 2 (TW) - NG442	57.8%	89.4%	-	100.0%	106.4%	138.7%	-	-	37.2%	39.8%	228	14.09	138	6.4	91.7%	95.5%	21	1	162,959	167,727	(4,768)
TWH	Ward 30 (TW) - NG330	83.4%	90.9%	-	100.0%	98.8%	115.1%	-	-	32.2%	19.1%	160	10.26	62	5.8	11.5%	100.0%	7	2	125,392	150,462	(25,070)
TWH	Ward 31 (TW) - NG331	80.0%	94.5%	-	100.0%	71.0%	147.5%	-	-	38.5%	12.0%	179	11.67	80	6.4	40.9%	94.4%	7	2	138,962	168,228	(29,266)
Crowborough	Crowborough Birth Centre (CBC) - NP775	56.9%	87.7%	-	-	0.0%	0.0%	-	-	2.0%	0.0%	3	0.08	0						103,021	49,293	53,728
TWH	Midwifery (multiple rosters)	76.4%	54.0%	-	-	85.5%	98.8%	-	-	16.3%	1.2%	778	43.13	147	14.9	8.4%	100.0%	1	0	726,750	834,505	(107,755)
TWH	Hedgehog Ward (TW) - ND702	111.2%	158.3%	-	-	126.7%	914.5%	-	-	62.8%	70.4%	288	19.96	80	13.7	5.7%	88.2%	1	0	139,456	215,074	(75,618)
MAIDSTONE	Maidstone Birth Centre - NP751	103.8%	98.1%	-	-	96.5%	93.5%	-	-	19.0%	0.0%	34	2.03	1	67.7	82.4%	100.0%	0	0	72,115	83,154	(11,039)
TWH	SCBU (TW) - NA102	85.4%	219.1%	-	100.0%	91.6%	-	-	-	25.7%	0.0%	144	8.18	5	17.0	0.0%	0.0%	0	0	177,929	191,327	(13,398)
TWH	Short Stay Surgical Unit (TW) - NE901	75.5%	56.1%	-	100.0%	71.0%	100.0%	-	-	8.0%	17.4%	29	2.06	9	12.1	19.7%	100.0%	2	0	75,794	71,470	4,324
MAIDSTONE	Accident & Emergency (M) - NA351	95.4%	72.3%	-	100.0%	101.7%	90.4%	-	-	48.2%	29.9%	493	34.84	73		0.7%	100.0%	2	0	283,070	462,362	(179,292)
TWH	Accident & Emergency (TW) - NA301	88.4%	73.7%	-	100.0%	90.4%	91.0%	-	100.0%	48.2%	44.6%	623	43.88	133		0.4%	96.7%	8	0	389,304	544,480	(155,176)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	88.7%	86.4%	-	100.0%	93.5%	-	-	-	18.7%	0.0%	31	2.18	5	13.3	22.5%	100.0%	2	0	67,488	54,051	13,437
MAIDSTONE	Peale Ward COVID - ND451	86.4%	81.0%	-	100.0%	107.3%	100.0%	-	-	22.7%	54.5%	115	7.94	66	8.8	0	0	4	0	110,447	105,139	5,308
MAIDSTONE	Foster Clark - NS251	93.0%	90.7%	-	100.0%	95.2%	90.3%	-	-	12.6%	13.8%	65	4.46	31	6.9	28.2	97	3	0	90,001	143,313	(53,312)
MAIDSTONE	Short Stay Surgical Unit (M) - NE751	98.1%	97.6%	-	-	88.1%	-	-	-	14.4%	12.9%	32	1.78	7	22.2	14.9	100	0	0	63,685	54,676	9,009
MAIDSTONE	Short Stay Surgery Unit (M) - NE959	-	-	-	-	-	-	-	-	No Hours	No hours	No Demand	No Demand	No Demand		0	0			0	1,338	(1,338)

Total Established Wards		**5,968,237**	**6,810,399**	**(842,162)**
Additional Capacity beds	Cath Labs	50,670	43,266	7,404
	Chaucer	0	0	0
	Foster Clarke Winter Escalation 20	0	0	0
Other associated nursing costs		5,026,116	5,053,965	-27,759
		11,045,023	**11,907,631**	**(862,518)**

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%

Exceptional People, Outstanding Care

The Future of the Strategy Deployment Process

MTW

NHS
Maidstone and Tunbridge Wells
NHS Trust

Progress to Date

MTW

NHS
Maidstone and Tunbridge Wells NHS Trust

Exceptional People Outstanding Care Improvement Programme

Strategy Deployment	Continuous Improvement Team	Capability Building	Patient First Improvement System (PFIS)	Improvement Projects
*Identifying **a number of strategic priorities** and **cascading** these through the organisation*	*Ensuring structured **accountability, support and a consistent approach** for improvement*	***Developing capability** improvement across the organisation underpinned by Lean*	*Developing **management-level capabilities** and **standard systems** for managing improvement across the organisation*	*Identifying **specific improvement initiatives** based on selected processes or pathways*

Achievements to Date

Within the last year we have:

- Agreed strategic vision for the Trust, supported by six strategic themes that describe and define what success would look like
- Completed strategic A3 Thinking process on each strategic theme and identified the breakthrough objective in each theme that will provide the biggest contribution to moving us towards our vision
- Identified 8 corporate projects; multi-divisional projects that support the delivery of our strategic themes and vision
- All underpinned by our strategic initiatives that support multiple strategic themes in moving forward.
- As part of the Exceptional Leaders programme, ensured that the leadership behaviours we focus on are aligned with leading continuous improvement
- Supported the inclusion of coaching approaches and methodologies in Exceptional Leaders that underpin the SDR approach.

Achievements to Date (2)

- Trained a significant cohort of senior and middle managers in the components of the strategy deployment process, but also their leadership role in the process.
- Led by the Strategy, Planning and Partnerships team, supported Divisions to work through the “catchball” process
- Divisions have agreed scorecards of priority metrics and projects that link back to the Trust’s strategic themes
- Trained a cohort of staff who will lead divisional priority work in the A3 Thinking process
- Made significant progress in completing the Divisional priority A3 Thinking work for each metric – although not completed
- Commenced the Divisional Strategy Deployment Reviews with each clinical division
- Led by the Business Intelligence team, redesigned the Trust’s Integrated Performance Report around the six strategic themes, and incorporated the strategy deployment process into the approach to reporting

Achievements to Date (3)

- Appointed a new Director of Improvement and Delivery, as well as a new Head of PMO and a new Head of Continuous Improvement
- Begun the process of redesigning the Improvement and Delivery team to meet the requirements of the Strategy Deployment process, as well as enhancing our project management methodologies
- Worked continuously with our partners at University Hospitals Sussex NHS FT (UHSx) who supported and helped train our teams.
- Observed both the training of staff and the various processes in operation at UHSx – who have also provided documentation and training materials for us to utilise and adapt as necessary
- Begun preparations for the next phases of the programme

The Future – Exceptional People, Outstanding Care Improvement Programme

MTW

NHS
Maidstone and Tunbridge Wells NHS Trust

Exceptional People Outstanding Care Improvement Programme

Strategy Deployment	Continuous Improvement Team	Capability Building	Patient First Improvement System (PFIS)	Improvement Projects
*Identifying **a number of strategic priorities** and **cascading** these through the organisation*	*Ensuring structured **accountability, support and a consistent approach** for improvement*	***Developing capability** improvement across the organisation underpinned by Lean*	*Developing **management-level capabilities** and **standard systems** for managing improvement across the organisation*	*Identifying **specific improvement initiatives** based on selected processes or pathways*

Key Focus Areas

- Review and embed process introduced to date to ensure operating effectively
- Introduce remaining elements of the Strategy Deployment process
- Plan, train and support the implementation of the Patient First Improvement System (PFIS)
- Build capability and capacity
  - Across the Trust
  - Within the Improvement and Delivery Team
- Focus on the delivery of the communications plan, particularly continued reinforcement of the core narrative throughout the organisation
- Work in conjunction with other strategies / strategic initiatives to ensure congruence and synergy

Strategy Deployment reporting Structure

Phase One Divisional SDR currently in place

Quarterly report on SDR to TME
(Focus on review of themes Trust Vision, BO, CP)

Monthly SDR to Trust Board
(Focus on review of themes Trust Vision, BO, CP)

Board Reporting
TBC

Monthly Executive Trust Management/Senior Leader SDR
(Focus on review of integrated Vision, BO, CP)

Executive Trust Management SDR

Divisional Strategy Deployment Reviews (SDR)

Monthly Executive /Divisional SDR
(Focus on review of integrated scorecard, Drivers and divisional Projects)

Weekly Divisional/Care Group Driver Meetings
(Focus on Drivers and Project delivery)

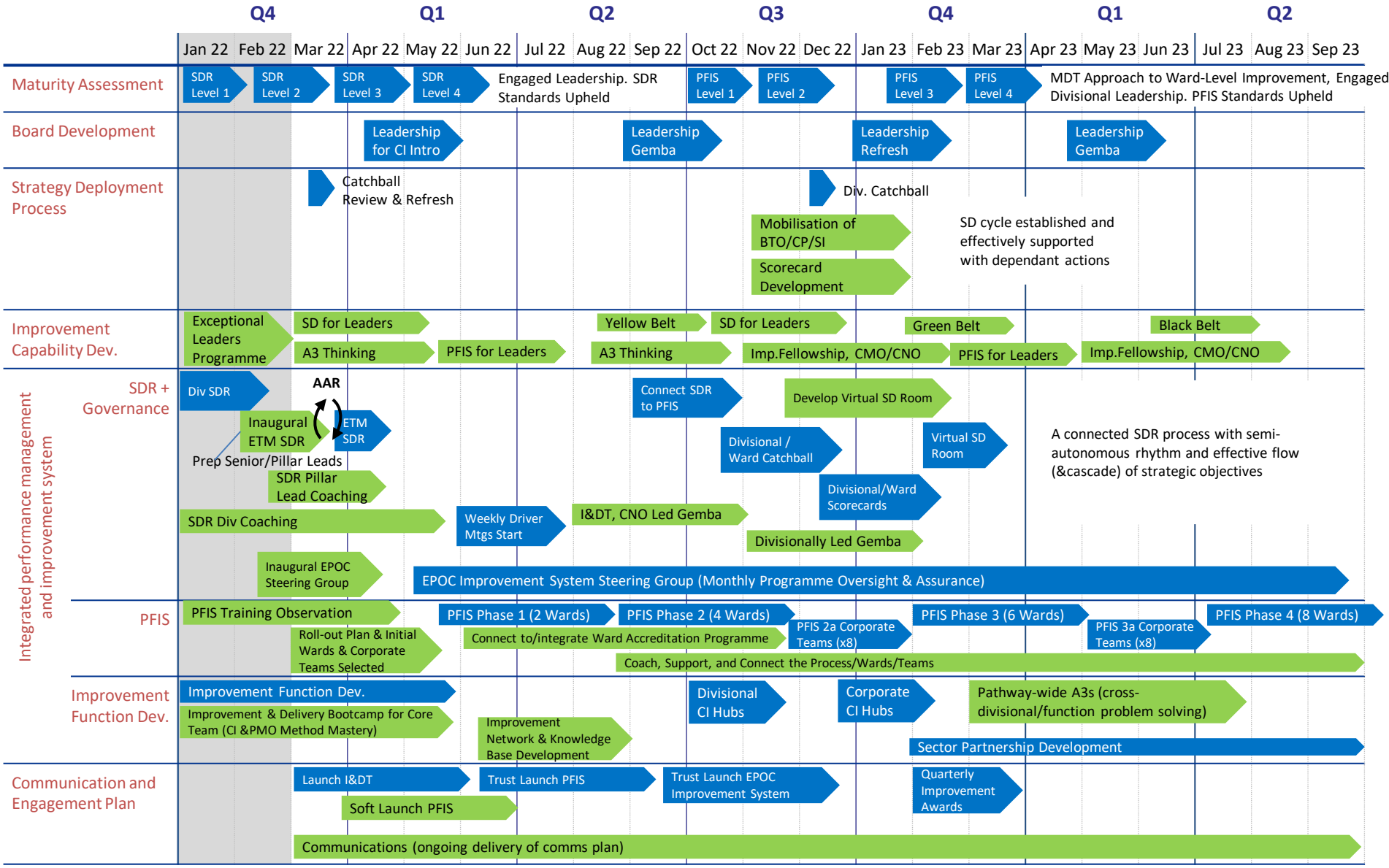
Divisional / Care Group Weekly Driver Meetings

Weekly PFIS Improvement Huddles
(Focus on review of integrated scorecard, Drivers and Projects)

Unit Level Patient First Improvement Huddles

Exceptional People Outstanding Care

MTW EPOC IP Roadmap '22-23



NHS Maidstone and Tunbridge Wells NHS Trust

Cardiology public engagement feedback **Director of Strategy, Planning and Partnerships**

In October 2021 the Board supported the Trust aspirations for developing a business case for the reconfiguration of cardiology inpatient and cardiac catheter lab services to deliver the following objectives:

- Transform the way the cardiology department delivers services to ensure the needs of patients are met now and, in the future
- Deliver and develop services that are clinically viable and financially sustainable
- Deliver services in line with recognised National Institute for Health and Care Excellence (NICE) and Getting It Right First Time (GIRFT) recommendations and embrace the delivery of the Trust strategy to develop the service.

The principles supporting an improved cardiology service at MTW focus on delivering the GIRFT recommendations to improve the quality of care and increase the service provision; centralisation of the inpatient cardiology service and the cardiac catheter laboratories onto one of the Trust hospital sites; delivering a 7-day service which is appropriately resourced with the required skilled staff to deliver improved quality of care, service efficiencies, minimised waits and enhanced patient experience. All of which will ensure the cardiology service is in a strong position to manage future growth. The Strategic Outline Case (SOC) outlined the options for developing the service as follows:

a) Do nothing (option 1)
b) Internal reconfiguration to centralise on the Maidstone site by redeveloping current estate for the cardiac catheter lab (option 2)
c) Internal reconfiguration to centralise on the Tunbridge Wells site (option 3)
d) Part new build and part internal reconfiguration to centralise the service on the Maidstone site (option 4)

Each option was assessed against nine criteria and the overview of these criteria is outlined in the report. The outcome of this options appraisal is also supported by a 14-week public engagement process as agreed with Kent HOSC in July 2021. Originally 12 weeks, this was extended by two weeks due to the Christmas holiday period to encourage more responses from stakeholders.

The 14-week engagement process ran from 22nd October 2022 until midnight on 14th January 2022. A wide variety of research, engagement, and involvement methodologies were used to elicit views, feedback, and ideas in response to the cardiology proposals as detailed below and also supported by the pre-engagement activities undertaken by Engage Kent during the summer of 2021.

1) Survey
2) Targeted engagement including social media and hard to reach groups
3) Online public listening events
4) Telephone interviews
5) Pop-up information stands x5 across geographies
6) Direct stakeholder feedback and individual responses
7) Staff feedback

Analysis of the engagement responses demonstrates there is a clear understanding of, and support for, the clinical case for change and agreement that the consolidation of services on a single site will bring benefits to patient care and outcomes. The importance of improving cardiology services at MTW has widespread and unequivocal support from respondents, with the majority favouring the consolidated service at the Maidstone hospital site. The engagement process was positively received

by many of those who responded (including scrutiny committee colleagues) in terms of the clarity of the case for change and the efforts made by the Trust to raise awareness of the proposals and the opportunity to respond. The Trust has been nominated for a Healthwatch award for the thoroughness of the process undertaken to engage with the public and other key stakeholders.

MTW is grateful to the partners, stakeholders, organisations, and individuals who have taken part in the engagement process and shared their views, thoughts, and experiences.

The main challenge or concern regarding the proposed centralisation on the Maidstone site, is the increased travel times for patients and visitors from the Weald and Sussex areas of the catchment area. The concerns focussed on patient and visitor travel but also on the time taken to get to the right site and the possibility of delay to treatment and support. These concerns are valid, and consideration has been given to mitigating these and is detailed in the body of the report.

On the basis of the assessment of the nine criteria detailed in the report and the feedback from the engagement process, the Board are asked to support the recommendation in this report that the reconfigured cardiology inpatient and cardiac catheter lab services are centralised on the Maidstone site. As previously stated outpatient clinics will be unaffected and will continue at both MTW hospital sites as well as at Sevenoaks and Crowborough hospitals, as will outpatient diagnostics which will continue on both MTW hospital sites.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 15.02.22

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

To agree and confirm the recommendation to reconfigure cardiology inpatient and cardiac catheter laboratory services so they are centralised on the Maidstone site and agree to move towards the development of a business case and implementation.

[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

Recommendation of the site option for reconfigured inpatient cardiology and cardiac catheter laboratory services

1 Introduction

The cardiology programme is aimed at delivering the standards set out by GIRFT and the aims and objectives of the Trust Clinical Strategy both of which require equipment replacement and reconfiguration of specialist cardiology inpatient and catheter lab services to one site.

This report focusses on the outcome of a 14 week engagement process on the site options, the responses to this engagement, initial thinking on mitigating concerns raised during this engagement period and makes a recommendation to the Board for the site of the reconfigured services. The decision-making process for the preferred site is supported by an options appraisal as set out in the Strategic Outline Case and the feedback from the 14-week engagement period undertaken from October 2021 to 14th January 2022. The report will include the following:

- details and outcome from the 14-week engagement period
- assessment against the nine criteria in the options appraisal
- recommendations to the Board

2 14-week engagement period

The public engagement period commenced on 22nd October 2021 and was completed on 14th January 2022. A detailed engagement plan was developed to ensure that staff, stakeholder, and public engagement activities could be targeted at key groups, organisations, and individuals, with a focus on ensuring that we heard from those most likely to be impacted by the proposals. The grouping for the engagement activities are outlined in **table 1** below and demonstrate how consideration has been given to the individuals and communities that maybe affected by the proposed changes. All of these groups were communicated with prior to the launch of the engagement period so that there was a level of awareness about the engagement period and opportunities to respond to the proposals.

Table 1 – Stakeholder groups

Priority 1 audiences - internal
• MTW Board • MTW senior leadership team • Directorate/division/service leads • All cardiology clinical and non-clinical staff • Staff side/unions
Priority 1 audiences - external
• Local MPs • Kent HOSC Chair and members • East Sussex HOSC Chair and members • NHSEI regional lead • NHSEI regional director • NSHEI regional communications leads • Head of South East Clinical Senate • Care Quality Commission regional lead • KMCCG/ICS accountable officers • KMCCG governing body members • Healthwatch Kent • Healthwatch East Sussex Media (via media release)
Priority 2 audiences
• All MTW staff • MTW patient/stakeholder groups • CCG (Kent) member practices, PCNs and local area teams • KMCCG staff • KM ICS Board/system partnership board • ES ICS Board/system partnership board • West Kent ICP • East Sussex ICP • K&M provider collaborative communications leads • Neighbouring K&M and East Sussex acute provider CEOs and MDs CEOs of KCHFT (Paul Bentley) and KMPT (Helen Greatorex) • Leader of KCC – Roger Gough, Corporate Director KCC – David Cockburn
Priority 3 audiences
• Royal Colleges and professional organisations • Local health partners – LMCs, HWB, patient groups, voluntary organisations • District/borough councils • Patients, carers and public – via websites, social media, traditional media and other existing communications channels (e.g. bulletins and newsletters

2.1

Engagement activities

Engagement activity was focussed in the following geographic areas:

- The catchment area served by our cardiology service - Maidstone, Tonbridge, Tunbridge Wells, Crowborough, Sevenoaks, and Paddock Wood, as well as patients from the East Sussex border
- In the top 20 postcode areas with the highest admissions to the service between 2017-2019
- We also welcomed and sought views from people across Kent and East Sussex.

Core engagement materials (including the engagement document, a summary version, survey, frequently asked questions) were published on a dedicated engagement page on MTW's website. Ensuring widespread awareness and understanding of, and engagement with, these materials

formed the basis of engagement activity. The website was updated as new information or details about events and activities went live. A communications cascade to key stakeholders and audiences was used to highlight the start of the engagement period and offer recipients easy access to engagement materials. This cascade approach was repeated halfway through the engagement period and in the week before the engagement closed, to encourage last minute responses. A communications cascade will be used to inform stakeholders about the decision-making process and next steps.

Engagement activity was a mix of online and face-to-face engagement (working in a COVID-safe way and within government guidelines), exploiting digital means to reach people, but also recognising that not everyone can or wants to engage digitally. Pop-up information stands and telephone polling were also used to reach people who may not engage via digital means. Anyone without access to the internet could write to or telephone MTW's engagement team and ask for information to be sent to them.

Key areas of activity set out below.

1 Survey
2 Targeted engagement
3 Online public listening events
4 Telephone interviews
5 Pop-up stands x5 across geographies
6 Direct stakeholder feedback and individual responses
7 Staff feedback

More detail about the activities undertaken during the public engagement period and a summary of responses is detailed below.

2.1.1 Survey

A survey was developed by an independent research agency as part of the engagement activity (Developing cardiology services at Maidstone and Tunbridge Wells NHS Trust) and feedback was encouraged from local people, organisations, and health and care staff. A total of 98 responses were received from 93 individuals and five organisations. The organisations are:

- Cardiomyopathy UK
- High Weald Primary Care Network
- Kent Community Health Foundation Trust
- The Beacon Surgery Patient Participation Group; c/o Beacon Surgery, Crowborough
- Ashdown Forest Health Centre, patient reference group

A review of these responses (table 2) shows the following in support of the options outlined within the proposal. Out of the 98 respondents 62 (63%) expressed preference for the Maidstone site, with 24 (24.5%) expressing preference for the Tunbridge Wells site and 8 (8%) preferring no change.

Table 2 – Summary of survey feedback

Option	Number of responses

Option 1 – Do Nothing	8 (8%)
Option 2 - Internal reconfiguration to centralise on the Maidstone site by redeveloping current estate for the cardiac catheter lab	45 (47%)
Option 3 - Internal reconfiguration to centralise on the Tunbridge Wells site	24 (25%)
Option 4 - Part new build and part internal reconfiguration to centralise the service on the Maidstone site	17 (17%)
No preference recorded	4 (4%)

The most frequently mentioned advantage was the same across all respondent groups, that of improved staffing ratios and improved quality of care for patients. Other themes of efficient and cost effective use of resources, staffing levels and staff retention, reduced waiting times and a reduced need to travel between the two current sites, were mentioned by all groups, but with differing frequencies. The most frequently mentioned disadvantage of journey times, transport and distance to travel was the same for all respondent groups. Other disadvantages were themed around, impact on staff, use of resources and physical space within hospital sites, internal transfers between sites and a negative impact on patient care.

2.1.2 Targeted engagement

An independent agency (EK360) recruited 52 individuals to ensure a representative mix of the general public and the following seldom heard groups totalling 28 responses with the remainder from the general public. The gender mix of the feedback was male – 23, female 28 and transgender 1. The seldom heard group mix is detailed below:

- people with a physical disability (8)
- people from ethnic minority backgrounds (8)
- people from the LGBTQIA+ community (6)
- people living in areas of multiple indices of deprivation (6)

This targeted engagement was undertaken through conversations and meetings where reactions to the case for change and the options were explored. Themes have been identified with a similar response to the survey on the options as follows:

- Broad support for the case for change and the options proposing to consolidate services, with a total of 62% supporting either option 2 or 4 (consolidation on the Maidstone site), 14% supporting option 3 (consolidation on the Tunbridge Wells site), 10% supporting option 1 (do nothing) and 14% wanting another option. These focussed on services on both sites with service improvements to deliver high standards on both sites.
- Recognition that improvements to cardiology services were needed and the plans proposed would bring benefits to patient care
- Concerns were raised about the availability and cost of public transport to either hospital site as a result of consolidation (Maidstone or Tunbridge Wells) and suggestions were made for supporting both visitors and staff, including patient transport, shuttle or minibuses and car shares.
- Participants also expressed concerns about the availability and accessibility of parking at both hospital sites.

2.1.3 Online public listening events

Two online public listening events took place during the engagement period on 9 and 15 December 2021. Although the listening events did not specifically ask for views on the options, the feedback received supported the direction of travel to consolidate the cardiology inpatient and cardiac catheter lab services on one site. While only a small number of attendees came to the sessions, the quality

of the feedback and the depth of understanding and engagement with the proposals, meant the sessions were highly useful in drawing out detailed responses to the proposals. Points and views raised by attendees at both meetings and in follow-up correspondence via email included:

- Broad support and understanding for the service consolidation 'case for change' – *'this is the right approach'*
- Questions about the practicalities of implementation for patients and staff including the transfer of patients across sites.
- Support for the consolidation approach with one attendee supporting the Option 2 proposal: *'I can see that better recruitment and retention, better training & support, and the general move towards a centre of excellence can only be positive news for the team, the hospital, and eventually, the patients.*
- Feedback on the clarity of the case for change and engagement approach and materials: *'…you are to be congratulated for pulling together an ambitious plan and for explaining it so clearly and rationally to all stakeholders'*

One attendee was also a representative of Cardiomyopathy UK, where he has a role as a Change Maker. The opportunity to meet with him and explore his specific responses to the proposals gave the programme team significant insights and he followed these up in an email after the event.

2.1.4 Telephone interviews

A specialist independent research agency (DJS Research) was commissioned to conduct a telephone survey that collected the views of a representative sample of 200 residents across the engagement catchment area. The fieldwork took place between 24 November and 15 December 2021 and the full complement of 200 interviews were completed.

Key findings were that the proposals are generally very well received; however, there are some concerns, mainly relating to the additional travel required to access a different facility.

- There is strong support for the idea of **consolidating some specialist care at one hospital**, agreeing that the plans would improve the care and experience of inpatients.
- There is also strong support for the idea of **bringing specialist and inpatient cardiology services together onto one hospital site**.
- When asked to think about the most important factors to consider when evaluating the options, the fact that it provides **the best clinical outcome for patients** far outweighs any other factor. Travel time is a concern for around half of the people interviewed
- Potential advantages of bringing services together focused on **receiving specialised services in a single location** and no changing between hospitals.
- Potential disadvantages of bringing services together focused by far on **the distance to each site** – this was an equal concern for both Maidstone and Tunbridge Wells postcodes.
- The hospitals/Trust could reduce the impact of the disadvantages of bringing the services together on one site by **improving transport offerings** (e.g. taxi, shuttle bus, etc).
- Other potential options that would address the need to change include **better access to GPs/quicker appointment times**.
- **Participants like to be consulted/listened to,** so this needs to continue throughout the process.

2.1.5 Pop-up information stands x5 across geographies

Five pop-up stands with information on the proposals, manned by programme representatives, were held during December 2021. Royal Victoria Place in Tunbridge Wells on 26th November, Crowborough Town Centre on 3rd December, Bligh's Walk Meadow in Sevenoaks on Friday 10 December, Fremlin Walk Maidstone, Wednesday 15 December and High Street, Uckfield on Thursday 16 December.

The nature of the engagement means that the primary function is to provide information and more than 300 A5 flyers were handed out. Ad hoc feedback from approximately 50 people who representatives spoke to on the days suggested:

- an understanding of the clinical case for change
- agreement that consolidation would lead to improved outcomes for patients
- concerns about the impact of additional travel times for patients and families in peripheral areas and the availability/cost of public transport within these areas

Programme representatives took the opportunity to visit community areas such as shops, pharmacies, and vaccination centres during these times to hand out leaflets and information to residents.

2.1.6 Direct stakeholder feedback and individual responses

Feedback was received via the dedicated email address from six key stakeholders and the programme team met with two Patient Participation Groups (PPG) as well as receiving a written response to the proposals from one PPG. The stakeholder feedback is summarised below with the key themes being consistent with the other engagement activities:

- five out of the six stakeholders understood the reasons behind the proposed change
- one stakeholder would prefer the service to be developed with compromise to the delivery of all standards but keep services across both sites
- there was support for the Maidstone site.

Concerns were raised about travel and accessibility for patients and visitors from the Weald and Sussex areas and emergency management of patients should they present to the non-inpatient site. These did not detract from the recognition of the need undertake the reconfiguration rather to ensure the Trust takes these issues into account and mitigating actions are in place to support patients from these areas. Suggestions made about travel improvement and the use of technology will be considered in development of the case.

A summary of the feedback from stakeholder is outlined below:

Friends of Crowborough Hospital – a letter dated 10th January 2022 was received from the group in response to the proposals. The group welcomed the opportunity to respond and believed that local residents had been able to engage effectively. Key points raised related to the accessibility of Maidstone Hospital as set out in Options 2 and 4 for residents from the Crowborough area, the associated limitations of public transport, the need for consideration for parking at Maidstone Hospital and specific concerns about the impact of the proposals on the future of Crowborough Hospital.

'The Friends understand the reasoning behind the clinical case for change and the need to consolidate services. We understand that the proposals offer the potential for MTW to provide an enhanced range of cardiology interventions and other related procedures so that it will be possible to develop the new site as a 'centre of excellence' over time.'

'Maidstone Hospital is significantly less accessible from the Crowborough area.'

'We believe the impact on residents of High Weald of locating the Cardiology "centre of excellence" at Maidstone can be significantly mitigated if MTW were to: 1) Commit to maintain the much-valued and various cardiology outpatient clinics at Crowborough Hospital. 2) Develop these outpatient cardiology outpatient clinics (especially diagnostic capabilities and follow-up care) so that patient travel to Maidstone is minimised. 3) Provide effective telemedicine to support remote consultant advice from the specialist site.'

The programme team has developed a full response to this letter, addressing these specific concerns and describing how the points raised will be included in the business case and the future development of the service.

Wadhurst and Ticehurst PPG – the group sent an email response to the proposals during the engagement period (13 January 2022). They agreed that there was a need to improve cardiology services, however, could not support consolidation at a single site as they believed that this would not benefit the wider population. Instead they proposed that *'examining the resources to achieve the best compromise would produce a better outcome'*.

It was suggested that resources should be based across two sites as '*cardiac care is a vital service within the NHS, obesity and diabetes are going to make cardiac care an ever increasing part of the NHS workload and the service should be as close to as many people as possible.'* Concerns about the potential impact on longer journeys for patients were raised, especially within the context of how this would affect the local ambulance service.

The programme team developed a detailed response to the points made and have offered a meeting with the group to explore the issues they have raised.

East Sussex HOSC – as patients from East Sussex fall into the catchment area for the proposals, programme representatives presented the proposals to the East Sussex Health Overview and Scrutiny Committee (HOSC) at its meeting on 2nd December. The HOSC submitted a written response to the engagement on the proposals for cardiology services on 10th December 2021.

The response was clear that HOSC members understood the reasoning behind the case for change and believed the proposals offered the potential for MTW to provide an enhanced range of cardiology interventions and develop the new site as a centre of excellence. They recognised that an improved service would help reduce length of stay and improve outcomes and welcomed the availability of telemedicine for paramedics as part of future plans for the service. Concerns were expressed about the impact of a longer journey to hospital for patients and visitors to Maidstone, should the consolidation go ahead at this site and urged MTW to *'look to help mitigate the impact of these increased travel times, for example, by increasing available car parking or offering hospital to hospital transport.'*

'HOSC is concerned that cardiac patients may still arrive at the Emergency Department of the hospital not chosen to host the CCU and cath labs, for example, a patient attending with chest pains. The Committee is reassured that this ED will still be able to offer emergency care and will be able to use telemedicine to receive remote consultant advice from the specialist site, including whether the patient needs transferring to the specialist site.'

'The HOSC welcomes the engagement being conducted by MTW and believes that residents of the High Weald area are sufficiently aware of and able to engage with the proposals.'

East Sussex Clinical Commissioning Group – the CCG gave its formal response via letter on 14th January 2022. Points raised related to the potential impact on the small cohort of East Sussex patients impacted by the proposals and patient flow activity data (elective and non-elective) was included for further discussion with MTW colleagues. There was a recognition that some patients and families might need to travel further. The CCG welcomed continued discussion with the programme team and expressed the need for joint work to communicate the outcome of the decision and implementation planning to local populations and GPs.

***'**…we completely understand the case for change, recognise your drivers for proposing this change, and agree with your proposed model of care, as the service provided to local people by ESHT is in a very similar position.'*

Kent Community Healthcare NHS Foundation Trust - the trust submitted queries regarding the level of cardiac expertise at Tunbridge Wells Hospital should the decision be made to consolidate services at Maidstone Hospital. The programme team gave a detailed response to these queries

during the engagement period. KCHFT submitted their formal response to the proposals via the survey.

Specific feedback from KCHFT raised within their survey response includes the following points about the advantages of the proposals, mitigation of the disadvantages and a proposal to work more closely with MTW on community cardiac service provision.

The advantages explained in the consultation document are clear and the Trust would agree that the stated benefit of being able to meet key clinical standards of care such as 7-day a week ward rounds, and 24/7 on-call consultant cover would be aided by the consolidation of specialist services on one site. This would have the added value of attracting and retaining specialist cardiology staff. An increase in invasive cardiac interventions with comprehensive services provided by two catheter labs will also be beneficial to reducing local access times. KCHFT refer only to MTW for non-invasive testing, and it is assumed that this will continue. An increase in non-invasive capacity (including echos and 24hr tapes) would improve the medical management of cardiac patients in the community setting. The proposal includes an increase of capacity at the weekends for elective and urgent patients so this may go some way to reducing waiting times and improving access for patients that KCHFT are managing.

The KCHFT clinical team would seek to mitigate potential disadvantages through joint work with the MTW Cardiology team to best understand the criteria for the patients cared for at TWH and the level of cardiology provision that will be available at TWH (for emergencies and non-elective patients). It will remain important that each patient at TWH receives a cardiology review prior to discharge. TWH patients should also continue to have access to cardiac specialists including clinical nurse specialists that can offer patient (and staff) education as well as provide specialist input to those that are often complex, frail, heart failure patients or those that require steady unloading to reduce oxygen demand and allow their heart to recover. KCHFT would welcome any increase in non-invasive cardiac intervention capacity to minimise waiting times for those patients who are waiting changes in their medication requiring an echo prior to an MDT discussion. Our clinical team would therefore wish to work with MTW to understand the operational implications for the proposed weekend access to non-invasive interventions for elective/urgent patients.

We would like to work with you to agree any changes you may deem helpful or necessary to community cardiac services or other community services as a result of the change. For example, this may be a good opportunity to jointly explore with Commissioners and MTW subcontracting KCHFT to undertake cardiac rehab and treatment initiation services.

Forest Row Community Transport – the coordinators of this patient transport service submitted an email response on 14 January 2021, outlining their opposition to the proposal to consolidate what they termed as *'cardiology/medical services'* at Maidstone Hospital. They cited concerns about the availability of volunteer drivers: ***'***As with any organisation dependent on volunteers, we often find it very difficult to cover all requests, particularly appointments further away. We have between 10 and 12 drivers, all volunteers, who drive residents in Forest Row and Ashurst Wood or a patient at Ashdown Forest Health Centre, to medical appointments of all kinds and who would otherwise struggle to attend without our help.'*

Programme representatives responded to this email, reassuring the coordinators that the proposals related to inpatient and cardiac catheter lab services only and that outpatient appointments would remain unaffected by the proposals. The response recognised that travel and transport were a concern for some patients in peripheral areas and this issue would be considered as part of the decision-making work.

PPG meetings – programme representatives met with the following PPG groups **West Kent PPG Chair meeting** – **11 January 2022**

Programme team representatives outlined the proposals to 23 attendees at the meeting and took feedback on the proposals. Key themes from the discussion are set out below:

- There is a clear need to consider the travel and transport impact of the changes and how people will know where to go (including health and care professionals working for the ambulance service)
- Questions about the availability of step-down beds and how discharge arrangements would be made should the proposals get the go-ahead
- The timing and implementation of the proposals once a decision is made about the future.
- Changes to the patient pathway that might see patients treated locally and then moved to a London hospital for further specialist procedures.
- Consideration should be given to how families and loved ones might visit patients (help with parking, remote technical digital support to help maintain contact).

The preferred option at Maidstone was felt to be the best scenario and the changes proposed had the potential to improve patient care and this will outweigh the travel and transport implications.

West Kent ICP – Stakeholder Engagement Advisory Group – 21 December 2021

Programme representatives presented the proposals to nine attendees at this meeting. Key themes from the discussion are set out below:

- This proposal was considered to be 'excellent' and a commitment was made to promote engagement opportunities, including the survey, through local networks to encourage people to have their say.
- Clarity on how the proposed changes would meet best practice (including national standards) was requested at the meeting.
- Questions were asked about the proportion of patients who would go to Maidstone and the potential impact on patient pathways if the proposals were agreed and implemented.

Individual responses

An email was received from a cardiology patient (also a staff nurse at Maidstone Hospital) on 13 January 2022 in response to the proposals.

Support was given for Option 4 - *'to consolidate services at Maidstone with a new build,' sounds like the best option. Not only will this improve the Cardiology services as a whole and keep all the team together, centralise equipment, staff etc.*

A Cardiology patient – a response was received via email on 7 December 2021 outlining personal experience of being a local cardiology patient. No specific option was endorsed however the respondent cited Maidstone as a central location that would be accessible from East Sussex *'where patients look to MTW for health services'.* The respondent flagged the potential need for travel improvements and asked whether consideration had been given for space for additional parking at a new build centre.

2.1.7 Staff feedback

Staff feedback from three staff sessions held on 17th November (10 staff), 22 November (35 staff) and 1st December (two members of staff) and the proposals were welcomed with the key themes outlined below:

- There is a clear case for change and staff welcome being involved in the development of the proposals
- The location of non-clinical staff if Option 4 was to go ahead was raised.
- Maidstone was felt to be geographically well-placed for other cardiology services across the area and this may be the same for this proposal

- Consolidating services at a single site may help with ongoing workforce issues around recruitment and staff could see the benefits of this approach however the question was raised as to whether three rather than two cath labs had been considered
- Attendees requested reassurance that staff would continue to be involved and kept up to speed as plans developed
- Participants agreed with the 'case for change' and saw that in order to meet the 'gold standard' of patient care, that consolidation is necessary
- Questions were asked about the location of a new build at the Maidstone site under Option 4
- Ongoing challenges with recruitment and retention of staff were highlighted with questions asked as to how the proposals might help with these issues
- The importance of educating patients that this is happening so that they understand the benefits for their own care and treatment
- Feedback included the comment that it would be important to see the plans as *'an exciting opportunity and challenge as well as a change'*.

2.2 Overall analysis

The engagement process was, on the whole, received positively by those who did respond in terms of the clarity of the case and raising awareness and we are delighted to have been nominated for a Healthwatch award for the quality of the engagement we undertook on our proposals for the future of inpatient cardiology services.

Analysis of the engagement responses is summarised in the table 3. Overall responses demonstrate there is a clear understanding of the clinical case for change and agreement on the whole that the consolidation of inpatient and cardiac catheter lab services on a single site will bring benefits to patient care and outcomes. The importance of improving cardiology services at MTW has widespread and unequivocal support from respondents with the majority favouring the consolidated service at the Maidstone hospital site. The engagement was focussed on the cardiology inpatient and cardiac catheter lab services although some responses assumed the changes affected outpatient services as well. Should the Board agree to go ahead with the proposal, we will ensure the post-decision communication is clear on this point. The supporting engagement documents are on the Trust website.

The main challenges and concerns regarding the reconfiguration are:

- Travel times and access for patients and visitors from Sussex and the northwest of Kent. In this instance public transport is sporadic and travel times may be longer so increased costs of driving and parking are a concern
- Clinical safety of the site without the inpatient service
- Travel between sites if patients present to ED on the site without the inpatient service.

In mitigation of these concerns the Trust will developing the business case with the following considerations which are summarised in table 3 below:

- Travel plans which allow patients from these outlying areas to use Trust inter site transport
- Work with the bus services to extend the free bus travel with a Trust letter
- Consideration of visiting times to allow visitors to use public transport
- A review of car parking arrangements for specific patient and visitor groups
- A robust protocol with ambulance services to support decision making to take patients to the correct site. This may involve the use of telemedicine which has been successfully implemented in the stroke service

- Robust protocols for the management of patients who present on the non-inpatient site or those who become unwell with a cardiac condition while in hospital for another condition. These will be supported by staff development on a rolling basis on the non-inpatient site.

Table 3 - Summary of Feedback

Media	Volume of Responses	Main themes	Mitigations
Survey	98	**Advantages:** • Improved staffing ratios • Improved staff retention • Improved quality of care for patients. • Efficient and cost effective use of resources • Reduced waiting times and a reduced need to travel between the two current sites **Disadvantages:** • Increased journey time • Increased distance for some patients and relatives • Lack of public transport • Impact on some staff and patients and relatives	• Travel plans which allow patients from these outlying areas to use Trust inter site transport • Work with the bus services to extend the free bus travel with a Trust letter • Consideration of visiting times to allow visitors to use public transport • A robust protocol with ambulance services to support decision making to take patients to the correct site. This may involve the use of telemedicine which has been successfully implemented in the stroke service. • Robust protocols for the management of patients who present on the non-inpatient site or those who become unwell with a cardiac condition while in hospital for another condition. These will be supported by staff development on a rolling basis on the non-inpatient site.
Targeted Engagement	52	**Advantages:** • Improved quality of care for patients • Reduced need to travel between the two current sites. • Benefits to finance and staffing. **Disadvantages:** • Journey times and distance will increase for some, • Potential disadvantages for staff who live further away • Concerns about finance and disruption to services.	As above
Online Public listening Events	2	**Advantages:** • Support for the clinical case for change and consolidation approach • Better recruitment and retention of staff **Disadvantages:** • Practicalities of implementation for staff and patients and patient transfers	As above
Telephone interviews	200	**Advantages:** • The plans would improve the care and experience of inpatients and improve clinical outcomes • Receiving specialised services in a single location and no changing between hospitals	As above

Media	Volume of Responses	Main themes	Mitigations
		Disadvantages: • Distance to each site and impact on patient and family travel and transport	
Pop up stands	Approximately 50 interactions and 300 flyers distributed	**Advantages:** • Agreement that consolidation would lead to improved outcomes for patients **Disadvantages:** • Impact of additional travel times for patients and families in peripheral areas and the availability/cost of public transport within these areas	As above
Stakeholder feedback	7 (KCHFT's response is counted under the survey response)	**Advantages:** • Improvement to patient care, experience, and outcomes • Opportunity for MTW to provide an enhanced range of interventions • Reduction in length of stay • Opportunity to further develop community-based services **Disadvantages:** • Travel, transport and accessibility for patients and families, especially those coming from peripheral areas • Impact on volunteer driver services • Opposition to the proposal and a request to consider improving services at both sites • Emergency transfers of patients arriving at the non-specialist site and potential confusion for both staff and patients	• As above, plus ongoing dialogue with clinical commissioning group colleagues across the catchment area, regular engagement with, and reporting to, council scrutiny colleagues and the offer of further meetings to explore specific issues with Wadhurst and Ticehurst PPG.
Individual responses	2	**Advantages:** • Improved quality of care for patients. efficient and cost effective use of resources, staffing levels and staff retention • Reduced waiting times and a reduced need to travel between the two current sites **Disadvantages:** • Increased journey times, transport and distance to travel • Impact on staff, use of resources and physical space within hospital sites internal transfers between sites • Negative impact on patient care	As above
Staff feedback	47	**Advantages:** • Opportunity to meet 'gold standards' of patient care, experience and outcomes • Help with staff recruitment and retention, making it a more attractive place to work **Disadvantages:** • The need for three rather than two cath labs • Impact on staff if changes are made and how will this be managed • Lack of understanding by patients and carers as to the changes and how they will help improve patient care and outcomes	• As above plus ongoing engagement and dialogue with all staff, especially those affected by the proposals and the inclusion of staff concerns within implementation planning for the changes/transition should the proposal go ahead.

3 Overall Assessment of the Options

The SOC reviewed each of the four options against a set of nine criteria detailed below, with the addition of a score for the outcome of the engagement feedback.

1 Meet non-compliant GIRFT recommendations in full
2 Provide more efficient and integrated approach to patient care
3 Improve patient flow and patient experience.
4 Deliver value for money
5 Create capacity to support the Trust clinical strategy aspiration.
6 Travel for patients within catchment area to be accepted by public.
7 Clinical acceptability – must be accepted by the clinical team as a reasonable and safe adjustment to the service
8 Sustainability
9 Achievability
10 Outcome of the engagement feedback (new criterion)

A review of the options against the criteria is summarised in **table 4**. The scoring assumes 1 is not compliant and 5 is fully compliant with the evaluation criteria. The scoring assumes equal weighting of each of the criteria as equally important in the reconfiguration of the service. The total score available for fully meeting all ten of the criteria is 50. The options are scored against the criteria outlined in table 2, with the overall assessment for each option in **table 5.**

All criteria are equally weighted due to the subjective nature of the individuals/organisations perspective.

Table 4 - Scoring

Score	1	2	3	4	5
Impact	Does not meet the criteria and will have a negative impact on the service	Meets certain elements of the criteria but insufficient to improve the service in line with expectations and standards	Meets certain elements of the criteria and could be mitigated deliver the service in line with expectations and standards	Almost fully meets the criteria and is sufficient to support delivery of expectations and standards with minor mitigation	Fully meets the criteria

Table 5 – Overall assessment of the reconfiguration options

Options	GIRFT recommendations	Efficient and integrated care	Patient flow and patient experience	Value for money	Support clinical strategy aspirations	Travel acceptability	Clinical acceptability	Sustainability	Achievability (Inc. timescale)	Engagement Feedback	TOTAL	% score
1: Do Nothing	2	2	2	2	1	5	2	1	4	1	22	44
2: Internal Reconfiguration at Maidstone Hospital	5	5	5	4	5	3	4	4	3	4	42	84
3: Internal Reconfiguration at Tunbridge Wells Hospital	4	4	4	1	5	3	4	3	1	2	31	62
4: Part new build/part internal reconfiguration at Maidstone Hospital	5	5	5	2	5	3	4	4	2	4	39	78

The overall outcome of the four options against the 10 criteria indicates that the reconfiguration on the Maidstone site is the most favourable. Each option is summarised below:

1 **Do nothing –** the lowest scoring option scoring '1' in three of the criteria, '2' in five of the criteria '4' in one criterion and 5 in 1 criterion. The '4' and '5' scores were assumed because the service would not be changing. This option does not allow for the development of the service to meeting the GIRFT recommendations, deliver an efficient service to improve quality, or meet clinical expectations regarding the future of inpatient and invasive cardiology at MTW. The risks associated with this, particularly in relation to the service reputation and future recruitment, could see the cardiology service eroded irreparably.

2 **Internal reconfiguration at Maidstone Hospital –** the most favourable option scoring '5' in four criteria, '4' in four criteria, and '3' in two criteria. This option delivers the GIRFT recommendations and quality improvements whilst, based on high level costing, representing the best value for money. It is also has a high level of clinical support and can be delivered in the shortest timescale.

3 **Internal reconfiguration at Tunbridge Wells Hospital –** the second lowest score with '5' in one criterion, '4' in four criteria, '3' in two criteria, '2' in one criterion and '1' in two criteria. The main challenge with this option is the cost and timescale for delivery due to PFI status of the site. There is also concern regarding the ability to create a dedicated cardiology ward due to size constraints on the site.

4 **Part new build/Part internal reconfiguration at Maidstone Hospital** – the second highest scorer with '5' in four criteria, '4' in three criteria, '3' in one criterion and '2' in two criteria. The main challenge with this option is the cost of a new build cardiac catheter lab and the timescale for delivery.

On the basis of the evaluation of each option against the agreed criteria in the SOC and the outputs from a robust and inclusive engagement process the recommendation is that the preferred site for the cardiology inpatient and cardiac catheter laboratory services is on the Maidstone Hospital site.

4 Next Steps

The Trust plans to undertake the following actions to ensure continued progress with the development of the business case for the reconfigured inpatient cardiology and cardiac catheter lab service once the site decision is made, and this will include:

- communicating the Board's decision to all key stakeholders and audiences as outlined in section 2.0
- completion of the procurement process for managed equipment service and recommendation of a preferred equipment management process
- the development of an Outline Business Case for Board approval in April 2022
- the implementation of a governance structure to ensure clinical staff are fully involved in the service development.
- maintenance of an open dialogue and regular communication with all stakeholders including CCGs, ambulance services and HOSC regarding the ongoing development and implementation of the programme of work.

5 Recommendations

The Board are asked to consider the recommendations as follows:

1 Note the report and the contents
2 Note the breadth and depth of engagement activity and confirm they are happy that the process was robust
3 Note that issues and concerns raised are being considered as part of the development of the business case
4 Confirm the outcome of the options appraisal including the mitigations
5 Support the recommendation the reconfigured cardiology inpatient and cardiac catheter laboratory services are centralised on the Maidstone site and agree to move towards the development of a business case and implementation
6 Note the next steps in developing the service

NHS
Maidstone and Tunbridge Wells NHS Trust

APPROVAL OF THE INITIAL PLANNING SUBMISSIONS FOR 2022/23	DIRECTOR OF STRATEGY, PLANNING & PARTNERSHIPS

Please find enclosed a report for approval of the initial planning submissions for 2022/23.

Which Committees have reviewed the information prior to Board submission?
- Executive Team Meeting, 22/02/22 (AM)
- Finance and Performance Committee, 22/02/22 (PM)

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

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

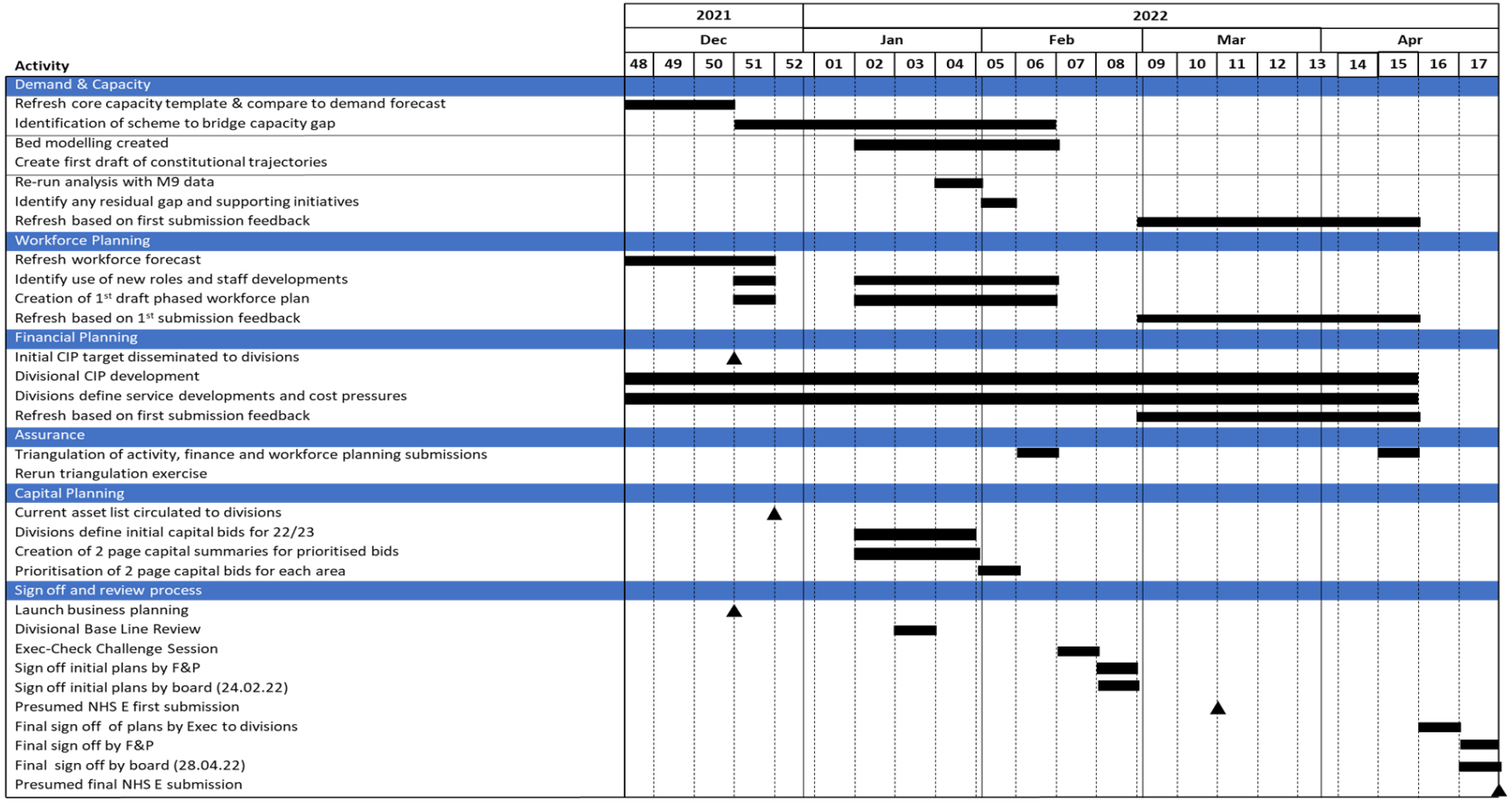
2022/23 Operational Planning

February 2022

MTW

NHS
Maidstone and Tunbridge Wells
NHS Trust

Timeline for Business Planning



Timetable:

3rd Week Jan:
Divisional Base Line Review Meeting

3rd Week Feb:
Executive Check and Challenge Session

4th Week Feb:
Initial Plan sign off F&P and Board

2nd Week March:
First Draft to NHSE

3rd Week April:
Final sign off F&P and Board

End April:
Final Submission to NHSE

Agenda

Activity Plans
Workforce Plans
Finance Plans

Our core activity plans including funded efficiency schemes exceed the 104% minimum provider threshold at each point of delivery if the known impact of endoscopy pathways changes are factored into day cases.

Elective IP	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Year Total
1920 Actual	543	558	604	591	583	632	582	687	595	571	626	717	7289
National Target - % of 1920	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%
National Target Volume	597	614	664	650	641	695	640	756	655	628	689	789	8018
22/23 Plan as % of 1920	110%	120%	108%	115%	118%	114%	116%	101%	109%	121%	102%	101%	111%
22/23 Plan Volume	597	670	652	682	686	718	676	691	647	690	640	723	8072
Var Plan 22/23 vs Target	**0**	**56**	**-12**	**32**	**45**	**23**	**36**	**-64**	**-8**	**62**	**-48**	**-66**	**54**
Actual 21/22 as % of 1920	94%	111%	104%	107%	92%	100%	105%	85%					
Actual 21/22 Volume	509	622	630	635	539	630	610	582					

Elective DC	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Year Total
1920 Actual	3535	3476	3639	3701	3474	3873	3451	3838	3360	3349	3454	3869	43019
National Target - % of 1920	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%
National Target Volume	3889	3824	4003	4071	3821	4260	3796	4222	3696	3684	3799	4256	47321
22/23 Plan as % of 1920	98%	110%	101%	104%	116%	104%	111%	105%	109%	114%	106%	108%	107%
22/23 Plan Volume	3472	3811	3660	3841	4032	4027	3831	4024	3652	3834	3669	4188	46042
Var Plan 22/23 vs Target	**-417**	**-12**	**-343**	**-230**	**210**	**-234**	**35**	**-198**	**-44**	**150**	**-131**	**-67**	**-1279**
Actual 21/22 as % of 1920	98%	100%	100%	102%	103%	95%	107%	107%					
Actual 21/22 Volume	3461	3479	3643	3758	3571	3693	3679	4118					

Total Elective (IP and DC)	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Year Total
1920 Actual	4078	4034	4243	4292	4057	4505	4033	4525	3955	3920	4080	4586	50308
National Target - % of 1920	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%
National Target Volume	4486	4437	4667	4721	4463	4956	4436	4978	4351	4312	4488	5044	55339
22/23 Plan as % of 1920	100%	111%	102%	105%	116%	105%	112%	104%	109%	115%	106%	107%	108%
22/23 Plan Volume	4069	4481	4312	4523	4718	4745	4507	4715	4299	4524	4309	4911	54113
Var Plan 22/23 vs Target	**-417**	**44**	**-355**	**-198**	**255**	**-211**	**71**	**-263**	**-52**	**212**	**-179**	**-133**	**-1225**
Actual 21/22 as % of 1920	97%	102%	101%	102%	101%	96%	106%	104%					
Actual 21/22 Volume	3970	4101	4273	4393	4110	4323	4289	4700					

NB: Mar-20 Activity Levels were impacted by COVID. These have therefore been adjusted as per the national counterfactual guidance

Providers are asked to achieve at least 104% of 19/20 levels of elective activity at each point of delivery. The national ambition is to achieve 110%, with ERF available for activity levels above 106% of 19/20

Assumptions:

1. Identified funded initiatives are fully delivered
2. Baseline corrections to day case endoscopy activity are accepted.
3. Levels of Activity sent to the Independent Sector (IS) remains similar to 2021/22 Levels

As we have indicated throughout H1/H2 the impact of endoscopy pathways changes adversely impacts our elective day case attainment of 19/20 and therefore our overall Elective performance.

Elective IP	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Year Total
1920 Actual	543	558	604	591	583	632	582	687	595	571	626	717	7289
National Target - % of 1920	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%
National Target Volume	597	614	664	650	641	695	640	756	655	628	689	789	8018
22/23 Plan as % of 1920	109%	119%	107%	114%	116%	112%	115%	99%	108%	119%	101%	100%	109%
22/23 Plan Volume	590	662	645	674	678	710	668	683	640	682	633	714	7981
Var Plan 22/23 vs Target	**-7**	**48**	**-19**	**24**	**37**	**15**	**28**	**-72**	**-15**	**54**	**-55**	**-74**	**-37**
Actual 21/22 as % of 1920	94%	111%	104%	107%	92%	100%	105%	85%					
Actual 21/22 Volume	509	622	630	635	539	630	610	582					

Elective DC	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Year Total
1920 Actual	3783	3832	4090	3909	3795	4326	3880	4280	3649	3835	3982	4381	47742
National Target - % of 1920	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%
National Target Volume	4161	4215	4499	4300	4175	4759	4268	4708	4014	4219	4380	4819	52516
22/23 Plan as % of 1920	92%	100%	90%	98%	106%	93%	99%	94%	100%	100%	92%	96%	97%
22/23 Plan Volume	3475	3815	3663	3845	4035	4030	3835	4027	3655	3838	3672	4192	46079
Var Plan 22/23 vs Target	**-687**	**-401**	**-836**	**-455**	**-140**	**-729**	**-433**	**-681**	**-359**	**-381**	**-709**	**-627**	**-6437**
Actual 21/22 as % of 1920	91%	91%	89%	96%	94%	85%	95%	96%					
Actual 21/22 Volume	3461	3479	3643	3758	3571	3693	3679	4118					

Total Elective (IP and DC)	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Year Total
1920 Actual	4326	4390	4694	4500	4378	4958	4462	4967	4244	4406	4608	5098	55031
National Target - % of 1920	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%
National Target Volume	4759	4829	5163	4950	4816	5454	4908	5464	4668	4847	5069	5608	60534
22/23 Plan as % of 1920	94%	102%	92%	100%	108%	96%	101%	95%	101%	103%	93%	96%	98%
22/23 Plan Volume	4065	4477	4308	4519	4713	4740	4503	4710	4295	4520	4305	4906	54060
Var Plan 22/23 vs Target	**-694**	**-352**	**-855**	**-431**	**-103**	**-714**	**-406**	**-754**	**-374**	**-327**	**-764**	**-702**	**-6474**
Actual 21/22 as % of 1920	92%	93%	91%	98%	94%	87%	96%	95%					
Actual 21/22 Volume	3970	4101	4273	4393	4110	4323	4289	4700					

NB: Mar-20 Activity Levels were impacted by COVID. These have therefore been adjusted as per the national counterfactual guidance

The activity plan includes the "Funded" efficiency opportunities identified by the Divisions as well as endoscopy daycase activity.

DC Plans have been adjusted to take into account for the impact of QFIT testing in the Community, colon capsule activity, as well as the already known impact of the Trust now not providing a Bowel Scope Service (which was provided in 19/20). The impact of these pathway changes is that DC Gastroenterology activity is 61% of 19/20 activity levels

Our Total Core First Outpatient activity plans including funded efficiency schemes exceed the 104% provider threshold of 19/20 activity levels

Consultant-Led First OP	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Year Total
1920 Actual	13212	12281	14152	14431	12558	14712	13849	14694	13339	13070	13528	15003	164829
National Target - % of 1920	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%
National Target Volume	14533	13509	15567	15874	13814	16183	15234	16163	14673	14377	14881	16503	181312
22/23 Plan as % of 1920	112%	132%	111%	113%	136%	116%	118%	117%	117%	125%	115%	119%	119%
22/23 Plan Volume	14786	16240	15645	16365	17074	17120	16355	17135	15610	16308	15566	17880	196084
Var Plan 22/23 vs Target	**253**	**2731**	**78**	**491**	**3260**	**936**	**1121**	**971**	**937**	**1931**	**685**	**1377**	**14772**
Actual 21/22 as % of 1920	91%	97%	97%	87%	93%	89%	90%	94%					
Actual 21/22 Volume	12045	11859	13670	12620	11650	13143	12521	13792					

Non-Consultant Led First OP	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Year Total
1920 Actual	3642	3946	3442	4342	3569	3636	3917	3647	3428	3841	3434	3808	44652
National Target - % of 1920	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%
National Target Volume	4006	4341	3786	4776	3926	4000	4309	4012	3771	4225	3777	4189	49117
22/23 Plan as % of 1920	93%	84%	95%	72%	90%	88%	81%	88%	94%	87%	93%	83%	87%
22/23 Plan Volume	3387	3301	3261	3139	3217	3214	3175	3212	3223	3346	3193	3158	38826
Var Plan 22/23 vs Target	**-619**	**-1040**	**-525**	**-1637**	**-709**	**-786**	**-1134**	**-800**	**-548**	**-879**	**-584**	**-1030**	**-10292**
Actual 21/22 as % of 1920	93%	84%	95%	72%	90%	88%	81%	88%					
Actual 21/22 Volume	3387	3301	3261	3139	3217	3214	3175	3212					

Total Combined First OP	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Year Total
1920 Actual	16854	16227	17594	18773	16127	18348	17766	18341	16767	16911	16962	18811	209481
National Target - % of 1920	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%	110%
National Target Volume	18539	17850	19353	20650	17740	20183	19543	20175	18444	18602	18658	20692	230429
22/23 Plan as % of 1920	108%	120%	107%	104%	126%	111%	110%	111%	112%	116%	111%	112%	112%
22/23 Plan Volume	18173	19541	18906	19504	20290	20333	19530	20346	18833	19655	18759	21038	234909
Var Plan 22/23 vs Target	**-366**	**1692**	**-447**	**-1146**	**2551**	**150**	**-12**	**171**	**389**	**1053**	**101**	**346**	**4480**
Actual 21/22 as % of 1920	91%	93%	95%	83%	91%	88%	87%	92%					
Actual 21/22 Volume	15299	15013	16801	15645	14705	16155	15519	16796					

NB: Mar-20 Activity Levels were impacted by COVID. These have therefore been adjusted as per the national counterfactual guidance

The Consultant Led First OP Activity Plans achieve the 110% Target. Actual activity so far this year is below the 19/20 levels.

Non-consultant Led First OP Activity Plans (mainly Radiotherapy, Maternity and Therapies) are below the 104% provider threshold, however overall the activity plans exceed the 104% Threshold

Assumptions:

1. Identified funded initiatives are fully delivered
2. Levels of Activity sent to the Independent Sector (IS) remains similar to 2021/22 Levels

By the end of March 2023 provider are asked to reduce OP follow ups by 25% of 19/20 levels, and maintain this throughout 2024/25. This includes Consultant and Non-Consultant Led OP as shown below

Consultant-Led Follow Up OP	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Year Total
1920 Actual	22437	20960	24153	23412	21857	24098	23328	25634	22208	23696	22954	25455	280192
National Target - % of 1920	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	110%
National Target Volume	16828	15720	18115	17559	16393	18074	17496	19226	16656	17772	17216	19091	210144
22/23 Plan as % of 1920	93%	105%	90%	96%	106%	98%	97%	93%	98%	94%	94%	98%	97%
22/23 Plan Volume	20855	22054	21704	22590	23123	23669	22651	23792	21865	22295	21498	25038	271136
Var Plan 22/23 vs Target	**4027**	**6334**	**3590**	**5031**	**6731**	**5596**	**5155**	**4567**	**5209**	**4523**	**4283**	**5947**	**60992**
Actual 21/22 as % of 1920	107%	112%	106%	104%	105%	108%	107%	108%					
Actual 21/22 Volume	23988	23506	25666	24275	22916	26080	24880	27711					

Non-Consultant Led Follow Up OP	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Year Total
1920 Actual	9260	9739	8153	9309	8807	8349	9162	8179	7706	8952	8226	9124	104966
National Target - % of 1920	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	110%
National Target Volume	6945	7304	6115	6982	6605	6262	6872	6134	5780	6714	6170	6843	78725
22/23 Plan as % of 1920	74%	67%	88%	77%	83%	90%	77%	91%	92%	82%	85%	77%	81%
22/23 Plan Volume	6823	6504	7176	7152	7353	7548	7043	7410	7095	7345	7007	7020	85473
Var Plan 22/23 vs Target	**-122**	**-800**	**1061**	**170**	**747**	**1286**	**171**	**1275**	**1315**	**631**	**837**	**177**	**6749**
Actual 21/22 as % of 1920	74%	67%	88%	77%	83%	90%	77%	91%					
Actual 21/22 Volume	6823	6504	7176	7152	7353	7548	7043	7410					

Total Combined Follow Up OP	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Year Total
1920 Actual	31697	30699	32306	32721	30664	32447	32490	33813	29914	32648	31180	34579	385158
National Target - % of 1920	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	110%
National Target Volume	23773	23024	24230	24541	22998	24335	24368	25360	22436	24486	23385	25934	288869
22/23 Plan as % of 1920	87%	93%	89%	91%	99%	96%	91%	92%	97%	91%	91%	93%	93%
22/23 Plan Volume	27677	28558	28881	29742	30476	31217	29694	31202	28960	29640	28505	32058	356609
Var Plan 22/23 vs Target	**3905**	**5534**	**4651**	**5201**	**7478**	**6882**	**5326**	**5842**	**6524**	**5154**	**5120**	**6124**	**67741**
Actual 21/22 as % of 1920	95%	96%	99%	94%	96%	102%	96%	102%					
Actual 21/22 Volume	30228	29360	32107	30735	29570	32974	31308	34377					

NB: Mar-20 Activity Levels were impacted by COVID. These have therefore been adjusted as per the national counterfactual guidance

Divisions have identified a number of specialities where follow up reduction is possible. It is proposed that the OP transformation programme supports development of schemes to achieve the required reductions across the trust with step change in performance from October 2022 through to March 2023 as shown on the next slide

The National Elective Recovery planning ambitions are for two year waits to be eliminated by July 2023, and waits of over 18 months by April 2023. The trust is planning for zero elective waits over 52 weeks through the year.

Trajectory 2022/23

RTT >52 wk Waiters	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Actual	0	0	0	0	0	0	0	0	0	0	0	0

The 52 week wait position has improved significantly and the number of 52 week waiters is currently at 1 (January 22 Month End Position) therefore the trajectory for 2022/23 is zero

We are required to submit an RTT Total Waiting List size, where the ambition is that total waiting list size will reduce. The RTT Performance trajectory is shown for information only.

Estimated Trajectory	Dec-21	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Total Waiting List	39002	38241	37620	37057	36128	35367	34563	33933	33396	32520	31831	31147	30257
Total Backlog	11053	10338	9622	9021	8317	7780	7213	6714	6376	6036	5763	5530	5311
Total %	**71.7%**	**73.0%**	**74.4%**	**75.7%**	**77.0%**	**78.0%**	**79.1%**	**80.2%**	**80.9%**	**81.4%**	**81.9%**	**82.2%**	**82.4%**

Assumptions:

1. Identified funded initiatives are fully delivered
2. Levels of Activity sent to the Independent Sector (IS) remains similar to 2021/22 Levels
3. Referrals return to 1920 levels for most specialties with some specialties remaining slightly lower than 1920 levels based on current estimates.

The ambition is to achieve 120% of 1920 Activity levels for Diagnostic Activity. This includes the Modalities as shown below

MRI Scans	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Year Total
1920 Actual	1984	2167	2143	2328	2340	2183	2381	2147	2029	2401	2186	2425	26714
National Target - % of 1920	120%	120%	120%	120%	120%	120%	120%	120%	120%	120%	120%	120%	110%
National Target Volume	2381	2600	2572	2794	2808	2620	2857	2576	2435	2881	2623	2910	32057
22/23 Plan as % of 1920	117%	118%	112%	112%	110%	118%	110%	120%	111%	104%	110%	109%	112%
22/23 Plan Volume	2317	2553	2411	2616	2568	2568	2616	2568	2253	2490	2412	2646	30015
Var Plan 22/23 vs Target	**-64**	**-48**	**-161**	**-178**	**-240**	**-52**	**-241**	**-9**	**-182**	**-391**	**-211**	**-264**	**-2042**
Actual 21/22 as % of 1920	96%	101%	107%	115%	104%	114%	100%	107%					
Actual 21/22 Volume	1914	2190	2296	2680	2442	2492	2375	2306					

CT Scans	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Year Total
1920 Actual	4074	4420	4462	4645	4588	4484	4726	4471	4500	4762	4356	4873	54361
National Target - % of 1920	120%	120%	120%	120%	120%	120%	120%	120%	120%	120%	120%	120%	110%
National Target Volume	4889	5304	5354	5574	5506	5381	5671	5365	5400	5714	5227	5848	65233
22/23 Plan as % of 1920	140%	141%	132%	141%	137%	139%	138%	140%	124%	127%	136%	129%	135%
22/23 Plan Volume	5694	6236	5868	6534	6305	6228	6532	6276	5562	6042	5919	6295	73491
Var Plan 22/23 vs Target	**805**	**932**	**514**	**960**	**799**	**847**	**861**	**911**	**162**	**328**	**692**	**447**	**8258**
Actual 21/22 as % of 1920	127%	127%	122%	118%	115%	120%	120%	126%					
Actual 21/22 Volume	5187	5601	5440	5486	5264	5363	5668	5623					

NOUS	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Year Total
1920 Actual	4577	4789	4677	4929	4387	4428	4711	4662	4297	4717	4382	4846	55402
National Target - % of 1920	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	110%
National Target Volume	4577	4789	4677	4929	4387	4428	4711	4662	4297	4717	4382	4846	55402
22/23 Plan as % of 1920	93%	97%	95%	100%	107%	103%	110%	109%	106%	103%	107%	102%	103%
22/23 Plan Volume	4237	4665	4446	4943	4705	4574	5192	5092	4547	4837	4701	4933	56872
Var Plan 22/23 vs Target	**-340**	**-124**	**-231**	**14**	**318**	**146**	**481**	**430**	**250**	**120**	**319**	**87**	**1470**
Actual 21/22 as % of 1920	86%	91%	97%	92%	97%	104%	93%	95%					
Actual 21/22 Volume	3954	4344	4552	4539	4241	4589	4364	4435					

NB: Mar-20 Activity Levels were impacted by COVID. These have therefore been adjusted as per the national counterfactual guidance

Both the MRI and NOUS Plans are currently showing below the 120% target at 112% and 103% for the year respectively. The Plan for CT Scans is achieving the 120% target

MRI: Planning currently underway to bring a second MRI scanner online at Hermitage Court. Ambition to be online from end of March giving additional 138 scans per week.

NOUS: Recruitment in the pipeline, additional 3 x US machines capital bid progressed for the CDC. Likely to come on line May /June.

The ambition is to achieve 120% of 1920 Activity levels for Diagnostic Activity. This includes the Modalities as shown below

Echocardiography	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Year Total
1920 Actual	881	887	833	991	750	889	971	919	803	997	895	979	10795
National Target - % of 1920	120%	120%	120%	120%	120%	120%	120%	120%	120%	120%	120%	120%	110%
National Target Volume	1057	1064	1000	1189	900	1067	1165	1103	964	1196	1074	1175	12954
22/23 Plan as % of 1920	48%	83%	96%	81%	107%	112%	82%	87%	100%	80%	89%	102%	89%
22/23 Plan Volume	420	740	800	800	800	1000	800	800	800	800	800	1000	9560
Var Plan 22/23 vs Target	**-637**	**-324**	**-200**	**-389**	**-100**	**-67**	**-365**	**-303**	**-164**	**-396**	**-274**	**-175**	**-3394**
Actual 21/22 as % of 1920	78%	77%	71%	64%	75%	88%	71%	85%					
Actual 21/22 Volume	684	684	594	631	562	784	688	783					

Echocardiography is showing a plan of below the 120% target at 89% for the year. This is mainly due to additional capacity coming in part way through the year but not available at the beginning of the year.

NB: Mar-20 Activity Levels were impacted by COVID. These have therefore been adjusted as per the national counterfactual guidance

The Target is to achieve 120% of 1920 Activity levels for Diagnostic Endoscopy Activity. This includes the Modalities as shown below

Colonoscopy	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Year Total
1920 Actual	497	497	442	452	486	419	467	471	387	443	436	481	5478
National Target - % of 1920	120%	120%	120%	120%	120%	120%	120%	120%	120%	120%	120%	120%	110%
National Target Volume	596	596	530	542	583	503	560	565	464	532	523	577	6574
22/23 Plan as % of 1920	44%	43%	38%	43%	44%	43%	30%	30%	45%	41%	40%	41%	40%
22/23 Plan Volume	219	213	167	193	213	179	139	143	173	182	173	200	2195
Var Plan 22/23 vs Target	**-377**	**-383**	**-363**	**-349**	**-370**	**-324**	**-421**	**-422**	**-291**	**-349**	**-350**	**-378**	**-4379**
Actual 21/22 as % of 1920	44%	43%	38%	43%	44%	43%	30%	30%					
Actual 21/22 Volume	219	213	167	193	213	179	139	143					

Flexi Sigmoidoscopy	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Year Total
1920 Actual	184	211	176	191	219	309	262	322	228	238	350	389	3079
National Target - % of 1920	120%	120%	120%	120%	120%	120%	120%	120%	120%	120%	120%	120%	110%
National Target Volume	221	253	211	229	263	371	314	386	274	286	420	467	3695
22/23 Plan as % of 1920	132%	86%	101%	103%	99%	50%	44%	33%	72%	72%	47%	49%	67%
22/23 Plan Volume	242	181	177	196	216	154	116	105	164	172	164	189	2076
Var Plan 22/23 vs Target	**21**	**-72**	**-34**	**-33**	**-47**	**-217**	**-198**	**-281**	**-109**	**-113**	**-256**	**-278**	**-1618**
Actual 21/22 as % of 1920	132%	86%	101%	103%	99%	50%	44%	33%					
Actual 21/22 Volume	242	181	177	196	216	154	116	105					

Gastroscopy	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Year Total
1920 Actual	371	461	442	391	358	428	509	450	406	547	438	487	5288
National Target - % of 1920	120%	120%	120%	120%	120%	120%	120%	120%	120%	120%	120%	120%	110%
National Target Volume	445	553	530	469	430	514	611	540	487	656	526	584	6346
22/23 Plan as % of 1920	117%	97%	91%	105%	106%	82%	62%	65%	88%	69%	82%	85%	86%
22/23 Plan Volume	434	448	402	411	380	353	314	293	359	377	359	413	4544
Var Plan 22/23 vs Target	**-11**	**-105**	**-128**	**-58**	**-50**	**-161**	**-297**	**-247**	**-128**	**-279**	**-166**	**-171**	**-1802**
Actual 21/22 as % of 1920	117%	97%	91%	105%	106%	82%	62%	65%					
Actual 21/22 Volume	434	448	402	411	380	353	314	293					

NB: Mar-20 Activity Levels were impacted by COVID. These have therefore been adjusted as per the national counterfactual guidance

Lower levels of activity have been seen so far this year due to the introduction of QFIT testing in the Community as well as the already known impact of the Trust now not providing a Bowel Scope Service (which was provided in 1920). Plans for 2022/23 have therefore been set at the same level as 2021/22 Activity. Endoscopy activity also affects the Day Case Activity mainly for General Surgery and Gastroenterology

We are forecasting to maintain compliance with all cancer standards throughout 22/23.

	Cancer 2WW (93%)	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
	Total Patients Seen	1,562	1,448	1,637	1,674	1,511	1,749	1,759	1,902	1,787	1,670	1,670	1,670
	>2 week wait	102	94	106	109	98	114	114	124	116	109	109	106
Cancer 2WW (93%)	Peformance %	93.5%	93.5%	93.5%	93.5%	93.5%	93.5%	93.5%	93.5%	93.5%	93.5%	93.5%	93.7%

	Cancer 31 Day First (96%)	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
	Total Patients Seen	198	225	246	248	237	240	219	237	218	231	228	231
Cancer 31 Day First	>31 day wait	7	9	9	8	8	8	8	8	8	8	8	8
(96%)	Peformance %	96.5%	96.0%	96.3%	96.8%	96.6%	96.7%	96.3%	96.6%	96.3%	96.5%	96.5%	96.5%

	Cancer 62 days (85%)	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
	Total Patients Seen	127	125	125	121	119	108	112	131	95	138	103	136
Cancer 62 days	>62 day wait	18	18	18	18	17	16	16	19	14	20	15	20
(85%)	Peformance %	85.8%	85.5%	85.6%	85.1%	85.7%	85.2%	85.7%	85.5%	85.3%	85.5%	85.4%	85.3%

New Indicator: Cancer Faster Diagnosis 28 Days

	Cancer Faster Diagnosis 28 Days	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
	Total Patients	1,633	1,498	1,671	1,645	1,471	1,647	1,634	1,749	1,665	1,623	1,623	1,623
Cancer Faster	>28 days or no date	408	374	417	411	367	411	408	437	416	405	405	405
Diagnosis 28 Days	Peformance %	75.0%	75.0%	75.0%	75.0%	75.1%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%

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2022/23 Workforce phasing

Staffing Group	Agreed 2022/23 Core Establishment	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
A&C/Sen Man Substantive	598.55	486.87	499.61	506.11	515.13	524.6	525.39	527.56	536.25	544.28	553.18	563.58	575.38
A&C/Sen Man Bank	0.00	81.49	63.33	76.51	74.22	99.03	86.76	87.79	73.67	80.45	71.67	71.67	71.36
A&C/Sen Man Agency	0.00	13.23	9.48	13.42	19.57	19.64	13.13	23.3	40.64	23.89	40.64	41.14	41.64
A&C/Sen Man Staff Total	**598.55**	**581.59**	**572.42**	**596.04**	**608.92**	**643.27**	**625.28**	**638.65**	**650.56**	**648.62**	**665.49**	**676.39**	**688.38**
Medical Staff - Substantive	904.48	752.37	744.39	746.58	794.68	892.05	790.74	819.66	792.07	795.44	795.44	796.84	803.84
Medical Staff - Bank	0.00	105.83	97.05	96.62	74.03	75.69	66.97	103.49	63.49	91.19	77.07	80.12	79.27
Medical Staff - Agency	3.00	57.69	59.13	76.53	71.44	57.76	84.84	70.52	78.69	93.49	92.35	92.68	91.68
Medical Staff Total	**907.48**	**915.89**	**900.57**	**919.73**	**940.15**	**1025.5**	**942.55**	**993.67**	**934.25**	**980.12**	**964.86**	**969.64**	**974.79**
Nurses Substantive - Trained	2084.53	1562.71	1590.45	1573.15	1586.24	1573.2	1588.38	1582.34	1633.78	1618.61	1617.41	1646.79	1662.54
Nurse Bank	0.00	186.74	136.38	158.47	136.8	197.68	168.4	189.39	180.46	216.3	183.97	180.21	173.7
Nurse Agency	0.00	92.01	108.35	76.44	143.97	90.79	175.97	138.5	131.01	157.53	131.01	131.01	131.01
Nursing Total	**2084.53**	**1841.46**	**1835.18**	**1808.06**	**1867.01**	**1861.67**	**1932.75**	**1910.23**	**1945.25**	**1992.44**	**1932.39**	**1958.01**	**1967.25**
Ambulance + Paramedics Trained	7.47	10.77	10.57	8.85	8.42	8.56	9.46	9.24	8.8	8.8	8.8	8.8	8.8
Qualified Ambulance + Paramed Total	**7.47**	**10.77**	**10.57**	**8.85**	**8.42**	**8.56**	**9.46**	**9.24**	**8.8**	**8.8**	**8.8**	**8.8**	**8.8**
Scientific Therap & Tech - Subst	905.27	756.09	748.13	741.96	745.39	749.72	763.42	768.20	775.00	770.77	775.81	780.50	792.70
Scientific Therap & Tech - Bank	0.00	25.07	18.24	20.13	18.43	24.82	19.52	23.73	23.10	26.01	23.10	23.10	23.10
Scientific, Therap & Tech - Agency	0.00	31.86	28.96	25.24	30.12	37.11	33.71	20.21	26.26	33.74	30.20	32.95	34.95
Scientific Therap & Tech Total	**905.27**	**813.02**	**795.33**	**787.33**	**793.94**	**811.65**	**816.65**	**812.14**	**824.36**	**830.52**	**829.11**	**836.55**	**850.75**
Support Substantive	552.88	532.39	516.37	520.85	520.02	529.01	527.43	523.23	515.41	513.78	517.78	522.44	525.44
Support Bank	0.00	65.81	51.74	65.17	61.22	95.41	80.94	83.47	73.01	97.65	73.01	73.01	73.01
Support Agency	0.00	40.46	29.32	-4.42	1.91	7.23	19.62	21.33	22.19	15.09	18.64	18.64	18.64
Support Staff Total	**552.88**	**638.66**	**597.43**	**581.6**	**583.15**	**631.65**	**627.99**	**628.03**	**610.61**	**626.52**	**609.43**	**614.09**	**617.09**
Support to Clinical Staff - Subst	2063.90	1691.19	1713.18	1748.95	1728.84	1726.24	1716.72	1737.90	1751.69	1767.59	1785.84	1804.11	1823.64
Support to Clinical Staff - Bank	0.00	157.47	117.60	140.91	130.42	192.76	167.21	169.30	168.86	187.62	168.86	168.86	167.65
Support to Clinical Staff - Agency	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Support to Clinical Staff Total	**2063.90**	**1848.66**	**1830.78**	**1889.86**	**1859.26**	**1919**	**1883.93**	**1907.2**	**1920.55**	**1955.21**	**1954.7**	**1972.97**	**1991.29**
Grand Total	**7120.08**	**6650.05**	**6542.28**	**6591.47**	**6660.85**	**6901.3**	**6838.61**	**6899.16**	**6894.38**	**7042.23**	**6964.78**	**7036.45**	**7098.35**

<u>Headlines (data cut from 16/02/22)</u>

A forecast of a net increase of 448.30 WTE over 22/23:

- Substantive staff increases by 399.95 WTE to 6,183.54WTE
- Bank staff usage reduces by an equivalent of 34.32 WTE
- Agency staff usage increases by an equivalent of 82.67 WTE

Areas of note for 22/23

Recruitment

- Forecast recruitment is significant, building on steady progress made in the latter half of 21/22. Assuming turnover rates do not change significantly compared to 21/22, over 1,000 substantive staff will need to be recruited to achieve this forecast.
- In order to be assured this ambitious level of activity can be delivered, it is essential that regular and robust planning be undertaken at divisional level with close manager, HR and Finance collaboration, primarily through HR Business Partners / Finance Managers and also regular engagement with the Resourcing team to ensure recruitment campaigns are planned and resourced properly to deliver.
- Such significant recruitment of substantive staff will also require a reduction in bank and agency usage to ensure overall spend does not breach agreed budgets. Bank and agency usage will need to have target trajectories set to achieve this, with regular reporting to provide assurance this risk is managed.
- Continued recruitment across MTW will create an opportunity for the Trust to make improvements towards the national challenge of having 19% BAME representation at all bands by 2025.

Retention

- Retention is a priority for 22/23 – the turnover rate remains above the Trust target of 10%, in particular for Nursing staff. This is a national as well as Trust issue with a national/trust response required.
- To improve this, we will introduce a range or retention tools, including greater consistency around allowances, improved role design, succession planning for key posts and improved guidance supporting policies such as Retire & Return, flexible working practices and pension recycling.
- In addition, we will support colleagues through the new Welfare team and the continued roll out of leadership development programmes which will upskill new / existing managers and create a compassionate and inclusive environment.

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2022/23 Draft Plan

	Income	Expenditure	Total
	£ m	£ m	£ m
2021/22 Outturn	**605.2**	**-605.2**	**0.0**
21/22 underlying			
Other income - H2 plan x2	4.1		4.1
Increase in Pay run rate		-7.4	-7.4
One off Benefits in 21/22		-2.0	-2.0
Non recurrent costs in 21/22		2.9	2.9
FYE Energy Price Change		-3.2	-3.2
Other		0.2	0.2
22/23 Impacts			
COVID	-10.1	2.0	-8.1
Reduction in ERF	0.0		0.0
Growth	10.5	-6.6	3.9
Local and National Efficency Target	-15.5	20.0	4.5
CIPS 21/22		10.0	10.0
Net Inflation Pressure	14.5	-17.2	-2.7
Assume Contingency held in system 0.5%		0.0	0.0
Service Developments		-5.7	-5.7
Cost Pressures		-6.6	-6.6
Additional CCG income	10.0		10.0
22/23 Plan	**618.7**	**-618.7**	**0.0**

The draft financial plan for 2022/23 is a breakeven position, albeit based on a number of assumptions.

The Income contract values are still being confirmed with commissioners. The starting point for 22/23 Clinical Income is H2 x2. This is adjusted for non recurrent funding and then uplifted for growth at 2.5% and inflation at 2.8%. There is a national efficiency ask of 1.1% and a local system efficiency of 2.5%. 0.5% of the local system efficiency is kept in contingency reserve that the Trust plans to access if required. The Trust is looking for an additional £10m from the CCG to support the current levels of activity provided by the Trust.

The Trust has assumed receiving the same level of ERF income as was received in 21/22 (£20m)

COVID income is reducing by 50% (£10m), currently we are assuming that expenditure reduces by £2m.

The Trust has an internal CIP target of £20m for 2022/23 plus £10m of undelivered CIP from 21/22.

The plan currently includes an additional £18.9 to support growth (£6.6m), cost pressures (£6.6m) and service developments (£5.7m).

The plan includes £37.8m of risk which is detailed on the next slide.

Risks and Benefits

	Value £ m	Risk %	Risk Adjusted Value £ m
CIP Delivery 2022/23	20.0	25%	5
CIP Delivery 2021/22	10.0	75%	7.5
ERF Funding	20.0	100%	20
Additional CCG income	10.0	100%	10
Total Risks			42.5
Energy Prices	-3.2	75%	-2.4
Net Inflation Pressure	-2.7	50%	-1.3
COVID	-2.0	50%	-1.0
Total benefits			-4.7
Total Risks and Benefits			**37.8**

The goal between now and the final plan submission will be to minimise these risks, and manage any impact on the plan that crystallises.

The plan assumes full delivery of CIP but there is a risk that this may not be fully delivered in 2022/23. Plans are being developed with Divisions with support from the PMO but the pause in CIP in the last 2 years means CIP programmes are at a less developed stage than in previous years.

The Trust received £20m of ERF funding in 2021/22 and plans to receive the same again in 2022/23. This is dependent on meeting elective activity targets 104% higher than 19/20 levels. Current demand and capacity modelling shows 104% is likely.

The Trust also assumes an additional £10m from the CCG to support this, some of this may be accessed from the contingency reserve created. This additional level of funding has not yet been agreed.

There are potential benefits in the plan which could have a positive impact such as further reduction in COVID expenditure, or predicted energy and inflation increases being lower than expected.

Mitigations

	£ m
Ensure delivery of CIP	5
Workforce availability	3
Annual Leave accrual reduces	5
Non recurrent income in year	2
Reduce SD and CP investments	5
Total Mitigations	**20**

In order to mitigate risks in the financial plan the Trust has identified the following potential mitigations, some of which require further development

- Improve the delivery of CIP
- Workforce availability may limit recruitment ambitions
- Annual Leave accrual may reduce if staff are able to take their annual leave in full.
- Identify further non recurrent income support
- Reduce the level of investments in Service Developments and Cost Pressures.

Currently the mitigations do not outstrip the risks, and as such there would be a risk of this version of the plan failing to deliver.

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

The IPC BAF is required to be updated and reviewed by the Trust Board on a monthly basis during the Covid-19 pandemic
Changes are highlighted in red in the document. The BAF questions have been updated by NHSE&I. Where the wording of a question has changed but the previous answer remains relevant the question is noted in red but the answer is in black.

For this reporting period the BAF questions have undergone extensive revision by NHSE&I

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

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure that: • a respiratory season/winter plan is in place: ○ that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services ○ to enable appropriate segregation of cases depending on the pathogen. ○ plan for and manage increasing case numbers where they occur. ○ a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan.	• POCT in place for all admissions including Covid-19, Influenza A & B, RSV. Integrated with Pathology LIMS (Telepath). Also available for essential staff (following contact) and selected patients as required • Streaming in place for respiratory and non-respiratory pathways in ED with front door triage. • Isolation facilities and Covid cohort areas/wards in place. Red (Covid) ITU in place • Temperature checks in place at front door for obstetric patients and accompanying birth partner. Elective C section patients have Covid swab 48 hours prior to admission. • Escalation plan in place. Plan in place to flex in-patient Covid capacity as required • Winter planning meetings held and attended by MDT		

• health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.	• Covid precautions remain in place with universal mask wearing • Twice weekly LFT implemented • PCR testing available on request for staff • Social distancing encouraged for staff • Meetings remain online wherever possible • Working from home facilitated • All changes in practice communicated through team brief, huddles and the daily Pulse publication • Workplace risks identified, risk assessed and action plans in place		
• Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: ○ based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area. ○ applied in order and include elimination; substitution, engineering, administration and PPE/RPE. ○ communicated to staff.	• Hierarchy of Controls risk assessment template in place and available on the Trust intranet • Risk assessment for the use of FFP3 masks in place and available on the staff intranet. Updated for Omicron variant • All staff caring for Covid positive patients wear FFP3 masks • Communicated to staff via the Pulse and team briefs/huddles		
• safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.	• Safe systems of working in place following national guidance • IPCT attend weekly system and regional IPC meetings • DIPC chairs K&M IPC leadership forum • All changes of guidance discussed at system and regional level and reviewed at IPCC		
• if the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been	• National guidance followed however local decisions made around delaying standing down some precautions due to local risk assessments – discussed at IPCC		

approved through local governance procedures, for example Integrated Care Systems.	• FFP3 masks worn by all staff caring for Covid positive patients – risk assessment in place		
• risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents.	• Risk assessments completed by ward managers in collaboration with IPCT		
• if an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered.	• FFP3 masks in use for all staff caring for Covid positive patients		
• ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services.	• Work is ongoing to reduce the number of moves for patients to a maximum of 3 unless discussed with manager on call. Moves have been necessitated to enable co-horting of infectious patients and maximum use of beds due to capacity pressures. • Patients with confirmed Covid infection cohorted in specified wards. Patients moved for escalation of care and de-escalation from ICU care only.		
• the Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep.in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases	• Signed off by Head of ICC under delegated authority from CEO • Daily analysis shared with senior staff		
• there are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas.	• Execs and senior managers visit clinical and non-clinical areas regularly		
• resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	• IPC audit plan in place and is included in the annual work plan. • Additional auditing undertaken for ward-based periods of increased incidence of		

	C. difficile and Meticillin sensitive *Staphylococcus aureus*. • All staff receive infection control training at induction which includes a section on Covid-19 • National e-learning package level 1 and 2 in place since November 20. Face to face training prior to this. • All clinical staff have annual infection prevention and control training (level 2) which includes Covid-19 • Non-clinical staff have bi-annual training (level1) which includes Covid-19 • Additional ad hoc training on ward during IPC visits • Junior doctors have induction training including Covid delivered by DIPC • IPC booklet available for bank and agency staff. • Contractors required to adhere to appropriate IPC measures including mask wearing		
• the application of IPC practices within this guidance is monitored, eg: ○ hand hygiene. ○ PPE donning and doffing training. ○ cleaning and decontamination.	• Hand hygiene audited as part of monthly ward and IPCT triangulation audits • PPE audits completed by the fit testing and PPE team • Cleaning and decontamination audited as part of the National Standards of Cleanliness audits using the My Audit platform		
• the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board.	• IPC Board Assurance Framework is updated by the DIPC and reviewed monthly at Trust Board. Evidence base is available as required • From July 2021, BAF to be reviewed by Board when new guidance is published or there is significant change to report		

• the Trust Board has oversight of ongoing outbreaks and action plans. • the Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required.	•Outbreak meetings take place weekly. •Summary reports reviewed at IPCC and reported to Board through the Quality committee •Executive team receives the daily outbreak sitrep •A range of FFP3 masks are available to staff including UK made masks. Staff fit tested against a minimum of two masks. •Reusable masks and air powered respirators available for those who fail FIT testing		
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • the Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level. • the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms • cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	• Implementation plan completed and National standards in use across the Trust. • Implementation was monitored through the IPCC and reported to Board through Quality committee • Communications in place using Teletracking • IPCT liaise closely with operational and facilities teams • Cleaning audits completed according to national standards. Action plans created as required. • All standards exceeded with >90% achieved in all areas (95% in high risk areas)		

	• Bespoke MyAudit platform developed by collaboration between MTW and parent company.		
• increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas. • Where patients with respiratory infections are cared for : cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses.	• Cleaning levels well established and implemented for all areas. • Covid areas have enhanced cleaning as routine • Diff X is cleaning/disinfecting agent used in the Trust. Confirmed as active against respiratory viruses and enveloped viruses including Covid • Decision made in collaboration with IPCT		
• manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.	• Manufacturer's guidance is followed in all areas • Instructions are displayed where needed • Environmental cleaning policy reflects manufacturers requirements		
• a minimum of twice daily cleaning of: ○ patient isolation rooms. ○ cohort areas. ○ Donning & doffing areas	• Increased frequency of cleaning complies with national guidance for isolation rooms, cohort areas and donning and doffing areas		
○ 'Frequently touched' surfaces eg, door/toilet handles, patient call bells, over bed tables and bed rails. ○ where there may be higher environmental contamination rates, including: ▪ toilets/commodes particularly if patients have diarrhoea.	• Frequently touched surfaces cleaning in place since June 2020 • Increased frequency in place • Commode cleaning audited with triangulation audits in addition. Reported to IPCC		

• A terminal/deep clean of inpatient rooms is carried out:
  ○ following resolutions of symptoms and removal of precautions.
  ○ when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens);
  ○ following an AGP **if room vacated** (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).
	• Level 3 clean plus UVC decontamination for areas/rooms stepped down from Covid to non-covid
	• Terminal clean of single rooms based on infectivity of patient. Information on levels of cleaning widely available.
	• Disposable curtains used throughout the Trust with criteria in place for replacement
	• Following AGP level 3 terminal clean plus UVC decontamination completed		

• reusable non-invasive care equipment is decontaminated:
  ○ between each use**.**
  ○ after blood and/or body fluid contamination
  ○ at regular predefined intervals as part of an equipment cleaning protocol
  ○ before inspection, servicing, or repair equipment.
	• Re-usable non-invasive care equipment decontaminated according to the Trust policy.
	• Pre-existing guidance remains in place for clinical areas
	• Disinfectant wipes used which are active against Covid-19.
	• DiffX used for commode cleaning		

• Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	• Commode cleaning audited with triangulation audits in addition. Reported to IPCC • Other cleaning of nursing equipment monitored daily by matrons as part of daily ward checks		
• As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance. In patient Care Health Building Note 04-01: Adult in-patient facilities.	• Tunbridge Wells Hospital was constructed fourteen years ago and is designed with ventilation supply and extract systems in clinical, rest, dining and administration areas. The ventilation in this building is compliant with the NHS Health Technical Memoranda HTM 03-01. HTM 03-01 specifies a high standard of supply and extract ventilation design with single pass air supply and no recirculation of internal for infection control purposes.		

• the assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer. • a systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways • where possible air is diluted by natural ventilation by opening windows and doors where appropriate • where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group. • when considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.	• 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. • Estates team work closely with IPCT on risk assessments for ventilation • Review has been undertaken. Risk not mitigated by ventilation controls in Covid areas • Windows in ward bays and side rooms to be opened for 15 minutes 3 times per day to improve ventilation • Additional ventilation brought into some areas. Hybrid model of partial recirculation with UVC cleaning of air implemented in ED RAP area and to be extended to other areas • Screen and partitions in widespread use. Cleaning in place		
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and process are in place to ensure that: • arrangements for antimicrobial stewardship are maintained	• Antimicrobial stewardship continues as for pre-Covid. • Antimicrobial stewardship group has continued to meet throughout. ASG reports to Drugs, Therapeutics and Medicines Management Committee		

• previous antimicrobial history is considered
 	
• the use of antimicrobials is managed and monitored:
  ○ to reduce inappropriate prescribing
 	
  ○ to ensure patients with infections are treated promptly with correct antibiotic.
 	
• mandatory reporting requirements are adhered to, and boards continue to maintain oversight.
 	
• risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.
	• Antimicrobial report to IPCC
	• Ward pharmacists review prescribing
	• Prescribing of antibiotics is low compared with peer K&M organisations
	• Audits and reporting restarted and maintained in second wave
	• Ward based audits were suspended in March and April 2020 but reinstated for May 2020 and have continued
	
	• Training for new doctors has continued and includes advice on taking into account previous antibiotic history
	
	• Antimicrobial guidelines in place
	• Certain antibiotics controlled and can only be prescribed with permission of the microbiologist
	• Empirical guidance in place
	• Sepsis pathway in place
	• Guidelines for antibiotic treatment of Covid patients issued by ASG
	
	• Mandatory reporting of antimicrobial usage has continued.
	• IPCC and DTMMC report to Quality committee
	
	• Information on national increase of Aspergillus infection in Covid patients in the ITU setting has been shared with ITU clinicians
	• Antimicrobial resistance monitored
	• Systems in place to screen for CRE/CPE and MRSA
	• ITU staff wear short sleeved gowns to ensure 'bare below the elbows' and hand hygiene can be maintained in Covid areas		

	• Regular screening of ITU patients for potentially infectious organisms		
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors	• Routine visiting re-started from 29 March 21 and extended 17 May 21. One hour per patient each day • Additional visitors permitted only on compassionate grounds and to assist patients with specific needs. ITU has separate arrangements • Two birth partners allowed. Both parents and grandparents can visit in neonatal unit. Covid testing in place to facilitate this. • Outpatients have accompanying person only when required for care needs • Surgical mask provided to patients and visitors • Extended visiting for compassionate reasons e.g end of life • iPads available to assist patients in maintaining contact with loved ones		
• national guidance on visiting patients in a care setting is implemented.	• Local decisions based on risk assessment.		
• restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment.	• Visiting not permitted on outbreak wards unless for compassionate/end of life reasons		
• there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing.	• Posters prominently displayed in public areas • Graphics on trust Covid internet pages		

• if visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM. • visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (eg, parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible. • visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment eg, carer/parent/guardian. • Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been adopted C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	• Posters in wards to encourage patients to wear face masks • PPE guidance for visitors available – ward staff advise individual visitors. Non-Covid infectious patients able to have visitors. • Covid patients do not have visitors except for compassionate/end of life reasons • Visitors asked about respiratory symptoms on arrival and turned away if they are symptomatic unless compassionate reasons etc. Arrangements for video call made as required • Visitors are not present during AGPs unless essential carers or for compassionate /end of life • Use of the toolkit has been considered and elements will be implemented as part of the IPC strategy		
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	• Signage displayed at main entrance, oncology entrance and ED entrance.		

• infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred. • staff are aware of agreed template for screening questions to ask. • screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment. • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance. • triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible. • there is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved. • patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated. • patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result.	• Covid status and other diagnoses included on electronic discharge notification. • Also included in handover documents for ward to ward transfers and transfers to other care facilities • Standard triage template supported by EPR system (Sunrise) and printed version • Elective patients are Covid tested up to 72 hours prior to admission • Triage and screening by questioning for patients attending ED and out patient clinics. • In addition, ED patients have temperature checking • 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 wear face masks as long as tolerated • Patients tested on admission, day 3 and day 5-7. • Weekly testing introduced February 2022 in response to increasing nosocomial risk • All patients are provided with FRSM and encouraged to wear them where it can be tolerated. • All patients encouraged to wear masks when moving away from their bed space. • Patients with respiratory symptoms move through the ED respiratory		

	pathway and are separated from other non-respiratory patients • Patients on this pathway have rapid Covid test. Where negative and Covid still suspected, a laboratory PCR test is also taken. • Patients isolated whilst awaiting results		
• patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing.	• Patients with respiratory symptoms are isolated pending results of tests		
• patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare eg, priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered.	• Criteria in place for admission to haematology ward to ensure only Covid negative patients are on the ward • Staff LFT monitored • CEV patients isolated in ED and on wards and prioritised for single rooms		
• where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes.	• In place. Clinical review determines risk vs benefit of proceeding with treatment in symptomatic or recently Covid positive patients		
• face masks/coverings are worn by staff and patients in all health and care facilities.	• 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 • All staff wear masks unless in a Covid secure area		
• where infectious respiratory patients are cared for physical distancing remains at 2 metres distance.	• All beds at a minimum of 2m spacing • Cubicles in ED separated by solid walls		

• patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, eg, to protect reception staff.	• Seating spaced at 1.5 metres in waiting areas • Reception staff protected with screens		
• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly.	• Suspected patients who test negative have medical review prior to step down to non-Covid ward. Those who continue to be suspected cases have repeat testing and remain in side room on Covid or quarantine ward • Any patients with new symptoms after admission are tested and isolated until the result is known		
• isolation, testing and instigation of contact tracing is achieved for all patients with new-onset symptoms, until proven negative.	• Patients who develop symptoms after admission are tested promptly and moved to side room on Covid ward. The rationale for testing is documented in the patient's notes • Contact tracing carried out if patient tests positive. Business Intelligence programme in place to track contacts • Patients exposed to confirmed case are isolated and given information and duty of candour letter. Medically fit patients who are discharged to their own home continue to self-isolate at home. • Patients from residential care are swabbed prior to discharge and care facility informed of the result. IDT manage discharge to residential care. • All laboratory results submitted to PHE for national track and trace • Contacts are screened twice per week for 14 days		
• patients that attend 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 • Patients for elective admission who are unwell on the day of admission despite a negative pre-admission Covid swab have a medical review to determine if their planned treatment can proceed.		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • appropriate infection prevention education is provided for staff, patients, and visitors.	• Patients and visitors are advised on basic infection control including hand hygiene and mask wearing. • All staff have access to IPC education		
• training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely.	• Local induction for new staff. PPE officers provide training. • Dedicated FIT testing team. All results recorded and database maintained • Nurse in Charge of a shift ensures bank and agency staff aware of PPE expectations • PPE officers provide face to face training on wards. • IPC team provide training to staff • Mandatory IPC e-learning package includes Covid-19. National package in use • Donning and Doffing videos available on Trust intranet site.		
• all staff providing patient care and working within the clinical environment are trained in the selection and use	• PPE officers provide workplace training.		

of PPE appropriate for the clinical situation and on how to safely put it on and remove it; • adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk. • gloves are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's. • 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	• Donning and doffing stations provided on Covid wards • FIT testing available for all staff who require it and tested on a minimum of two masks • Signage and posters displayed in donning and doffing areas • PPE audits ongoing and reported to IPCC • Combined hand hygiene and PPE audit in place • Action plans for non-compliance • Local decision to use FFP3 masks for all direct patient care of Covid positive patients since late December 2020. Decision kept under review and stepped down to national guidance 14 April 21 in view of low numbers of patients and high uptake of vaccine amongst staff • New risk assessment in July 2021 using hierarchy of controls to allow staff to wear FFP3 masks when giving direct care to Covid positive patients • Provision made for staff with risk factors etc to continue to use FFP3. • Some clinical areas with long standing variations to the guidance to allow staff to wear FFP3 masks such as obstetric ultrasound, and these variations will continue • Green wards use Standard Infection Control Precautions plus masks – informal training on wards by IPCT and circulated through Pulse • Hand air dryers are not in use in the Trust		

located close to the sink but beyond the risk of splash contamination as per national guidance. • staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace • staff understand the requirements for uniform laundering where this is not provided for onsite. • all staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance.	• All hand wash basins are co-located with paper towel dispensers • Staff advised of social distancing rules • Reminders posted on intranet and in daily Pulse • Scrubs are worn on all Covid wards and several other wards and clinical areas. • Scrubs are laundered by the Trust laundry and staff are advised not to take them off-site • Staff launder their own uniforms. Guidance has been published through the daily bulletin and Covid intranet page. • All staff advised to travel to and from work in their own clothes and change on site • Staff changing and shower facilities provided on both sites • Guidance in place for staff regarding household infections and contacts. • Guidance regularly updated and cascaded to managers. Published in Pulse and on intranet Covid pages • Return to work guidance also in place in line with national guidance • 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		

• to monitor compliance and reporting for asymptomatic staff testing	• Rapid tests available for essential staff due on shift when they have contact • All staff have access to LFT • Compliance with testing and reporting by asymptomatic staff is monitored • Email reminders sent to staff who are late in submitting results		
• there is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals).	• Surveillance by BI at system level with local data and shared with senior managers and discussed at daily strategic command meetings. • Nosocomial infections closely monitored • Daily outbreak sitrep widely available • Daily staff sickness rates reviewed at strategic command call daily		
• positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	• IPCT monitor all Covid positive inpatient results • Outbreaks declared according to national guidance • All outbreaks are investigated and Serious Incidents declared. • Concise investigation and consistent Terms of reference developed –under review • Weekly outbreak meetings • Outbreaks reported via national online platform		
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • that clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare	• All in-patients advised to wear face masks where this can be tolerated and especially when moving away from their bed space	• Audits not consistently in place	• TWH is >90% single roomed hospital

facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs. • separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients. • patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals. • patients are appropriately placed ie, infectious patients in isolation or cohorts. • ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements). • standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result • the principles of SICPs and TBPs continued to be applied when caring for the deceased	• Clinic schedules designed to have telephone appointments between face to face appointments to reduce the number of patients in the waiting room at any time • Seating is socially distanced • Patients advised to wear FRSM to reduce risk of infection • Clear pathways in place to segregate Covid positive patients and others with infectious respiratory pathogens • Theatre pathway in place for Covid positive patients • Facilities in place for chemotherapy to be given to recovering Covid patients and ensure separation from other patients • Covid treatment pod set up to give community high risk patients approved treatments • Patients cared for in single rooms wherever possible or cohorted together depending on infecting organism • Ongoing reviews take place depending on demand for beds • Beds never less than 2m apart on wards • Standard infection control precautions used for all patients on the green (non-Covid) pathway • Use of SICPs and transmission based precautions (and when they should be used) detailed in the care of the Dying and Deceased policy		• No capacity to undertake additional audit

8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
There are systems and processes in place to ensure:			
• testing is undertaken by competent and trained individuals.	• Testing undertaken by registered BMS staff with documented competencies • Method validated prior to diagnostic testing		
• patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance;	• In house testing turnaround time of less than 24 hours • Extended laboratory working hours to deliver service • All non-elective patients are tested on admission • All positive patient results are phoned to ward by IPCN and provided to site team and ICC. • All results reported to PHE via Co-surv • All elective patients are tested 48-72 hours prior to admission • Online booking for staff and elective patient testing. • POCT available in both EDs • 24/7 service for near patient testing across the Trust		
• staff testing protocols are in place	• All staff have access to LFT and PCR • Online booking system • Staff results sent by text message directly from on-line system • Staff testing protocols available on the intranet and changes are published in the Pulse and cascaded to managers		
• there is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available.	• Turnaround times closely monitored • Results usually available within 24 hours		

• there is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data).	• All positive inpatients reported directly to IPC team and site practitioners via email • All staff positives reported to Occupational Health via email • All positives reported to consultant microbiologists and IPCT • Results directly authorised and available in real time • Internal quality control completed on every test run		
• screening for other potential infections takes place.	• MRSA, MSSA, GRE, and CPE screening continues as in pre-covid policies • All routine diagnostic microbiology continues including C difficile		
• that all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission.	• Rapid POCT for other respiratory viruses available in ED for respiratory patients		
• that those inpatients who go on to develop symptoms of respiratory infection/COVID-19 after admission are retested at the point symptoms arise.	• Any inpatient who develops symptoms of Covid has a laboratory PCR test and clinical review		
• that all emergency admissions who test negative on admission are retested for COVID-19 on day 3 of admission, and again between 5-7 days post admission.	• All patients who test negative on admission are re-tested in line with national g All patients who test negative on admission are re-tested in line with national guidance on day 3 and day 5-7 • Testing guidance is published in the daily Pulse and available on the intranet • Weekly testing for patients who stay for longer than a week implemented February 2022		
• that sites with high nosocomial rates should consider testing COVID-19 negative patients daily.	• Trust nosocomial rate is in line with national experience. • Daily swabbing has not been implemented although consideration to alternate day testing when nosocomial rate is high depending on lab capacity		

• that those being discharged to a care home are tested for COVID-19, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge.	• Contacts of Covid patients are swabbed twice weekly for 14 days • All patients who have been negative throughout their inpatient stay are tested 48 hours prior to discharge to a care home • Results are shared with the receiving care facility • Post-Covid patients are not tested further for 90 days unless they develop new symptoms		
• those patients being discharged to a care facility within their 14-day isolation period are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance	• All patients within 14 days of initial diagnosis of Covid who require discharge to a care facility are discharged to a designated care setting		
• there is an assessment of the need for a negative PCR and 3 days self-isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance.	• All surgical patients are assessed for the need to self-isolate prior to admission • Patients within 90 days of positive test are not retested unless they develop new symptoms • PCR testing well set up and working efficiently with good patient uptake		

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that • the application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors). • staff are supported in adhering to all IPC policies, including those for other alert organisms.	• See section 1 page 3 • All pre-covid remain in place where they don't conflict with Covid policies		

• safe spaces for staff break areas/changing facilities are provided.	• Break out areas available. • Staff canteen has socially distanced seating • Changing facilities and showers available on both sites		
• robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	• Outbreak policy in place • Active management by infection control team • Lab results available in real time via emailed list • Outbreaks declared as Serious Incidents • Outbreak report to IPCC		
• all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance.	• All clinical waste related to possible, suspected or confirmed Covid-19 cases is disposed of in the Category B (orange) clinical waste stream. • New guidance for disposal of lateral flow tests and vaccination centres –current practice already in line with guidance • All linen from patients on amber and red pathways treated as infectious linen		
• PPE stock is appropriately stored and accessible to staff who require it.	• PPE central stocks held on both main sites • Active management of stock levels by procurement to ensure safe levels of stock • Regular (twice daily) deliveries of PPE to clinical areas during times of high usage. • Central email address for PPE orders. • Reusable masks distributed to named staff as required following FIT testing		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**

Systems and processes are in place to ensure that: • staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy.	• Guidance for staff is available on the Trust Intranet, daily Pulse, through team brief and daily huddles • Staff guided towards staff absence line, occupational health and managers for advice • IPCT available for advice to managers		
• bank, agency, and locum staff follow the same deployment advice as permanent staff.	• Advice applies equally to permanent, bank and agency staff		
• staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (see Staff isolation: approach following updated government guidance)	• National guidance is followed for staff who are contacts of Covid-19 • An exception exists for staff providing clinical care to CEV patients such as those working on the haematology ward		
• staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE.	• Staff are trained in safe systems of working including the use of PPE • Regular updates provided through daily huddles, the Pulse, staff intranet, etc		
• a fit testing programme is in place for those who may need to wear respiratory protection.	• The fit testing team is part of the IPCT • All clinical staff required to be fit tested annually • Ongoing programme in place • Urgent fit testing can be facilitated if required • New staff fit tested during induction		
• where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: o lead on the implementation of systems to monitor for illness and absence.	• System in place to monitor staff illness and absence • Dedicated staff absence reporting phone line		

○ facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce	• Occupational health work closely with IPCT and microbiologists to facilitate treatment as necessary. • Covid testing directorate manages vaccination programme for Covid		
○ lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19	• Monitoring systems in place. • Occupational health work closely with HR, Covid testing directorate and IPCT		
○ encourage staff vaccine uptake.	• Staff uptake of vaccine encouraged. • Current data: ○ Covid One dose 97.14% ○ Covid Two doses 95.36% ○ Covid Booster 92.44% ○ Influenza 69.85%		
• staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance.	• Clear guidance given to staff to ensure infection control precautions followed by staff who have been vaccinated and/or recovered from Covid. • National guidance followed		
• a risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19.	• Risk assessments carried out for all staff in at risk categories including pregnant women.		
○ A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups; ○ that advice is available to all health and social care staff, including specific advice to those at risk from complications.	• Risk assessments completed through discussion between staff and line managers • Advice is widely available through the Trust intranet pages • Updates shared through intranet, Pulse, team brief and staff huddles		
○ Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff.	• Bank, agency and locum staff follow the same advice		

○ A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff. • vaccination and testing policies are in place as advised by occupational health/public health.	• Risk assessments completed as required. • Vaccination and testing advice and protocols in place. Multi-disciplinary approach to decision making		
• staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance and a record of this training is maintained and held centrally/ESR records.	• FIT testing in place including training on fit, maintenance and cleaning. • Powered air respirators available for staff who fail all fit testing • Individual use reusable respirator masks available • FIT testing register held on central database		
• staff who carry out fit test training are trained and competent to do so.	• Dedicated Fit testing team in place and fully trained • Line managed by Deputy DIPC/ Nurse consultant in IPC		
• all staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used.	• All staff required to wear a FFP respirator are fit tested • Fit testing on new models available as required		
• all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	• All staff required to wear a FFP3 respirator are tested on at least two different masks		
• a record of the fit test and result is given to and kept by the trainee and centrally within the organisation.	• A database of fit testing outcomes is maintained • Staff are provided with information identifying the type of mask to be worn		
• those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators and hoods.	• As above • Re-usable masks and hoods are available for staff who fail FIT testing with disposable masks		

• that where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions.	• Records are kept and stored electronically • Re-usable masks and hoods are available for staff who fail fit testing with disposable masks • Training is given in care and decontamination of the re-usable mask or hood.		
• members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm.	• If all respirator options are unsuitable staff work from home wherever possible • Manager works with HR to identify re-deployment opportunities • New opportunities to work with vaccination teams available		
• a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health.	• Discussions are documented and records stored electronically		
• boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	• database of all staff maintained and includes record of all FIT testing • Any staff not tested and required to wear FFP3 provided with FIT testing prior to shift • All areas have access to powered air respirators		
• consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance.	• Clear principles established in the development of elective pathways • Green pathway for elective care in place • Theatre SOP and pathways in place to enable treatment of Covid positive patients if required in an emergency • Staff do not move from amber/red patients to green patients in the same shift		

• health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone.	• All non-clinical areas assessed for Covid security. • Maximum occupancy identified on signage • Disinfectant wipes available to staff in non-clinical areas to clean workstations • Homeworking support package including training and IT kit in place for staff who now work at home • Space committee established to maximise use of space and provide secure on site workplaces with social distancing		
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing.	• Staff welfare programme in place including free food, breakout areas, psychological support/ first aiders. • Staff sickness phone line in use and covered daily, providing advice and information on sickness, swabbing and other COVID sickness questions. • Ongoing work to proactively review staffing absence and ensure that ward shifts are effectively covered, supporting safe staffing. • ICC reports staff sickness • Occupational health support staff who are self-isolating and shielding. • Managers support staff working from home. Home working toolkit published • All staff able to access testing via on-line booking system • Symptomatic staff can access testing same day • Twice weekly LFT required • Trust-wide Pulse survey results reviewed at executive and divisional level. Learning identified • Staff vaccination available as required.		

• staff who test positive have adequate information and support to aid their recovery and return to work.	• Occupational health support Covid-positive staff and advise on return to work and re-testing • Psychological support available		

NHS Maidstone and Tunbridge Wells NHS Trust

Emergency Planning Annual Report, 2021 and future emergency planning — **Chief Operating Officer**

This report highlights the work of the Emergency Planning Response and Recovery Team during 2021. It summarises:

- Incidents
- Exercises
- Planning
- Risks & Governance
- NHS England Assurance Process Results

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

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

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Emergency Planning & Response Annual Report 2021

MTW Emergency Planning and Response

1.0 Introduction

1.1 This report summarises the Emergency Planning & Response Teams' (EPRR) activities since January 2021.

1.2 The Trust, as a Category One Responder as defined by the Civil Contingencies Act 2004 has specific statutory duties in relation to emergency planning, response and recovery. In addition, the organisation has other obligations as required by contracts and performance standards set by NHS England.

1.3 The EPRR team has had to change its focus to deal with the challenges of the ongoing Pandemic. However, as restrictions have eased, the team have been able to resume some of its normal activities.

2.0 Training & Exercising

2.1 Training

2.1.1 The team were able to increase the amount of face to face training available to staff. In addition, training was adapted to allow adequate infection control precautions.

2.1.2 Training has been restarted including:

- Loggist training sessions.
- Command refresher training days.
- Command Foundation Days.
- CBRN training days for both clinical and non-clinical staff.
- Introduction to Major Incident training sessions for new staff.
- Emergency Media Management.
- Radiation Training for KCHFT Minor Injury Units.
- CBRN for managers

2.2 Exercises

2.2.1 In July 2021 the Team ran an exercise with the Women's and Children's division focussing on Paediatric Surge response. The exercise was well received and enabled the division to create an action plan to expand capacity and work in partnership with other areas of the Trust not normally associated with paediatric flow.

2.2.2 In December 2021, the Trust was also involved in a multiagency exercise. Exercise Alert, coordinated by South East Coast Ambulance Service (SECAmb). This communications exercise was successful in both showcasing our strengths, as well as revealing some areas that needed improvement, for example educating new staff members on the critical processes needed to escalate an incident. Our emergency cascades via the Everbridge System have been tested on several occasions.

3. Business Continuity

3.1 Updating Templates

3.1.1 MTW continues to striving to be an outstanding Trust. To do this, it is important that we demonstrate best practice of all areas. In order to reach this status, the team have been updating the Business Impact Analysis (BIA) and Business Continuity Plan templates. These new templates have been designed based on research into how other trusts carry out their BIA and BCP templates, and amalgamated to create a new template suitable for MTW. This new practice aims to ensure consistency among the plans throughout all areas of the hospital. It will further ensure that the templates are more user friendly, encouraging divisions to keep their plans up to date.

3.1.2 The EPRR team have also updated the generic plan template. This update aims to ensure that there is consistency throughout all plans. Therefore, during an incident, it will be easier for people to locate and properly utilise the section of the plan that they require.

3.2 Clinical Area Resources

3.2.1 In an attempt to further improve awareness about Business Continuity, red lockers continue to be rolled out across clinical areas to replace the current emergency boxes. They contain the essential equipment that may be needed during an incident, such as torches, downtime forms, stethoscopes and batteries along with their red emergency folders with response action cards and procedures. The aim of the lockers is to centralise response material to assist staff both agency and trust employees changing wards in locating in an emergency.

3.2.2 The team purchased and distributed rechargeable torches to critical areas across the Trust. These torches automatically switch on during a power disruption and have USB charging capability for emergency phones.

3.3 Sunrise EPR

3.3.1 The EPRR team were heavily involved before, during and after the launch of the Trust wide electronic patient records system. To assist the roll out the team provided on site command and control response in a separate Incident control centre, in addition to supporting the COVID ICC. It was identified early on that Business Continuity (BC) arrangements needed to be robust for such a change. Therefore, the team were involved in creating the BC plans and arrangements for any failures in the system.

3.3.2 Some technical issues have required clinical areas to resort to their Business Continuity Plans & the EPRR team have supported this both in and out of hours to ensure clinical areas remain safe. The existing Business Continuity Plans were found to be robust and overall, worked to allow core hospital operations to continue.

4. Media & Communications

4.1 Training

4.1.1 The team have continued to develop training videos in line with latest material and best practice around Major Incident response and Business continuity response, and winter preparedness these are available to all staff either via the trust intranet or the eLearning platform. Over the coming months the team will be developing a further video to support site evacuation processes.

4.2 Phone Resilience

4.2.1 Nationally analogue phones lines will soon be completely obsolete requiring the trust to replace their disaster recovery analogue phone line system. The EPRR team have worked alongside IT and the trust have invested in a cloud-based system called 8x8 as the secondary line of resilience. To give a third level of communication resilience the EPRR team worked on having smart phones with the 8x8 app that use the existing numbers. These are located within in the onsite Incident control centres and accessible by the Clinical Site Managers to distribute as required for patient safety. This system is now fully rolled out Trust wide, with cheat sheets and charging stations for all phones. This is in addition to Satellite phones that provide a fourth line of resilience held in each Incident Control Centre.

4.3 Public Helplines

4.3.1 Having a public helpline accessible in an emergency to deal with incoming calls related to the incident to allow switchboard to continue business as usual is essential in any large hospital. The EPRR team have worked to ensure a system is in place on both sites, that staff are trained to activate them and that cheat sheets are available to support the operators. In total there are 15 lines at TWH and 5 at MGH that can be run alongside each other as a hunt group should this number be required. This system has already been activated successfully several times notably for Operation Sandpiper and is tested quarterly.

4.4 Clio

4.4.1 The team are also working on launching a new incident logging system known as CLIO. The system is available nationally and is currently in use locally the by SECAmb and Kent Police. MTW are presently the first acute trust that has invested in the system which could link to other services during an incident. The system will be used to log decisions made and events that occur during any incident by on call manager and the Clinical Site Managers in the early stages and then out to other disciplines and managers. Currently, the system is being set up to record overnight bed flow issues, such as escalation and de-escalation. With the aim to replace the site reports. The team are working with a group of clinical site managers in order to get their expert input on the creation of the templates.

5. Risk & Community Safety

5.1 Risk

5.1.1 EPRR team work on six keys areas over a 6-8-week period in a weekly report. The team will monitor emerging issues under the six key areas that have the potential to impact service from environmental impact to site changes and new guidance that could impact patient flow. This is made available to managers.

5.1.2 The EPRR Risk Register has been updated based on the risks identified on the Kent Resilience (KRF) forum risk register which reflect risks on the National risk register. The relevant risks from the KRF register were assessed again the Trust risk matrix and added to the EPRR risk register as appropriate. The team will continue to review and monitor this register at each Resilience Committee meeting, with all red risks agreed upon and escalated to the Trust risk register.

5.2 Safety Advisory Groups (SAGs)

5.2.1 The EPRR team has continued to offer advice and guidance to any events that come under Sevenoaks District Council, Tonbridge & Malling Borough Council, Wealden District Council, Maidstone Borough Council and Tunbridge Wells Borough Council that may have been held as the restriction from the pandemic began to be lifted in the summer. The focus of the guidance whilst directed at adequate medical cover and provisions for inclement weather also included advice on infection prevention and control measures and social distancing. We also attend a number of site visits for local events, such as the Tom Jones and Olly Murs concerts at the Hop Farm. This year as pandemic restrictions are being lifted and the Platinum Jubilee the number of public events planned in our area have increased significantly.

6. Adverse Weather

6.1 The challenges of this year and adverse weather have meant the team has work alongside Infection prevention and control and the temperature checking teams in ensuring patients, staff and visitors have been safe in adverse weather whilst queuing outside our sites. As winter approaches the team have also been focusing on winter planning in conjunction with estates and comms to ensure staff are as informed as possible.

6.2 The trust responded well to the snow experienced in February 2021.

7. Governance

7.1 Assurance

7.1.1 The Trust has a good record of full compliance on the NHS England & CCG annual assurance process and this year the outcome for the organisation was fully compliant. The team continue to deliver at a high standard. The CCG wrote to the Accountable Emergency Officer (AEO) to confirm this in December 2021. The team continue to receive excellent support from the Chief Operating Officer as the AEO.

7.1.2 The team would also like to record its thanks to Maureen Choong who has been the NED looking at EPRR over the past few years providing excellent support and encouragement.

7.2 Partnership Working

7.2.1 The team continue to work in partnership with other agencies, charities, businesses and NHS Trusts. This year the aim is to increase direct partnership with Kent Community Health NHS Foundation Trust.

7.3 Staffing

7.3.1 In the Autumn a new Emergency Planning Officer Andy Hall joined the team and has since been working hard to ensure the Trust is in a good position going into the colder months.

7.3.2 To support the acute & community partnership a joint student role is out to advert to work across both trusts, this role not only gives a potential newcomer to the role of emergency planning the opportunity to work in partnership with a community and acute organisation it delivers on thinking outside the box to develop EPRR professionals within the NHS for the future.

7.3.2 After 37 years with the Trust and 17 years with EPRR Julie Elphick retired in January. The Board is asked

to note and record thanks to Julie for her contribution to EPRR at MTW and across Kent.

8. Plans & Incidents

8.1 Major Incident

8.1.2 In preparation for the Major Incident Plan Review to take place in 2022, the Major Incident cascade has now been reviewed. It was updated to be more user friendly and ensuring that all extension numbers are up to date.

8.2 Critical Incident

8.2.1 The critical incident plan has also been updated and reviewed in advance of the deadline, in order to add the new JESIP information briefing principle known as SBAR.

8.3 Helicopter Operations Policy

8.3.1 This was updated to include training flights enabling greater collaboration with our partners in the aviation profession. Training landings are of huge benefit to the organisation in allowing staff to practice procedures. The Trust has refreshed its partnership working with the Military during the year. In addition to improve safety public address systems have been installed to ensure maximum warning of inbound helicopters. These will also double to be used in hazardous incidents where staff need to safely give instructions to contaminated patients at a distance.

8.4 COVID 19 & Vaccinations Reflections

8.4.1 The team started 2021 supporting the Mass Vaccination Centre as the roll out of the COVID 19 vaccination started at pace. Using the Antibiotic Collection Centre Plan which the team wrote in 2012 as its foundation, the centre was a great success–able to deliver at pace in a safe and effective way even receiving a mention by the Secretary of State in Parliament. It should be appreciated just how remarkable that centre was to achieve over 1,000 vaccinations on one day whilst dealing with the new so-called Kent variant, increased winter activity, a new vaccine, additional training and staff shortages.

8.4.2 The Board have already had an in-depth report on the response to the COIVID 19 Pandemic by the EPRR Team. The Trust were able to respond effectively for a number of reasons, not least our amazing and innovative staff right across the Trust. There was however a significant amount of planning for a pandemic that had been going on since 2004. This included planning with ICU, ED, Paediatrics, Procurement and Infection Control. The threat of a pandemic has been on the Trust Risk Register for several years – although this was for flu the preparatory work was crucial and put the organisation on the front foot.

8.4.3 Relationships also allow rapid solutions to be found. The Director of EPRR & deputy and the Director of IPC have worked with each other for nearly 15 years for example. It was after the Swine Flu outbreak that the Trust agreed as part of the emergency plan to secure and store PPE items. It will important to bolster and refresh stock holding going forward.

8.4.4 The team are able to identify existing plans and therefore as soon as the pandemic was declared discussions on mass vaccination were started and the plan on the shelf for Mass Prophylaxis for Bioterrorism threats was just adapted to deliver mass vaccination.

8.4.5 At the start of the pandemic the team delivered a tabletop exercise highlighting what might face the Trust based on the Flu pandemic tabletop exercise scenario that was ready to go. On reflection almost, everything contained in the that exercise were experienced by the Trust.

8.4.6 The rapid establishment of command and control, daily communications, daily Common Operating Picture for managers were all co-ordinated by the EPRR at the start of the pandemic based on the existing emergency plans for a pandemic. This is also another legacy and a new Trust co-ordination centre will open shortly. An EPRR specialist has been part of the centre since Day 1.

8.4.7 The work undertaken by the team in fostering good relations with military and multi agency partners was also beneficial. This was seen several times including:

- establishment of rapid community testing in the early weeks of the pandemic jointly with KCHFT and SECAMB. We were the first area to have this up and running in Kent & Medway.

- rapid mobilisation and joint planning for a proposed nightingale hospital

8.4.8 The team are taking the lead in preparation for the COVID 19 Public Inquiry. Good record and log keeping during the pandemic using trained loggists trained as part of our emergency plans has stood us in good stead.

8.5 Incidents

8.5.1 There were three fire incidents in this reporting period where the team were involved for advice including a minor fire in an ambulance on the ED Ambulance bay, Smoke reported in WH Smith in September and a skip fire in October. All incidents were effectively and rapidly dealt with.

8.5.2 A thunderstorm caused very heavy rainfall in July 2021 causing flooding outside Maidstone ED requiring the attendance of Kent Fire & Rescue Service.

8.5.3 On the 30th of July 2021 a major incident was declared by the South East Coast Ambulance Service in response to a chemical incident in Aylesford. The Trust plan was effectively activated using the Everbridge Alerting platform. Through close liaison between EPRR, Site Management and SECAMB Incident Commanders plans were made that enabled the incident to be rapidly stood down to a local response. It is always impressive to see how our staff respond to these calls.

8.5.4 In December flooding affected services that MTW provide at Sevenoaks Hospital. The team supported the division to provide services at alternative locations.

8.5.5 It should be remembered that throughout all this the Trust is still responding to the challenges of a global pandemic. The team also provided support for the response to Operation Sandpiper as part of the Trust Tactical Team.

9. Future Risks

9.1 The team constantly horizon scan for the next type of incident or disruption. The team currently produce an 8-week horizon scan for managers aiming to improve preparedness for foreseeable risks. This is a dynamic process and involves a lot of research and communications with other partners. The list below is a summary of just some of the risks that are on the radar.

9.2 **Cyber Attacks** – the threat of cyber attacks has increased in recent years and the business continuity plans have been adapted however as the organisation becomes more reliant on technology – the importance of adequate IT security and maintenance of Business Continuity plans becomes more

critical.

9.3 **Workforce disruption** – there are well known reasons why there is a shortage of NHS workforce. The need for all departments to be reviewing their plans for staff shortages will become more crucial.

9.4 **Business Continuity Planning** – as the pandemic recedes it will be critical that divisions review and keep plans up to date. This includes maintaining any equipment, PPE and other contingency resources.

9.5 **Pandemic Infectious Diseases** – The Trust must maintain preparedness for another pandemic such as flu which might be more disruptive.

9.6 **Climate Change** – the Trust must consider the effects of extreme heat in the Summer and more storms and extreme weather events. The consequences of flooding both from extreme rainfall and river /coastal flooding. These can impact staff preventing them coming to work but also patient discharges. In addition, drains on site may not be designed for extreme conditions. Extreme heat especially in prefab buildings can be disruptive.

10. Conclusion

10.1 The Trust remains well prepared for emergencies.

10.2 The Board is asked to note the report and support three key recommendations:

- All divisions need to focus on business continuity planning to ensure our services continue to be resilient especially where services rely on third party contracts such as landlords.
- Divisions continue to release staff for training & exercising.
- Divisions continue to see emergency planning as a key divisional priority.
- Record its thanks to Julie Elphick on her retirement

A year in pictures…..2021

MTW

NHS
Maidstone and
Tunbridge Wells
NHS Trust

Vaccination Centre

Vaccination Centre

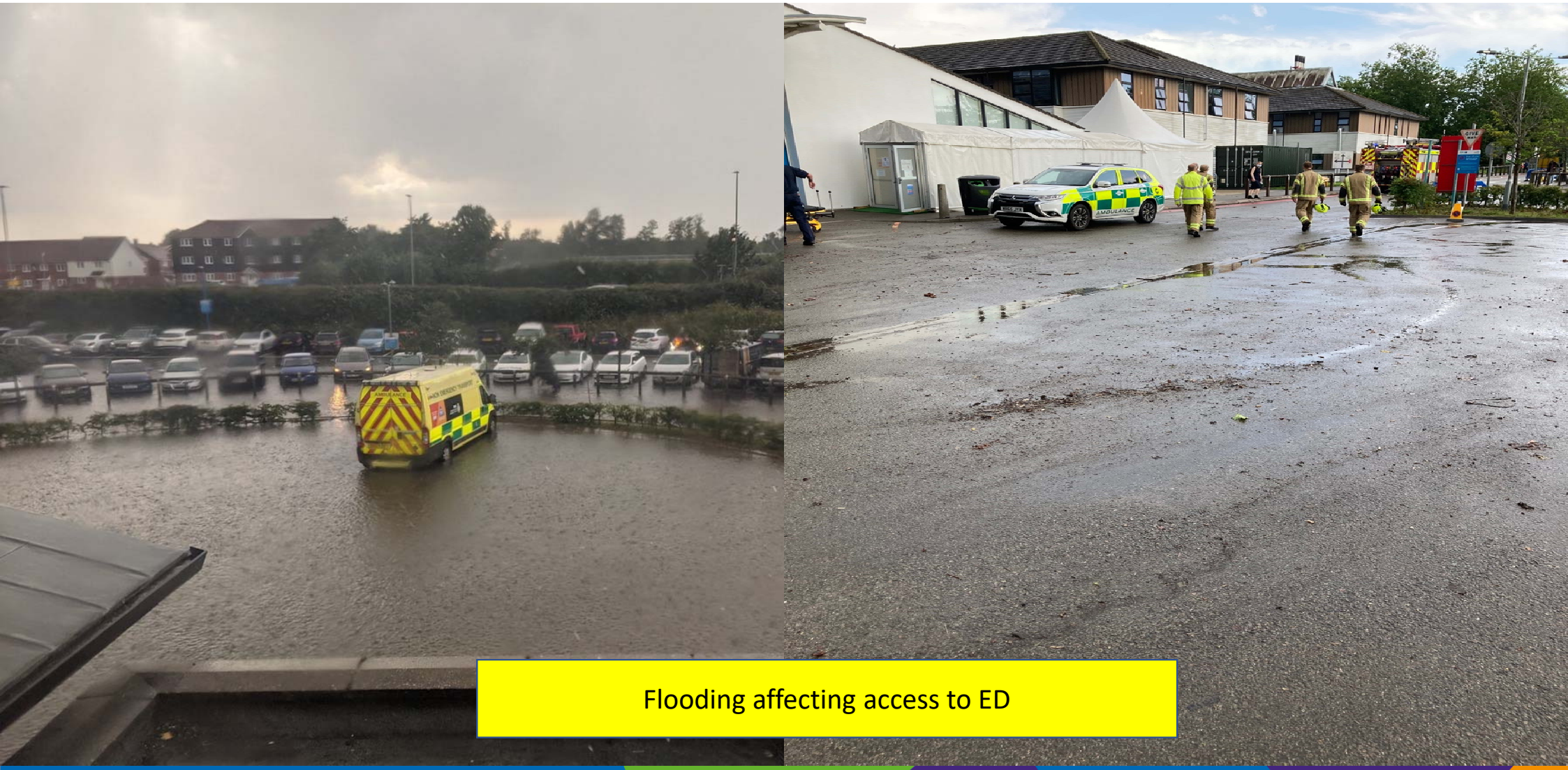
Exceptional people,
outstanding care

CBRN Training resumes

Exceptional people,
outstanding care

Maidstone Helipad has its busiest year to date

Exceptional people,
outstanding care

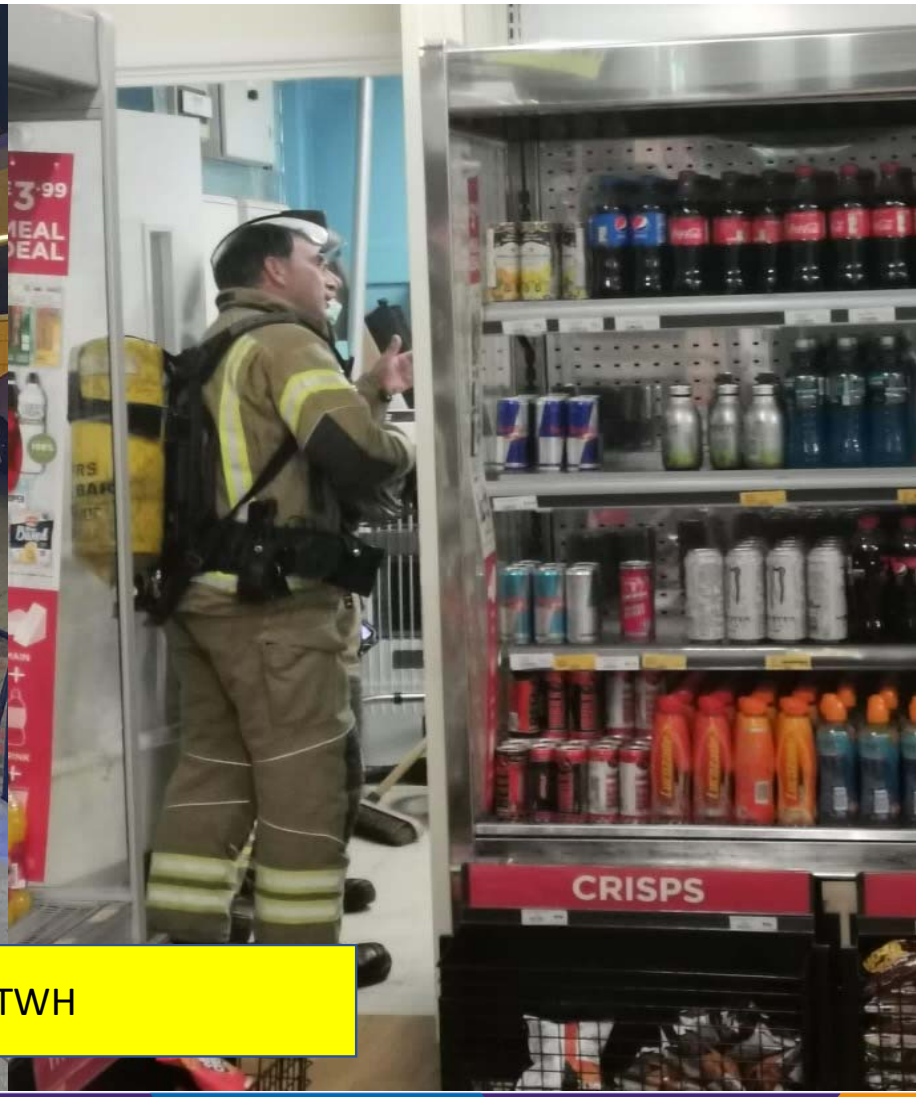


Flooding affecting access to ED

Exceptional people,
outstanding care

Major Incident Declared

Exceptional people,
outstanding care



Smoke in WH SMITH TWH

Exceptional people,
outstanding care

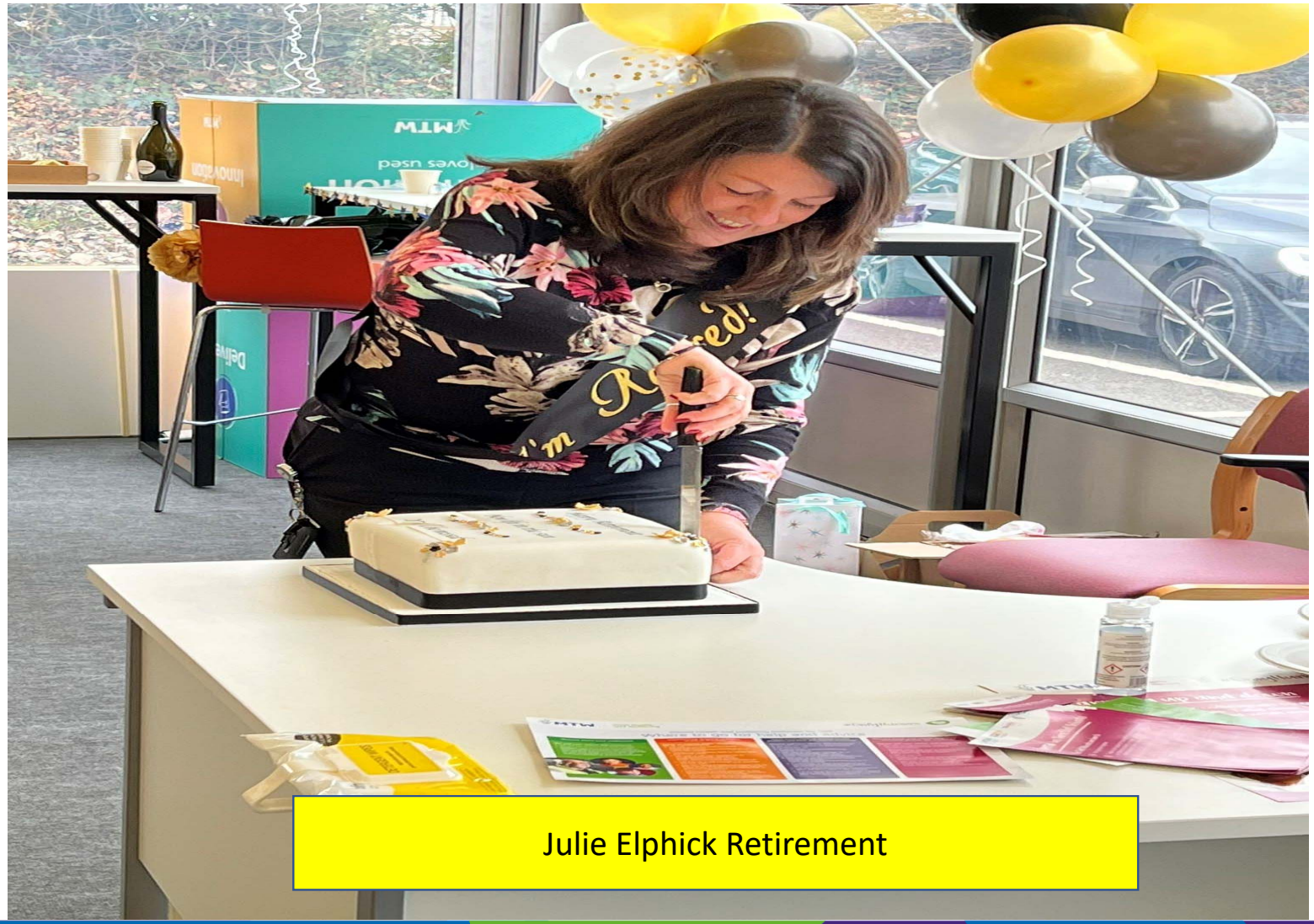
Fire in Ambulance TWH – Incident Commanders doing a great job

Exceptional people, outstanding care

Tunbridge Wells Helipad HM Coastguard

RAF Helicopter at TWH

Exceptional people,
outstanding care



Julie Elphick Retirement

Exceptional people,
outstanding care