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

Thu 27 January 2022, 09:45 - 13:00

Virtual Meeting, via webconference

NHS
Maidstone and Tunbridge Wells
NHS Trust

Agenda

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

01-1
To receive apologies for absence

David Highton

01-2
To declare interests relevant to agenda items

David Highton

01-3
To approve the minutes of the 'Part 1' Trust Board meeting of 22nd December 2021

David Highton

Board minutes, 22.12.21 (Part 1).pdf (8 pages)

01-4
To note progress with previous actions

David Highton

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

01-5
Report from the Chair of the Trust Board

David Highton

Chair's report.pdf (1 pages)

01-6

Report from the Chief Executive

Miles Scott

Chief Executive's report - January 2022.pdf (3 pages)

Reports from Trust Board sub-committees

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

Maureen Choong

Summary of Quality C'ttee, 12.01.22 (incl. revised Terms of Reference).pdf (6 pages)

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

David Morgan

Summary of Finance and Performance C'ttee 25.01.22.pdf (1 pages)

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

Emma Pettitt-Mitchell

Summary of People and Organisational Development Cttee, 21.01.22 (incl. Quarterly update from the Guardian of Safe Working Hours).pdf (4 pages)

Integrated Performance Report

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

Miles Scott and colleagues

Integrated Performance Report (IPR) for December 2021.pdf (43 pages)
Integrated Performance Report (IPR) for December 2021 - supplementary report.pdf (3 pages)

Planning and strategy

01-11
To approve the Business Case for the People and Culture Structure and Operating Model

Sue Steen

To approve the Business Case for the People and Culture Structure and Operating Model.pdf (41 pages)

Quality Items

01-12
Quarterly Maternity Services report

Sarah Blanchard-Stow

N.B. This item has been scheduled for 11:10am.

Maternity Services Quarterly Update Board Report Jan 2022 v2.pdf (14 pages)

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

Sara Mumford

Director of Infection, Prevention and Control Annual Report 2021.pdf (59 pages)

Assurance and policy

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

Christian Lippiatt and Ola Gbadebo-Saba

N.B. This item has been scheduled for 11:35am.

FTSU Quarterly Trust Board Report - January 2022.pdf (5 pages)

Corporate governance

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

David Highton and Kevin Rowan

NED champion roles.pdf (26 pages)

01-16
To consider any other business

David Highton

01-17

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 22ND DECEMBER 2021, 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)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Neil Griffiths	Non-Executive Director	(NG)
	Jo Haworth	Chief Nurse	(JH)
	Peter Maskell	Medical Director	(PM)
	David Morgan	Non-Executive Director (from item 12-6)	(DM)
	Steve Orpin	Deputy Chief Executive/Chief Finance Officer	(SO)
	Emma Pettitt-Mitchell	Non-Executive Director	(EPM)
In attendance:	Karen Cox	Associate Non-Executive Director	(KC)
	Richard Finn	Associate Non-Executive Director	(RF)
	Amanjit Jhund	Director of Strategy, Planning and Partnerships	(AJ)
	Sue Steen	Chief People Officer	(SS)
	Jo Webber	Associate Non-Executive Director	(JW)
	Kevin Rowan	Trust Secretary	(KR)
Observing:	The meeting was livestreamed on the Trust's YouTube channel.		

12-1 To receive apologies for absence

Apologies were received from Miles Scott (MS), Chief Executive. DH explained that MS was taking a well-deserved break, given that he would be working throughout the Christmas and new year periods. It was also noted that Sara Mumford (SM), Director of Infection Prevention and Control, would not be in attendance.

12-2 To declare interests relevant to agenda items

No interests were declared.

[N.B. DM however subsequently declared an interest under item 12-12]

12-3 To approve the minutes of the meeting of 25th November 2021

The minutes of the meeting of 25th November 2021 were approved as a true and accurate record of the meeting.

12-4 To note progress with previous actions

The content of the submitted report was noted.

Monthly performance

12-5 Update on the issues relating to Kent Police's Operation Sandpiper

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

- David Fuller was only one of only two offenders within the British justice system to receive two whole-life tariffs, and also received a cumulative 12-year term for additional offences, including a number of offences that took place in the mortuaries at Tunbridge Wells Hospital (TWH) and the Kent and Sussex Hospital.
- The Secretary of State for Health and Social Care had authorised the Trust to liaise with NHS Resolution and the legal representatives of the victims' families to establish a compensation scheme.
- The independent inquiry established by the Secretary of State for Health and Social Care, which effectively took over the Trust's internal investigation, had now started to be established, and one

of the final tasks of the Police Family Liaison Officers would be to ask family members whether they wanted their contact details passed to Sir Jonathan Michael, to enable the inquiry team to make contact.
- The Trust remained committed to complete openness and transparency on the matter and would make public as much as it could, whenever it could, but two important considerations that limited what the Trust could say at the present time. Firstly, it would be wrong for the Trust to undermine the work of the independent inquiry; and secondly the Police were investigating other possible crimes that Fuller may have committed, and it was imperative that the Trust did not prejudice any future legal proceedings.

12-6 Report from the Chair of the Trust Board

DH referred to the submitted report and highlighted the following points:
- The meeting was SDu's last Trust Board meeting and her eight years with the Trust preceded by 12 years at Dartford and Gravesham NHS Trust showed her strong commitment to the NHS.
- Interviews for a new Non-Executive Director would be held on 04/01/22.
- SDu's departure had led to some changes in roles, so NG would be the Vice-Chair of the Trust Board once SDu left the Trust Board.
- The "Enhancing board oversight: a new approach to non-executive director champion roles" guidance had been discussed with KR and a report would be submitted to the Trust Board in January 2022 that would confirm the Trust's response.

DH also then reported that he had been appointed as the Chair of the Trust Board at Buckinghamshire Healthcare NHS Trust, in addition to his role as the Chair of the Trust Board at Maidstone and Tunbridge Wells NHS Trust, and that role would be announced that day.

DH then noted the continued appointment of consultants, and noted that a further panel had been held on 17/12/21.

12-7 Report from the Chief Executive

SO referred to the submitted report and highlighted the following points:
- The Trust's hospitals continued to be under severe pressure, and the impact of the Omicron variant of coronavirus had started to be seen. SO wished to thank all Trust staff for their response to the pressures.
- The Trust was pleased to welcome the Chair Designate of the Kent and Medway Integrated Care Board (ICB), who had visited Maidstone Hospital (MH) recently.
- The main building of the new paediatric Emergency Department (ED) at TWH was now in place, & the internal fitting work continued. The new department was intended to open in January 2022.
- The Trust's staff networks continued to develop, and the LGBT+ Network recently submitted an expression of interest application to the national NHS Rainbow Badge – phase 2 scheme.

DH noted that the current pressures would be discussed further under item 12-13.

Reports from Trust Board sub-committees

12-8 Quality Committee, 08/12/21

SDu referred to the submitted report and highlighted the following points:
- The meeting had been a 'deep dive', and included a further review of maternity services and a review of the adverse patient outcomes from 2020/21. The latter focused on themes, and SDu regarded it as the best report she had seen on the subject, so JH and her colleagues should be commended.
- The meeting demonstrated where the Trust was in understanding its activities and focusing on the areas which still had challenges.

12-9 Finance and Performance Committee, 20/12/21

NG referred to the submitted report and highlighted the following points:
- The main theme of the Committee had been to review and assess some Business Cases that were focused on improving safety and quality.

- It was also acknowledged that the Trust had done very well in recovering its performance following the previous adverse impact of COVID-19.
- Two of the Business Cases had been submitted for approval to the Trust Board, and the Committee had recommended that the Trust Board give its approval.
- The Committee had also approved a Business Case for Maidstone ED substantive nursing / Clinical Support Worker (CSW) staffing to provide improved patient care, support staff and increase patient flow.

12-10 People and Organisational Development Committee, 17/12/21

EPM referred to the submitted report and highlighted the following points:
- The meeting had been a 'deep dive', but recruitment and retention had again been discussed, as was the case at every People and Organisational Development Committee meeting.
- The People and Organisational Development risk register was reviewed in detail.
- Succession planning and talent management was also discussed.

DH noted that the Committee was due to review the mandatory COVID-19 vaccination plan in January 2022. EPM confirmed that was the case.

12-11 Patient Experience Committee, 02/12/21 (incl. approved of revised Terms of Reference)

MC referred to the submitted report and highlighted that the meeting had focused on what it felt like to be a patient or carer at the Trust, and the Committee had been assured that there was a genuine tendency to listen and seek feedback. MC added that it had however been recognised that things were not perfect.

DH also noted that revised Terms of Reference had been submitted to the Trust Board, for approval. The revised Terms of Reference were duly approved as submitted.

12-12 Charitable Funds Committee, 23/11/21 and 15/12/21 (incl. approval of revised Terms of Reference and approval of Annual Report and Accounts of the Charitable Fund, 2020/21)

DM referred to the first submitted report and highlighted the following points:
- The main focus of the meeting on 24/11/21 had been the need for a clear strategy to expend the current charitable fund monies, which now exceeded £1m, and for a strategy regarding fundraising, but the existing investment strategy had been agreed to continue.
- The development of the Maggie's Centre had been discussed, and it was noted that the further work required related to the specific location for the Centre at MH.
- Revised Terms of Reference had been agreed and submitted to the Trust Board for approval.

The revised Terms of Reference were duly approved as submitted.

DM then referred to the second submitted report and highlighted that the meeting on 15/12/21 had recommended the Annual Report and Accounts for 2020/21 to the Trust Board for approval. DM then declared that his son worked for Grant Thornton LLP, but not in the public sector.

The Annual Report and Accounts of the Charitable Fund for 2020/21 were approved as submitted.

Integrated Performance Report

12-13 Integrated Performance Report (IPR) for November 2021

SO introduced the item and then asked the other members of the Executive Team to report on each domain. JH firstly referred to the "Safe" domain and highlighted the following points:
- Challenges with staffing levels remained, particularly at TWH, but a range of initiatives were in progress to help address the challenges.
- The number of Clostridiodes difficile cases had significantly reduced.
- Unwitnessed falls continued to be an area of concern, particularly at TWH, but Falls Improvement Groups had now been established, with three key strands of work i.e. equipment; processes; and staff and patients.

DH asked whether the unwitnessed falls at TWH were related to the single room layout at that hospital. JH confirmed that was correct, plus other geographical features, including the 'racetrack' layout in the wards, which affected visibility.

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

- Mortality would be covered separately under item 12-19.
- No data was yet available for stroke performance, but the Trust usually performed well on the Best Practice Tariff performance.

JH then referred to the "Caring" domain and highlighted the following points:

- The performance against the complaints response time target had improved significantly since October 2021, but the metric would likely be subject to "hit and miss" performance in the future, given the aforementioned staffing challenges.
- The Friends and Family Test (FFT) response rate performance was poor, as a result of staffing levels and some difficulties with the survey provider. Work was continuing, but resource had also been increased to enable work with the Divisions to increase the response rate. Caution should therefore be exercised in interpreting the "…% Positive" data, given the very low response rate.

SB then referred to the "Responsive" domain and highlighted the following points:

- The 62-day cancer waiting time target had been met for 28 months in a row, and the new 28-day day target had been met. The "Cancer - 31 Day" target had also been met, despite what had been reported on page 15 of the IPR.
- The DM01 standard performance continued to be a challenge, and equipment failures and staffing gaps had adversely affected the echocardiogram and bone density (DEXA) scanning performance.
- The MRI strategic Business Case was awaiting the approval of NHS England/Improvement (NHSE/I)

DH asked how long the NHSE/I regional team had been considering the MRI Business Case. SO replied that it had been approximately four weeks, and added that the Trust was lobbying with the team to expedite their consideration of the Case, but the same team had been focused on the allocation of the additional capital funding that had been released, which would be discussed under item 12-15. DH asked SO to advise him if any additional lobbying to the Regional Director was required.

SB then continued and highlighted that there were now only two patients waiting over 52 weeks for treatment, while there had been a major reduction in the patients waiting over 40 weeks for their treatment. DH noted that SB had reported at the Finance and Performance Committee that the Trust was also treating 60 patients per month from East Kent Hospitals University NHS Foundation Trust (EKHUFT). SB confirmed that was correct, and added that he welcomed liaison with EKHUFT in relation to the barn theatre Business Case that would be discussed under item 12-16.

SB then continued, and highlighted that the ED four-hour waiting time target continued to be strong, while ambulance handover times had also improved.

KC asked whether any Integrated Care System (ICS) issues were affecting the Trust's performance. SB confirmed that the support the Trust was providing to partners in the Kent and Medway ICS continued to affect the Trust's own performance, and noted that ambulance transfers were particularly challenging for patients, as they were located out of the area in which they lived. SB however stated that there were good relationships with the other local Trusts, including Medway NHS Foundation Trust, whose new Chief Operating Officer had engaged well with the Trust.

JW noted the data showed 30-minute handover delays, but asked about performance on 60-minute delays. SB acknowledged that there was always more that could be done, but only 2% of patients had waited over 60 minutes for the year to date, and much of that percentage was related to the planned introduction of the Electronic Patient Record (EPR), although the associated processes had now stabilised. JW also asked about dynamic conveyancing but SB confirmed that dynamic conveyancing had not been introduced for the current winter, although discussions had been held.

JW also asked about the status of medically optimised for discharge (MOFD) patients. SB reported that the number had reduced, but was still at 140 that day, and staff were very frustrated at the situation. SB then gave details of the work being undertaken in relation to community service capacity to address the issues. SB therefore summarised that the position had improved but remained a significant issue.

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

- There had been a significant 'deep dive' into recruitment and resourcing at the last People and Organisational Development Committee meeting.
- The People and Organisational Development function was managing the mandatory COVID-19 vaccination programme and it was likely that that would lead to some staffing challenges.
- The Trust had seen an increase in COVID-19-related absences, and the position was worsening daily, but the Trust had not yet seen the absence levels experienced at NHS Trusts in London.
- There had been changes in the mandatory sickness provisions, so staff did now not need to provide a doctor's certificate until 28 days, instead of the previous seven days. The impact of that would therefore be assessed.

DH also noted that staff who had a household member with COVID-19 could now return from work after they had received a negative test. SS clarified that the isolation period had been reduced from 10 days to seven days. PM however emphasised that the Trust was focused on ensuring staff were protected to the level it considered appropriate, so had, in response to the current challenging staffing situation, reduced its own self-isolation requirement from 10 days to five days.

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

- The Trust's financial position was in accordance with its plan.
- The demand for temporary staffing using remained significant, so the associated expenditure had not reduced as had been planned.

DM referred to page 21 of 32 and noted that the "Covid Positive - number of patients" was 129, which did not match the number in the daily Common Operating Picture. SO explained that the number in the IPR was a cumulative number for the month.

DH then asked whether the ICS' financial position was on plan. SO confirmed that was the case at present, but noted that there was some concern regarding the impact of the potential COVID-19 numbers over the next two months.

Planning and strategy

12-14 <u>The impact of the potential growth in COVID-19 positive cases on the winter plan</u>

SB reported the following points:

- The item had been a verbal report because the data was changing every day, and new modelling had been provided on 20/12/21, although there was some uncertainty over such modelling.
- The Trust's performance had been as good as it had been for six months.
- The winter plan work had had a positive impact, particularly in relation to the use of the Ambulatory Emergency Care (AEC), and the corresponding positive impact on patient flow.
- The Trust was also close to de-escalating two of its escalation wards, which meant that 2.5 wards would be free as the Trust headed into the forthcoming difficult period.
- 84% of staff had now had the COVID-19 booster vaccination.

PM then reported the following points:

- The modelling data that had been issued that week had caused a considerable amount of discussion across the ICS, and PM preferred to use the data for planning, rather than predictive, purposes. The Trust had been asked to model for three scenarios relating to the number of COVID-19 cases.
- The Trust had reviewed its visiting policy, and would continue to review the rules regarding staff COVID-19 testing.
- The redeployment of clinical staff would be considered.
- PM had been impressed that the Trust had been able to establish a COVID Medicines Delivery Unit within a week.

- A Respiratory Emergency Care Unit (RECU) would be established on Ward 21.
- The Clinical Reference Group had been re-established to consider pathways, while the COVID-19 Ethics Committee had also been re-established and it had confirmed, on 21/12/21, that the clinical support tool that the Trust Board had approved last year remained relevant.

DH asked whether the Omicron variant affected length of stay (LOS). PM confirmed that there was insufficient data to answer that question, but it had been known from the end of the previous week that anyone contracting COVID-19 would likely have the Omicron variant rather than Delta variant.

DM asked about the current status of flu. PM confirmed it was a further threat, but it had not materialised, and the numbers had been very low. PM also noted that the Trust had expected to see more cases of Respiratory Syncytial Virus (RSV) in children, but that had also not materialised.

RF asked PM to comment on the lessons that had been learned from the previous waves of COVID-19. PM confirmed he had discussed that issue that morning with the Chief of Service for Surgery, & noted that there were sufficient differences between previous waves and the current circumstances, which included the different status of Independent Sector Providers (ISPs). PM elaborated on some of the changes that would be made, which included that the RECU would be in a different location.

RF also asked what lessons had been learned in relation to safeguarding staff welfare and SS explained the steps that had been taken.

EPM noted that SB had referred to the high number of MOFD patients so asked whether that number was expected to reduce. PM reported that the state of the domiciliary care market meant it was difficult to obtain such care, although it had been agreed that beds could be 'spot purchased' as required. PM also noted that the discharge lounge had been opened from 7am, while other initiatives were in place, including respiratory hubs. SB added that staffing in social and community care was a major challenge, but each patient was subject to a weekly tracking meeting. SB however noted that some of the government-led initiatives in the first COVID-19 wave were no longer in place.

DH noted that the Chair Designate of the Kent and Medway ICB had been shown the TeleTracking system during his recent visit, and stated that it was important that community beds were now able to be seen on TeleTracking, so if the availability of all community-related beds could be seen, that would be a major step forward. The point was acknowledged.

NG asked what assumptions had been made regarding elective activity during the future weeks. SB stated that some elective activity had been transferred to ISPs, and discussions were underway to optimise the use of ISPs. SB continued that some outpatient clinics had also been stepped down, but there had been no universal reduction of such activity, and that continued to be the Trust's approach. SB also highlighted the work that the Trust had done to ensure elective activity continued during previous COVID-19 waves, when other Trusts had cancelled such activity.

DH noted that the aforementioned modelling had been discussed in detail at the Executive Team Meeting on 21/12/21, but highlighted that the Trust Board should be notified if and when any trigger points for action had been reached. SB agreed and noted that the Trust paid close attention to the Operational Pressures Escalation Level (OPEL) ratings, and the Trust had been at OPEL 4 for two days recently.

SDu asked SB to comment on the specific patient flow issues that had been previously raised at the Quality Committee. SB noted that much of the previous discussion at the Trust Board meeting had been relevant but also reported that staffing challenges had a direct impact on patient pathways and LOS had increased as a result, although that had recently improved. SB then elaborated on some of the other aspects that had affected the position.

12-15 <u>Update on capital programme funding and expenditure approvals 2021/22</u>

DH noted that although the report stated it was for discussion and assurance, the Trust Board needed to approve the additional allocations of capital in principle, and note the requirement to finalise the specific Business Cases. SO then referred to the submitted report and highlighted the following points:

- The Trust had always believed that some additional capital funding may be released during the year, and circa £11m of capital funding had now been released.
- The allocations that required specific approval by either the Finance and Performance Committee or Trust Board had been highlighted in yellow.
- Much of the expenditure would need to take place in the next two months, but there was an international national shortage of computer chips and this had led to increased lead times for some schemes.
- More detailed reporting on the capital programme would continue to be reported to the Finance and Performance Committee.
- The Trust Board was asked to approve the overarching programme and expenditure.

DH noted that the same report had been considered by the Finance and Performance Committee on 20/12/21, and that Committee had recommended that the Trust Board give the requested approval. The additional allocations of capital were duly approved in principle, and the Trust Board noted the requirement to finalise the specific Business Cases.

DH then asked that the staff who had worked to obtain the increased capital allocation be thanked on behalf of the Trust Board.

12-16 <u>To approve a Business Case for Increasing Elective Orthopaedic Capacity</u>

SB referred to the submitted report and highlighted the following points:
- The Case had been considered by the Finance and Performance Committee on 20/12/21.
- Discussions had been held with ICS partner organisations.
- The option was less expensive than outsourcing the work to ISPs.

DH noted that the Trust Board could give its approval but the Business Case would need to be approved definitively by NHSE/I. SO confirmed that was correct and noted that the Trust was exploring the available funding options. SO also reported that the version of the Business Case that had been submitted reflected the Trust's intentions, but the next iteration would need to reflect the wider ICS context. SO added that some comments had already been received by NHSE/I and the Trust was in a good position to mobilise quickly should NHSE/I give its approval.

JW asked whether there was any potential on the site to extend the theatre capacity, should that be required in the future, or would further sites need to be considered to address any future need. SO stated that the scheme used much of the available footprint on the site, while other developments, such as the Maggie's Centre that DM had referred to under item 12-12 were also competing for space in the same location. SO however continued that there was an opportunity to develop more capacity, as there would continue to be significant activity sent to ISPs.

NG asked whether the Business Case would mean that ICS-wide Primary Target Lists (PTLs) were closer. SB confirmed that he did not believe that would be the case and provided further context.

The Business Case for Increasing Elective Orthopaedic Capacity was then approved as submitted.

12-17 <u>To approve a Business Case for an Oncology Modular Building</u>

SB referred to the submitted report and highlighted the following points:
- The Case had been considered by the Finance and Performance Committee on 20/12/21.
- SB was grateful for the support of the Director of Estates and Facilities and SO.
- Demand for oncology had increased markedly over the past ten years, and was expected to continue to increase.
- The capital funding was available, but the revenue funding needed to be discussed further with the Clinical Commissioning Group, although the discussions held thus far had been very positive.

DH summarised that the capital funding was within the Trust's own control, but the revenue funding was still subject to commissioner approval. The Business Case for an Oncology Modular Building was then approved on that basis, as submitted.

Quality items

12-18 Update on the latest position regarding access to Tier 4 Child and Adolescent Mental Health Services (CAMHS) beds

JH referred to the submitted report and highlighted following points:

- The pandemic had had a huge impact on the mental health of children and adolescents and that had had a major impact on the number of patients requiring Tier 4 CAMHS & other types of beds.
- 82 children and young people were admitted to the Trust's paediatric inpatient ward with a mental health related issue between 01/04/21 and 30/11/21 and some had a very long LOS, including a 146-day LOS. Nine of the children awaited a Tier 4 bed at the Trust. However, the access the Tier 4 beds had improved recently.

EPM referred to the "MTW Paediatric Mental Health Support for Children and Young People Action plan – December 2021" on pages 4 to 6 of 6, and asked how the actions that were rated as amber would be monitored, particularly as some of the amber-rated actions had no text in the "Governance" column. JH noted that the local teams were monitoring their performance against the action plan, but mental health activity needed to be considered for inclusion in the Strategy Deployment Review (SDR) process. JH therefore confirmed she would give EPM's challenge further consideration.

Action: Consider, and confirm, how the amber-rated actions in the "MTW Paediatric Mental Health Support for Children and Young People Action plan – December 2021" (that was considered by the Trust Board on 22/12/21, as part of the "Update on the latest position regarding access to Tier 4 Child and Adolescent Mental Health Services (CAMHS) beds" report) would be monitored (Chief Nurse, December 2021 onwards)

EPM also asked whether there were any ICS-related developments that would help the situation, and JH gave her perspective on the likely impact of future collaborative working.

JW confirmed that the reported position was encouraging but asked what was expected in relation to social care packages for children, and Kent County Council's (KCC's) view of the position. JH confirmed she had no insight on KCC's view but noted the position on social care packages was worthy of further discussion. JW emphasised that the issue would not go away. PM pointed out that North East London NHS Foundation Trust attended the Integrated Care Partnership.

12-19 Quality mortality data

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

- PM had not seen a monthly Hospital Standardised Mortality Ratio (HSMR) figure so low, although it may increase slightly as the data was finalised.
- The Summary Hospital-level Mortality Indicator (SHMI) continued to decline gradually.
- The Trust's COVID-19 mortality data continued to be adjusted, and PM was ever more assured that the position should not be of concern.
- The CUmulative SUM (CUSUM) alert for sepsis continued to be explored.
- The implementation of the community Medical Examiners Service had been temporary halted due to staffing issues in the current service, but the implementation had now commenced. PM had recently met with HM's Senior Coroner to discuss the Medical Examiners Service.

12-20 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 (KMMS) accommodation. The requested authority was duly granted.

12-21 To approve the motion (to enable the Board to convene its 'Part 2' meeting) that in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest

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

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

Actions due and still 'open'

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

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
10-14	Review the categorisation of the themes included in the "Other" category in the "Data Collection; Concerns Raised" section of future quarterly reports from the Freedom to Speak Up Guardian	Deputy Freedom to Speak Up Guardian	January 2022 onwards	This has been addressed when in the quarterly report from the Freedom to Speak Up Guardian is submitted to the Trust Board in January 2022.
12-18	Consider, and confirm, how the amber-rated actions in the "MTW Paediatric Mental Health Support for Children and Young People Action plan – December 2021" (that was considered by the Trust Board on 22/12/21, as part of the "Update on the latest position regarding access to Tier 4 Child and Adolescent Mental Health Services (CAMHS) beds" report) would be monitored.	Chief Nurse	January 2022	Progress with the actions will be reported to the Safeguarding Committee for additional oversight (i.e. in addition to Directorate and Divisional oversight).

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**

New Non-Executive Director

I would like to welcome Wayne Wright to the Trust Board, following his recent appointment as a Non-Executive Director. Wayne has worked in some of the most celebrated corporate entities as well as fast growing medium sized businesses at senior and board levels, and for the last 20 years has led [W]sq solutions, a small boutique entrepreneur coaching organisation that works with fast growing businesses in accelerating growth and profitability. I will be considering which Trust Board sub-committees Wayne will be involved in, and confirm these in due course.

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?
17/12/2021	Consultant Haematology	Elvis	Aduwa	Haematology	TBC	Replacement
12/01/2022	Consultant Paediatrician with Special Interest in Neonatology	Bindu Mary	George	Paediatrics	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:

1. I want to start the new year by saying thank you to each and every one of our staff who have worked incredibly hard across every area of our Trust during 2021. It was a year of great challenges, but also a year of commitment, dedication, compassion and teamwork from everyone here at MTW. During 2021 the Trust cared for almost three quarters of a million patients across our sites; admitted approximately 1,400 COVID-19 positive patients; experienced record-breaking weeks for attendance at our Emergency Departments, with more than 160,000 patients coming through our doors, and in maternity had some of our busiest ever months for deliveries – welcoming around 6,000 babies into the world. This is just a snapshot of the achievements our teams have been able to make despite such a difficult year and I am exceptionally proud of what they have achieved.

2. As we look forward into 2022 there are lots of exciting new developments and plans ahead, an overview of which is listed below with anticipated operational dates:
   - **Quarter 1:** New paediatric Emergency Department at Tunbridge Wells Hospital; Expansion of our Community Diagnostic Centre and regional imaging training academic hub; Digestive Diseases Unit.
   - **Quarter 2:** Endoscopy training hub; Additional Outpatient clinic and administrative space in the Kent Oncology Centre at Maidstone Hospital.
   - **Quarter 3:** Preparatory work for Stroke new building work; Preparatory phase for cardiology development; Preparatory phase for new theatre block at Maidstone Hospital (barn theatres).
   - **Quarter 4:** Stroke new building work commences; Cardiology development work; Kent and Medway Medical School accommodation opens; New theatre block at Maidstone Hospital (barn theatres), expanding orthopaedic surgical capacity (awaiting approval)

   Further ahead we have Maggie's centre, providing free cancer support and information, due to be operational by 2024.

3. Dr Henry Taylor, Consultant Clinical Oncologist, is stepping down from the role of Chief of Service for Cancer and Philippa Moth, Consultant Obstetrician and Gynaecologist and Lead Cancer Clinician at MTW has been appointed as the new chief of service. I would like to thank Henry for the incredible commitment, hard work and leadership he has shown in his three years as chief and, prior to this, as Clinical Director for Oncology. Most notably he has led the Trust to achieving all the national cancer standards for the first time in six years and under his watch we have achieved this for 27 months in a row. Philippa has been a consultant at the Trust for six years and her primary focus when starting her new role will be to continue to maintain performance and expand the Oncology and Haematology services. Henry will step down in March but will remain in his role as a consultant clinical oncologist at MTW and he will also continue as clinical lead for the Kent and Medway Cancer Alliance where he has been an important lynchpin between the Trust and the Alliance.

4. The 12-week engagement period on proposed changes to cardiology services at MTW ended at midnight on 14 January. An independent agency will now compile and review the feedback and the final decision about the proposals will be made later this year.

5. Ongoing pressures continue across the Trust as we manage the winter demands and care for our COVID-19 patients. However, numbers are on their way down and we are now optimistic we are past our third wave peak of 74 patients during the Christmas and New Year period. Our teams have been managing this challenge during some of our busiest ever months, particularly in our Emergency Departments, Maternity Units and in recovering our elective surgery treatments. The latest wave has also brought new challenges such as the highly transmissible Omicron variant meaning we've been operating with many staff absences, however, with the

success of the vaccine, thankfully the number of patients who need critical care is now much smaller – a marked difference to the second wave in early 2021 and before the vaccine roll-out had come into full effect. Staff are encouraged to undertake twice weekly lateral flow tests to enable early detection of COVID-19. Our COVID-19 booster programme for staff continues at both sites to help keep both our staff and patients safe this winter. For those staff who are yet to have their vaccination, we are working with our HR Team and managers to ensure every unvaccinated member of staff has a one to one conversation to answer any questions or concerns they may have and support them to get vaccinated.

We continue to review our visiting policy and recently amended this to request that all visitors carry out a lateral flow test within 24 hours of visiting our hospital sites. At the end of last year, we established a virtual visiting hub for our inpatients, enabling patients to video call families and help keep connected with family and friends. The Trust has established a new unit to deliver COVID-19 treatments for non-hospitalised patients at the highest risk within the community. The treatments being administered are supplied by our Pharmacy team and involve Intravenous (IV) infusion of neutralising monoclonal antibodies or oral antiviral treatment to high risk patients who have had positive PCR tests. Evidence has shown that treating these patients early on, before symptoms develop further, reduces their risks of hospitalisation.

6. To help mitigate the staffing pressures across the Trust, our recruitment colleagues continue to work hard to roll out targeted recruitment campaigns with the aim of filling all current vacancies. Recruitment drives live this month include Respiratory, Therapies and Volunteering, with work underway in other areas such as Stroke, Cardiology, Midwifery, Radiotherapy, Emergency Department, ITU and Facilities.

7. Following the appointments of Cedi Frederick (Chair-designate) and Paul Bentley (designate Chief Executive Officer) for the NHS Kent and Medway Integrated Care Board, Kent and Medway remain in a good position in terms the preparatory work for the new ICS bodies and in maintaining robust existing arrangements for the CCG. Arrangements to establish the Integrated Care Board (the CCG's successor statutory NHS organisation) in shadow form continue to progress well; including appointments to the new Board and development of the wider system architecture and governance arrangements.

8. The Trust continues to be an active member of the West Kent Health and Care partnership (one of the four place-based arms of the wider Integrated Care System ICS). The partnership continues to make good progress on key transformations. Some highlights from this quarter include:
   - **The Children's Integrated Neuro Developmental Disorders (NDD) MDT Assessment Clinic** has secured accommodation at the Heathside Centre in Coxheath to pilot this new integrated clinical model. The clinic is preparing the site to start the service this month.
   - **The Maidstone Health Inequalities group** has reviewed local data and feedback from community stakeholders to identify: obesity, healthy eating and diabetes as key areas of focus for their work in the 2 most deprived wards in West Kent (Parkwood and Shepway). This work will engage local residents, community groups, professionals and clinicians in developing initiatives to address these key challenges together.
   - **West Kent HCP Integrated Therapies transformation group** has developed a shared tool for multi-agency partners to develop and record shared assessment for the moving and handling of patients. The single assessment approach is being trialled through the Kent and Medway Care Record (KMCR). This will ensure patients will have more consistent, high quality care as they move between therapeutic services to meet their full care needs.
   - **The West Kent HCP Workforce Group** has agreed four main objectives: developing a workforce sharing agreement; shared inductions across organisations; system leadership skills development and addressing geriatrician pressures.

9. As detailed in the December Board report, the sentencing in the David Fuller murder trial took place last month. We have contacted all families affected and support packages are ongoing for some, for other families no further support has been requested at the present time. We have the go ahead from the Secretary of State for Health and Social Care to agree compensation with

representatives from families so are pressing ahead with this. The independent inquiry is in the process of being established and we hope that Sir Jonathan Michael will soon commence engagement with stakeholders about terms of reference.

10. NHS 2022-23 planning guidance was issued on 24 December 2021, with Trust guidance published internally on 4 January 2022 – this provided detailed information on how we will collectively develop our plans for the coming year. Key indicative submission dates nationally are middle of March, with our final submission due by the end of April. The NHS is being asked to plan on the basis of low levels of COVID-19 activity from April 2022. There is a focus on restoring elective services, increasing capacity to treat as many people as possible in a timely manner to reduce the backlog of care. This focus has good synergy with the work the Trust is already planning around barn theatres to increase our elective capacity and enable us to continue to deliver outstanding patient care. The guidance equally includes a strong focus on supporting the NHS workforce, which aligns with much of the good work we have started organisationally here at the Trust, and work that we plan to continue and to grow. There are a number of transformational changes in the national planning guidance that we will work through, including with system partners, for example the creation of additional bed capacity, specifically through the development and expansion of virtual wards, and Outpatient transformation, including the expansion of advice and guidance services.

11. With a new year ahead of us our Networks continue to be very active across the Trust, supporting our staff. The Dis**ability** Network is hosting its first Autism Support Group meeting later this month to bring together anyone with Autism Spectrum Disorder (ASD), or those who have family or friends with ASD, for support and to try make positive change. At the end of the month our Cultural and Ethnic Minorities Network (CEMN) will be holding the consolidation event for the first cohort participating in our reverse mentoring scheme – feedback and learning from this event will be shared. There has been much positive feedback received to date and it is anticipated that many of the pairings will continue their mentoring relationship. The CEMN also has a busy schedule of events planned for the first quarter of the year, welcoming the following guests: Jo Haworth, Chief Nurse at the Trust; Dr Peter Maskell, MTW's Medical Director; Acosia Nyanin, Regional Chief Nurse for the South East and Cedi Frederick Chair-designate of the Kent and Medway NHS Integrated Care Board. Our LGBT+ Network is busy progressing work for phase 2 of the national NHS Rainbow Badge, working towards the June deadline for submitting evidence.

12. Congratulations to the winner of the Trust's Employee of the Month scheme for December, Erica Houghton. On behalf of the Trust Board I would like to say thank you to Erica for her fantastic work to help support our colleagues and patients.

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

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

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

Summary report from Quality Committee, 12/01/22 (Incl. approval of revised Terms of Reference) **Committee Chair (Non-Exec. Director)**

The Quality Committee met on 12th January 2022 (a 'main' meeting), via virtual means.

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

- The **progress with previous actions** was reviewed and it was agreed that the Chief Nurse should check, and confirm to Committee members, the forum at which the outputs from the Patient Led Assessment of the Care Environment (PLACE) 'lite' audits were reviewed. It was also agreed that the Trust Secretary and Assistant Trust Secretary should amend the Committee's Terms of Reference to reflect the decision that the Quality Committee should be the parent committee of the Sepsis Committee (instead of the Surgery Clinical Governance Committee), and subsequently submit the revised Terms of Reference to the 'Part 1' Trust Board meeting in January 2022, for approval. The revised Terms of Reference, with the requested amendment incorporated are enclosed in Appendix 1 (with the proposed changes 'tracked'), for the Trust Board's approval.
- The Trust Secretary attended for the **findings from the Quality Committee's evaluation for 2021** and the following agreements were made:
  - The Director of Quality Governance should liaise with divisional colleagues to review, and if necessary, amend, the template for divisional reports to the 'main' Quality Committee
  - The Trust Secretary should amend the template for other written reports to the 'main' Quality Committee meeting to include an Executive Summary, which all report authors should complete
  - The Trust Secretary should provide guidance to report authors regarding the content and scope of the Executive Summary, including the action required by the Quality Committee (if relevant), and any issues requiring escalation
  - The Trust Secretary should ensure the agenda for 'main' Quality Committee meetings stated the anticipated timings for each agenda item
  - The Trust Secretary should ensure the implementation of a 10-minute comfort break at the mid-point of future 'main' Quality Committee meetings
  - The Director of Quality Governance should liaise with divisional and other colleagues to review the forward programme of items/presentations for the Quality Committee 'deep dive' meeting and propose changes, as required, for the Chair of the Quality Committee to consider
- The Trust Secretary attended for a **review of the draft Internal Audit plan for 2022/23** wherein the further consideration in relation to the scheduling of the "SAS Doctors Charter" review was noted
- The issues raised from the **reports from the clinical Divisions** highlighted the challenges associated with staffing vacancies; sickness absence rates and increased operational pressures and associated implications on the delivery of patient care. It was agreed under the Diagnostics and Clinical Support Services Divisional Governance report that the Medical Director should liaise with the Deputy Chief Executive / Chief Finance Officer and Chief Operating Officer to investigate what, if any, further support could be provided to address the challenges associated with the Picture Archiving and Communication System (PACS) (as reported at the 'main' Quality Committee meeting on 12/01/22). It was also agreed that the Vice Chair of the Quality Committee should ensure that the next Digital Transformation Board meeting considered what, if any, further mitigations and support could be provided in relation to the challenges associated with the Picture Archiving and Communication System (PACS) (as reported at the 'main' Quality Committee meeting on 12/01/22).
- The Referral to Treatment (RTT) Operational Lead attended for the latest **update on harm reviews for patients who have waited a long time**.
- The Lead for Operational Programmes, Corporate Services presented a comprehensive **review of the Safer, Better, Sooner programme of work** and it was agreed that the Lead for Operational Programmes, Corporate Services and the Operational Director of Nursing should amend the "Safer, Better, Sooner" programme of work to reflect the comments

received at the 'main' Quality Committee meeting, 12/01/22.

- The Chief Nurse gave the latest **update on the work to achieve an 'Outstanding' CQC rating** which included the revised functionality of the Quality Improvement Committee.
- The Director of Quality Governance provided a **review of the progress with implementing the Quality Strategy** wherein it was agreed that the Assistant Trust Secretary should circulate the Trust's current Quality Strategy to all Committee members, to enable comments to be provided to the Director of Quality Governance and Chief Nurse, to inform the development Trust's future Quality Strategy. It was also agreed that the Director of Quality Governance should provide the Assistant Trust Secretary with the segmented version of the Trust's current Quality Strategy, to enable circulation to Committee members, for review.
- The Medical Director reported the latest **output from the COVID-19 Ethics Committee**, whilst the Chief of Service for Medicine and Emergency Care gave the latest **update on mortality** wherein the delay in the publication of the Dr Foster data was acknowledged.
- The Director of Infection Prevention and Control provided the latest **Update on Serious Incidents (SIs)** (incorporating the report from the Learning and Improvement (SI) Panel).
- The Assistant Deputy Chief Nurse provided the latest **update from the Enteral feeding and Nasogastric tube (NGT) placement working group** wherein the Committee commended the progress which had been made in relation to NGT placement.
- The Director of Quality Governance provided an in-depth **update on complaints (for quarters 1 and 2, 2021/22)** which included the enhanced support which would be provided to the Trust's Clinical Divisions to support the resolution of complaints.
- The **report of the Quality Committee 'deep dive' meeting, 08/12/21** was noted; as were the reports from the **Committee's sub-committees** (the Complaints, Legal, Incidents, PALS, Audit and Mortality (CLIPAM) group; The Drugs, Therapeutics and Medicines Management Committee; and the Health and Safety Committee), it was agreed under the latter that the Operational Director of Nursing should ensure the resolution of the breaching Central Alerting System (CAS) alert in relation to "inadvertent connection to medical air via a flowmeter".
- The **summary report from the Patient Experience Committee, 02/12/21** was noted.

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:

- The Committee's Terms of Reference are enclosed under Appendix 1 for approval

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

QUALITY COMMITTEE - TERMS OF REFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

1. Purpose

The Quality Committee is constituted at the request of the Trust Board to:

a) Seek and obtain assurance on the effectiveness of the Trust's structures, systems and processes to enable delivery of the Trust's objectives relating to quality of care
b) Oversee quality within the clinical divisions

2. Membership

- Non-Executive Director or Associate Non-Executive Director (Chair)*
- Non-Executive Director or Associate Non-Executive Director (Vice Chair)*
- One other Non-Executive Director or Associate Non-Executive Director*
- Chief Operating Officer*
- Chief Nurse*
- Medical Director*
- Deputy Medical Director*
- Director of Infection Prevention & Control (if not represented via another role within the membership)
- Deputy Director of Quality Governance*
- The Chiefs of Service for the five clinical divisions
- The Divisional Directors of Nursing & Quality (DDNQs) (or equivalent) for the five clinical divisions
- The Clinical Director of Pharmacy & Medicines Optimisation (as Chair of the Drugs, Therapeutics and Medicines Management Committee)

* Denotes those who constitute the membership of the 'deep dive' meeting (see below)

Members are expected to attend all relevant meetings, but will be required to attend at least four of the 'main' Quality Committee meetings per year (those who are also members of the 'deep dive' meeting will be required to attend at least three such meetings per year). Failure of a committee member to meet this obligation will be referred to the Chair of the Quality Committee for action.

3. Quorum

The 'main' meeting of the Committee will be quorate when the following members are present:

- The Chair or Vice Chair of the Quality Committee or one other Non-Executive Director or Associate Non-Executive Director[1]
- Two members of the Executive Team (i.e. Chief Operating Officer, Chief Nurse or Medical Director)
- Three clinical divisional representatives (i.e. either the Chief of Service, DDNQ (or equivalent) or an appropriate deputy for either)

The 'deep dive' meeting (see below) will be quorate when the following members are present:

- The Chair or Vice Chair of the Quality Committee or one other Non-Executive Director or Associate Non-Executive Director[1]
- Two members of the Executive Team (i.e. Chief Operating Officer, Chief Nurse or Medical Director). Deputies representing members of the Executive Team will count towards the quorum.

4. Attendance

The following are invited to attend each 'main' meeting

[1] For the purposes of quorum, the Chair of the Trust Board will be regarded as a Non-Executive Director

- The Chief Nurse (or an appropriate deputy, as they determine) from NHS Kent and Medway Clinical Commissioning Group

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

All other Non-Executive Directors (including the Chair of the Trust Board), Associate Non-Executive Directors, and members of the Executive Team (i.e. apart from those listed in the "Membership") are welcome to attend all meetings of the Committee. The same applies to representatives from Internal Audit.

5. Frequency of Meetings

Meeting will be generally held every month, but will operate under two different formats. The meeting held on alternate months will generally be a 'deep dive' meeting, which will enable detailed scrutiny of a small number of issues/subjects. For clarity, the other meeting will be referred to as the 'main' Quality Committee.

Additional meetings will be scheduled as necessary at the request of the Chair.

6. Duties

6.1 To seek and obtain assurance on all aspects of the quality of care across the Trust, and if not assured, to oversee the appropriate action or escalate relevant issues to the Trust Board, for consideration

6.2 To oversee all aspects of quality within the clinical divisions, and to obtain assurance that an appropriate response is given

6.3 To seek and obtain assurance on the mitigations for significant risks relating to quality

6.4 To seek and obtain assurance that the Trust Risk Management Policy is implemented, in relation to quality issues

6.5 To seek and obtain assurance on compliance with relevant policies, procedures and clinical guidance

6.6 To receive details of the learning arising from complaints, claims, inquests, and Serious Incidents (SIs)

6.7 To seek and obtain assurance on the Trust's compliance with the Fundamental Standards (as defined by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and reflected in the Care Quality Commission's 5 domains)

7. Parent committees and reporting procedure

The Quality Committee is a sub-committee of the Trust Board. The Committee Chair will submit a written summary report to the next Trust Board meeting following each Quality Committee meeting.

Any relevant feedback and/or information from the Trust Board will be reported to the Quality Committee by the Committee Chair, as they deem necessary.

The Committee's relationship with the Patient Experience Committees is covered separately, below.

8. Sub-committees and reporting procedure

The Committee has the following sub-committees.

1. The Cancer Services Divisional Clinical Governance Committee (or equivalent)
2. The Diagnostics & Clinical Support Divisional Clinical Governance Committee (or equivalent)
3. The Medicine & Emergency Care Divisional Clinical Governance Committee (or equivalent)

4. The Surgery Divisional Clinical Governance Committee (or equivalent)
5. The Women's, Children's & Sexual Health Divisional Clinical Governance Committee (or equivalent)
6. The Complaints, Legal, Incidents, PALS, Audit and Mortality (CLIPAM) group
7. The Infection Prevention and Control Committee
8. The Learning and Improvement (SI) Panel
9. The Joint Safeguarding Committee
10. The Drugs, Therapeutics and Medicines Management Committee
11. The Health and Safety Committee
~~11.~~ 12. The Sepsis Committee

A report from the Clinical Governance Committees of the five clinical divisions will be submitted to each 'main' Quality Committee meeting, using a format approved by the Chair of the Quality Committee.

Reports from the Quality Committee's other sub-committees will be given after each sub-committee meeting (either via submission of the minutes of the meeting, a written summary report or a verbal report from the Chair).

The Quality Committee may establish fixed-term 'Task & Finish' Groups to assist it in meeting its duties as it, or the Trust Board, sees fit.

10. Patient Experience Committee

The Quality Committee may commission the Patient Experience Committee to review a particular subject, and provide a report. Similarly, the Patient Experience Committee may request that the Quality Committee undertake a review of a particular subject, and provide a report.

A summary report of the Patient Experience Committee will be submitted to the Quality Committee (the summary report submitted from the Patient Experience Committee to the Trust Board should be used for the purpose).

11. Administration

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

The Trust Secretary will ensure that each meeting is given appropriate administrative support and will liaise with the Committee Chair on:

- The Committee's forward programme, setting out the dates of key meetings and agenda items
- The meeting agenda
- The meeting minutes and the action log

12. Emergency powers and urgent decisions

The powers and authority of the Quality Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least two of the Committee's members, one of whom should be a member of the Executive Team. The exercise of such powers by the Committee Chair shall be reported to the next meeting of the Quality Committee, for formal ratification.

13. Review of Terms of Reference

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

Review history

- Agreed by Quality and Safety Committee: 13 March 2013
- Approved by the Board: March 2013
- Agreed by the Quality & Safety Committee 'deep dive' meeting: 25th April 2014
- Terms of Reference (amended) agreed by the Quality & Safety Committee: 9th May 2014
- Approved by the Board: May 2014
- Terms of Reference (amended) agreed by the Quality & Safety Committee: 21st January 2015 (to remove reference to the Health & Safety Committee, which is a sub-committee of the Trust Management Executive)
- Revised Terms of Reference agreed by the Quality & Safety Committee, 13th May 2015
- Revised Terms of Reference approved by the Trust Board, 27th May 2015
- Revised Terms of Reference agreed by the Quality Committee, 6th January 2016
- Revised Terms of Reference approved by the Trust Board, 27th January 2016
- Revised Terms of Reference agreed by the Quality Committee, 11th January 2017
- Revised Terms of Reference approved by the Trust Board, 25th January 2017
- Terms of Reference approved by Trust Board, 18th October 2017 (to add Associate Non-Executive Directors to the membership)
- Revised Terms of Reference agreed by the Quality Committee, 10th January 2018
- Revised Terms of Reference approved by Trust Board, 25th January 2018
- Revised Terms of Reference agreed by the Quality Committee, 8th May 2019
- Revised Terms of Reference approved by Trust Board, 23rd May 2019
- Revised Terms of Reference agreed by the Quality Committee, 10th July 2019 (to add the Drugs, Therapeutics and Medicines Management Committee as sub-committee, and add the Clinical Director of Pharmacy & Medicines Optimisation as a member of the 'main' Quality Committee)
- Revised Terms of Reference approved by Trust Board, 25th July 2019
- Revised Terms of Reference agreed by the Quality Committee, 6th May 2020
- Revised Terms of Reference approved by the Trust Board, 21st May 2020
- Amendment approved by the Trust Board, 26th November 2020 (to add the Health and Safety Committee as sub-committee)
- Amendment approved by the Trust Board, 17th December 2020 (to enable deputies attending the Quality Committee 'deep dive' meeting for members of the Executive Team to count towards the quorum requirements)
- Revised Terms of Reference agreed by the Quality Committee, 12th May 2021
- Revised Terms of Reference approved by the Trust Board, 27th May 2021
- Amendment agreed by the Quality Committee, 12th January 2022 (to add the Sepsis Committee as a sub-committee)
- Revised Terms of Reference approved by the Trust Board, 27th January 2022

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the Finance and Performance Committee, 25/01/22	**Committee Chair (Non-Exec. Director)**

The Committee met on 25th January, via a webconference.

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

- The consideration of the **Committee evaluation findings for 2021** was agreed to be deferred to March 2022, to enable the Trust Board to consider, at the 'Part 2' Trust Board meeting in February, whether the Trust Board's sub-committees should change their role and membership in response to the Strategy Deployment Review (SDR) process.
- The Deputy Chief Executive/Chief Finance Officer introduced **the new Integrated Performance Report (IPR)** and it was agreed that the new format should be used for the next three months before considering whether any changes were needed. It was however agreed that future versions of the IPR should include details of the movement of KPIs between the "Consistently Passing", "Consistently Failing", "Hit and Miss" and "Achieved Target…" categories; and include a "Retained KPIs" section, to help explain the rationale for the retirement of certain KPIs from the previous version of the IPR. It was also agreed that the list of "Retired KPIs" in the IPR should be checked, to ensure it did not include KPIs that were still reported within the IPR.
- The **non-finance related performance for month 9** was reviewed, which included the latest position with diagnostic waiting time performance and the continued operation of the new Community Diagnostic Centre in Hermitage Lane, Maidstone.
- The **financial performance for month 9** was reviewed, and it was noted that although the Trust's finances remained on plan, pay expenditure had increased significantly.
- An **update on the Trust's Use of Resources assessment** was given and it was agreed that further updates would just be given by exception, as determined by the Deputy Chief Executive.
- The Committee agreed to a request to defer the review of the **Trust's draft financial strategy** until June 2022, to enable the strategy to be informed by the Trust's finalised plans for 2022/23.
- The draft initial **Terms of Reference for the Green Committee** were reviewed for the second time, and it was agreed that the Director of Estates and Facilities should arrange for the functioning of the Green Committee, and the management oversight of green-related activity, to be discussed and agreed at the Executive Team Meeting (taking into account the Finance and Performance Committee's comments), and report the outcome to the Finance and Performance Committee.
- The Director of Strategy, Planning and Partnerships attended to give an **update on the 2022/23 operating plan** and a useful discussion was held.
- A **Business Case for the lease of new office accommodation in Unit F of Hermitage Court** was reviewed, and approved as submitted.
- A **Business Case for the People and Culture Structure and Operating Model** was reviewed, with the Chief People Officer in attendance, and it was agreed to recommend that the Trust Board approve the Case, as submitted.
- The Programme Director for EPR (Sunrise) and Digital Transformation attended to give the latest **update on the implementation of the Electronic Patient Record (EPR)**, and they agreed to check and confirm the current status of the continued use of paper documentation within Microbiology (i.e. despite the implementation of the Sunrise EPR).
- The **draft Internal Audit plan 2022/23** was reviewed and no amendments were proposed.

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

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

- The Committee agreed to recommend that the Trust Board approve the Business Case for the People and Culture Structure and Operating Model (which has been submitted to the Trust Board under a separate agenda item).

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

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

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the People and Organisational Development Committee, 21/01/22 (Incl. Quarterly update from the Guardian of Safe Working Hours (covering October to December 2021))

Committee Chair (Non-Exec. Director)

The People and Organisational Development Committee met (virtually, via webconference) on the 21st January 2022 (a 'main' meeting).

The key matters considered at the meeting were as follows:

- The Committee reviewed the **actions from previous meetings**.
- The **monthly update on the latest People Key Performance Indicators (KPIs)** were reviewed and it was agreed that the Deputy Chief People Officer, People and Systems should ensure that future "Monthly update on the latest People Key Performance Indicators (KPIs)" reflected the comments received at the January 2022 'main' People and Organisational Development Committee meeting, or, where not yet feasible, provided an update on the mechanisms which would be implemented to address the comments received. It was also agreed that the Chief Nurse and Chief People Officer should investigate the mechanisms by which staff could be assured regarding the equitability of, and rationale for, the provision of enhanced rates of pay during periods of increase operational pressures.
- The Head of Staff Engagement and Equality presented the latest **findings from the 'Moving On' survey** and the following actions were agreed for the Deputy Chief People Officer, Organisational Development to enact:
  - Ensure that future "Quarterly review of the findings from 'Moving On' survey" reports outlined the response rate as a percentage of total staff leaving the Trust.
  - Confirm, to the Assistant Trust Secretary, the proposed scheduling, including the associated reporting frequency, of a "review of the outputs from the Business Intelligence Team's analysis of the Trust various staff survey data" item to future People and Organisational Development Committee meetings.
  - Investigate what, if any, actions could be implemented, by line managers and Trust staff, that would have a significant impact on staff satisfaction and wellbeing (e.g. group discussions between staff and members of the Executive Team; enhanced support for the provision of regular one to one meetings for wellbeing discussions; increased ward huddles at the start and end of shifts etc.).
- The Chief People Officer and Chief Nurse provided an **overview of the Trust's current staffing challenges, absence levels and associated mitigations** wherein the Committee acknowledged the impact of the redeployment of Trust Staff to alternative ward areas and it was agreed that the Chief Nurse and Chief People Officer should submit an "Update on the plans to support flexible working arrangements for retiring staff and those staff returning from retirement" to a future People and Organisational Development Committee meeting. It was also agreed that the Chief People Officer should ensure that Committee members were informed of the outputs from the meetings to discuss the actions which could be implemented to address the staffing challenges at Tunbridge Wells Hospital.
- The Committee conducted an **initial review of the implications of the "The Future of NHS Human Resources and Organisational Development report"** and supported the proposed areas for the further discussion at the February 2022 'deep dive' meeting; although it was also agreed that the Chief People Officer and Deputy Chief People Officer, People and Systems should Ensure that the "In-depth review of the implications of the "The Future of NHS Human Resources and Organisational Development report" presentation to the February 2022 People and Organisational Development Committee 'deep dive' meeting reflected the comments received at the January 2022 'main' People and Organisational Development Committee meeting.
- The Head of Staff Engagement and Equality provided the latest **update on Equality, Diversity and Inclusion (EDI)** (including details of the activity levels within the Trust's Networks) and it was agreed that the Head of Staff Engagement and Equality should ensure that future "Update on Equality, Diversity and Inclusion (EDI)" reports highlighted the impact of the Trust's EDI

programme of work, including the implementation of corresponding metrics where appropriate

- The Deputy Chief People Officer, Organisational Development provided the latest **update on employee engagement** wherein the Committee emphasised the importance of the continue provision and development of interventions to support staff health and wellbeing in the intervening period prior to the publication of the outputs of the national NHS staff survey 2021.
- The Deputy Chief People Officer, People and Systems provided a comprehensive **Update on the Trust's COVID-19 Vaccination plan** (including vaccination as a condition of deployment (VCOD)) wherein an in-depth discussion was held regarding the implications of the guidance issued by NHS England / Improvement and it was agreed that the Deputy Chief People Officer, People and Systems should check, and confirm to Committee members, the number of unvaccinated employees that were in scope of NHS England / Improvements guidance in relation to the COVID-19 vaccination mandate.
- The Committee reviewed the **draft Internal Audit plan for 2022/23** and no amendments were proposed.
- The Committee noted the latest recent **findings from relevant Internal Audit reviews** (6-monthly report); and **quarterly review of internal communications**.
- The latest **quarterly update from the Guardian of Safe Working Hours** (covering October to December 2021) was reviewed (and this is enclosed in Appendix 1, for information and assurance).
- The latest q**uarterly update from the Director of Medical Education** was noted and it was agreed that the Deputy Chief People Officer, Organisational Development should consider, and confirm to Committee members, the frequency by which an "Update on Learning and Development" item should be scheduled at the 'Main' People and Organisational Development Committee.
- The Committee confirmed that a **Committee evaluation** should be undertaken for 2021, via the completion of the same survey used in 2020.
- The **Committee's forward programme** was noted.
- Under the **evaluation of the meeting**, the quality of the submitted reports was commended.

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

- That the Deputy Chief People Officer, People and Systems should ensure that the Chair of the People and Organisational Development Committee was provided with a weekly update report on vaccination as a condition of deployment (VCOD) and the associated Manager feedback

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

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

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

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

'MAIN' PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE – JANUARY 2022

NHS Maidstone and Tunbridge Wells NHS Trust

QUARTERLY UPDATE FROM THE GUARDIAN OF SAFE WORKING HOURS (COVERING OCTOBER TO DECEMBER 2021)	**GUARDIAN FOR SAFE WORKING HOURS**

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

- 107 Exception Reports were raised.
- 27 General Medicine, 23 Gastroenterology, 23 ENT, 1 Obs & Gynae, 1 Geriatric Medicine, 8 General Surgery, Urology 3 and 21 Orthopaedics
- 67 from FY1 doctors, 26 FY2, 9 CT1 and 5 from ST7 doctors
- 107 exception reports were filed related to excessive hours worked/difference in work pattern, with 1 other related inability to take a break.
- Two work schedules were undertaken in this quarter (FY1 in Surgery/Urology)
- Chief of services, medical director informed of late exception report responses and action taken.

Reason for circulation to People and Organisational Development Committee

Assurance

Reporting Period: Oct- Dec 2021

Exception Reports

Exception reports by specialty and grade: Oct – Dec 2021				
Specialty	**Grade**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Orthopaedics	FY1	11	11	0
Orthopaedics	FY2	7	0	7
Orthopaedics	ST7	3	0	3
Gastroenterology	FY1	14	7	7
Gastroenterology	CT1	9	0	9
General Medicine	FY1	8	4	4
General Medicine	FY2	19	7	2
Geriatric Medicine	FY1	1	0	1
General Surgery	FY1	8	4	4
ENT	FY1	22	22	0
ENT	ST1	1	1	0
Urology	FY1	3	2	1
Obs & Gynae	ST1	1	0	1
Total		107	67	40

Report Commentary:

During the three-month period there were 107 Exception Reports received. 106 were related to excessive hours worked outside of the Junior Doctors work schedule. 1 report was filed related to lack of an ability to take a break.

Two work schedule reviews were undertaken with FY1 in surgery and urology, both related to excessive hours worked. There were no fines given in this period.

Looking at the ERs in more detail, ENT received 23 relating to junior doctors staying late at outpatient's clinic. This has been discussed at ENT governance and speedily resolved by the clinical supervisor. I have reiterated it to one of the Trainees who filed 22 ERs, that they need to be filed in a timely process, not 22 in one go. Also, that it would be more appropriate to discuss issues early with their clinical supervisor, than continue to stay late and file all reports over 3 weeks later.

It is to be noted that a proportion of the ERs received during this period are most definitely related to either junior staff catching Omicron, isolating due to a close contact, or increased worked load due to short staffing across allied health professionals on the wards. This is anecdotally from discussion with rota coordinators, as reports only mention excessive workload due to staff shortages.

Other reasons for extra hours worked include:
- Excessive Workload
- An inability to handover to late team as inappropriate for good patient care
- Unwell Patients at the end of a shift needing acute care
- Short staffing due to rota gaps

Lastly, regarding exception reports that are outstanding outside of the seven-day response time, I'm pleased to report on having repeated recent interaction with the Chief of services for the respective directorates, that ERs are beginning to be replied to quicker.

However, despite this a small number of clinical supervisors are still inappropriately slow to reply to outstanding reports and this on-going will be discussed at the various clinical governance meetings, with those individuals required to have a meeting with their respective directorate college tutors, to address any barricades to the ER process and any IT training required.

NHS Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report (IPR) for December 2021	Chief Executive / Members of the Executive Team

The IPR for month 9, 2021/22, is enclosed, along with the monthly finance report and the latest 'planned vs actual' nurse staffing data.

As Trust Board members have previously been notified the enclosed IPR represents the official launch of the new IPR format.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 25/01/22 (IPR) (AM)
- Finance and Performance Committee, 25/01/22 (IPR) (PM)

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

Review and discussion

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report

December 2021

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

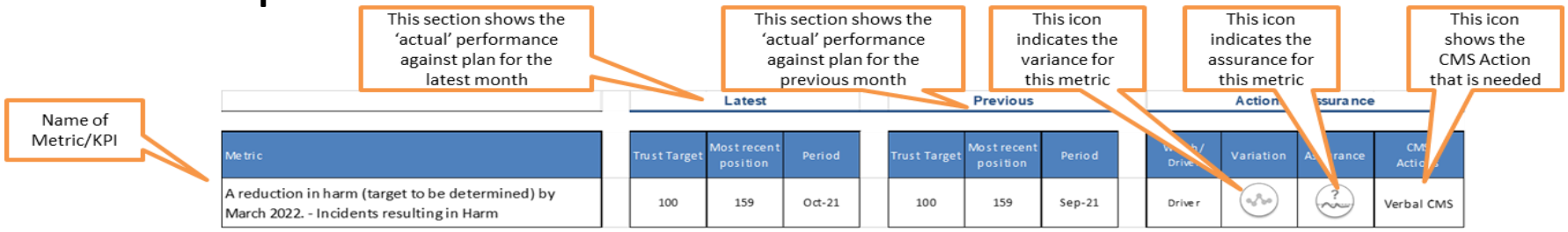
Escalation Rules:

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 moved into special cause variation of a concerning nature after a significant spike in December. 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. In addition, the Trust is managing a programme of work around the NHS Mandatory Vaccination which could have an impact on the future vacancy rate.

The Trust continues to achieve both the National Cancer 62 Day Standard and the 2 Week Wait (2WW) Standard, reporting 85.9% and 94.3% 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 81.1% 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 and Diagnostic Waiting Times performance has remained similar in December as elective activity continues to recover. Activity levels (including activity being undertaken by the Independent Sector) have remained slightly below plan for the last six months with an the estimate for December currently showing 92% of 19/20 levels for Elective Activity and 94% 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

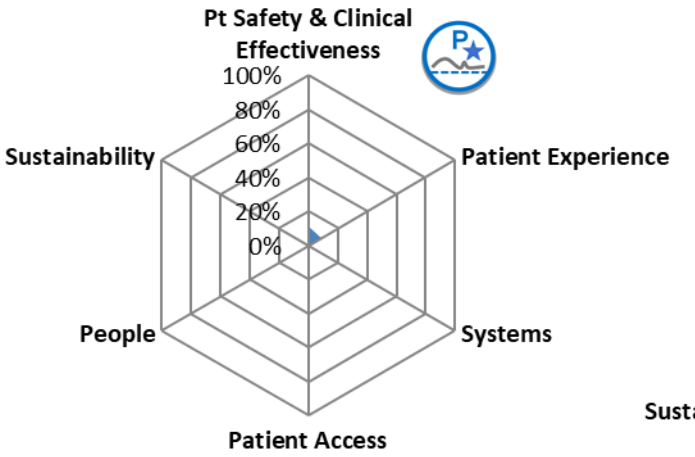
Patient Safety & Clinical Effectiveness:
- Falls Rate
- Safe Staffing
- Incidents Resulting in Harm
- SIs
- Infection Control

Patient Access:
- RTT Standard & 52 wk Waiters
- 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 & Colonoscopy

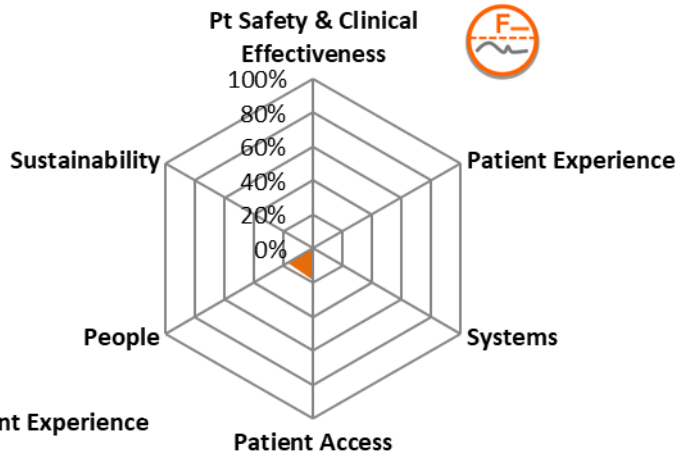
Patient Experience:
- Friends & Family Response Rates
- Friends & Family % Positive Rates
- Complaints

Assurance Radar Charts by Strategic Theme

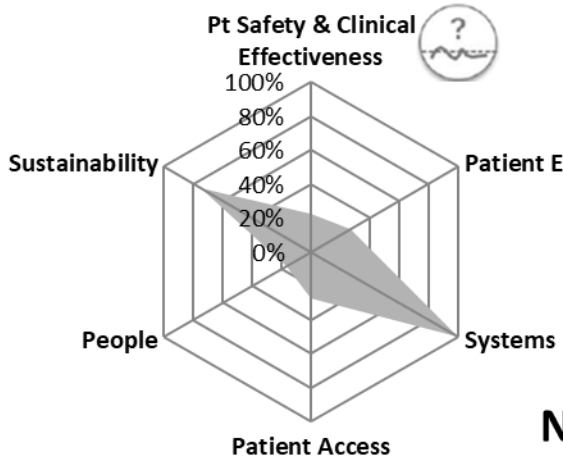
Consistently Passing



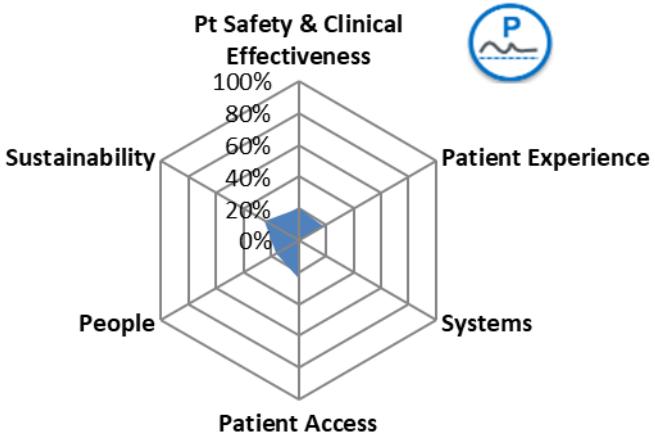
Consistently Failing



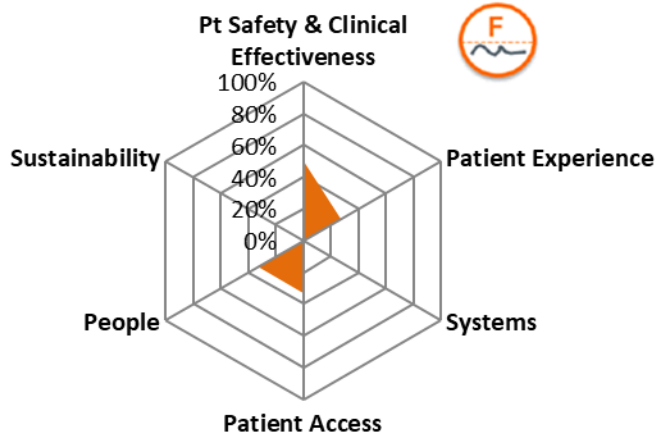
Hit and Miss



Achieved Target > 6 months



Not Achieved Target > 6 months



Matrix Summary

December 2021		Assurance				
		Pass ★	Pass	Hit and Miss	Fail	Fail -
Variance	Special Cause - Improvement	Statutory and Mandatory Training	Capital Expenditure (£k), Appraisal Completeness, Flow: % of Emergency Admissions that are zero LOS (SDEC)	Flow: Super Stranded Patients	RTT >52 wk Waiters	Transformation: CAU Calls answered <1 minute
	Common Cause	Standardised Mortality HSMR, % VTE Risk Assessment (one month behind)	FFT positive response: Inpatients, FFT positive response rate: Matenity, Activity levels match those pre-Covid - Follow Up Outpatients, 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 - MRI, CT, NOUS, Flexi Sigmoidoscopy, Gastroscopy Reduce average non-elective bed days relating to patients with high and very high AEC conditions by 10%, Reduce Agency Spend - £000, Never Events, Complaints Rate, % complaints responded to within target	Reduction in Incidents causing Harm, Hospital Acquired Covid, Activity levels match those pre-Covid - Elective, Activity levels match those pre-Covid - OP New, Activity levels match those pre-Covid - Colonscopy, Safe Staffing Levels, Rate of Hospital C.Difficile, Sickness Absence, Flow: % of Emergency Admissions into Assessment Areas	RTT Standard, FFT Response Rate: A&E, Vacancy Rate, Transformation: % OP Clinics Utilised (slots)
	Special Cause - Concern	0	0	% of staff that "Recommended MTW as a good place to work" taken from Quarterly Climate Survey, Reduction in non-elective bed days, Number of Hospital acquired MRSA, Reduction of number of patients on the 62d backlog	Increase Climate Survey response rates, Reduction in slips, trips and falls Rate, Increase FFT Response rate: Inpatients, Increase FFT response rates: Maternity, Increase FFT response rates: Outpatients, A&E 4 hr Performance, Flow: Ambulance Handover Delays >30mins	Access to Diagnostics (<6weeks standard)

Strategic Theme: People

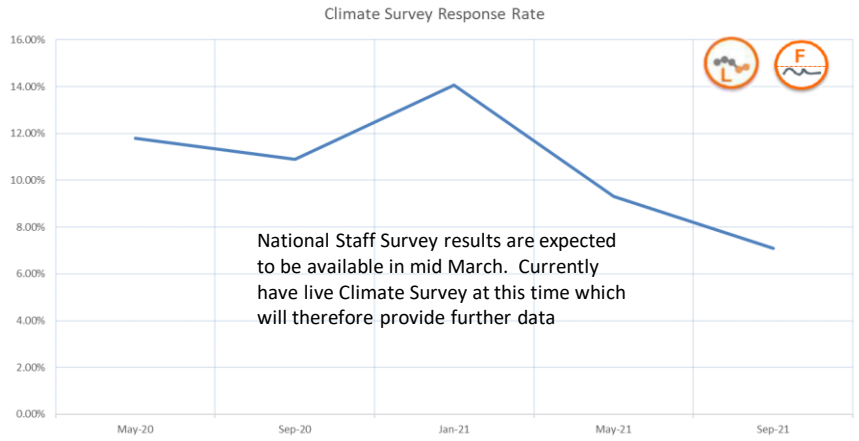
	CQC Domain	Metric	Latest: Trust Target	Latest: Most recent position	Latest: Period	Previous: Trust Target	Previous: Most recent position	Previous: Period	Actions & Assurance: Watch / Driver	Actions & Assurance: Variation	Actions & Assurance: Assurance	Actions & Assurance: CMS Actions
Vision Goals / Targets	Well Led	% of staff that "Recommended MTW as a good place to work" taken from Quarterly Climate Surveys	80%	63.8%	Dec-21	80%	71.2%	Feb-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%	7.08%	Sep-21	25%	14.10%	May-21	Driver			Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Well Led	Vacancy Rate	9.0%	13.0%	Dec-21	9.0%	12.5%	Nov-21	Driver			Escalation Page
	Well Led	Sickness Absence	3.3%	4.6%	Nov-21	3.3%	4.8%	Oct-21	Driver			Escalation Page
	Well Led	Appraisal Completeness	95.0%	89.3%	Dec-21	95.0%	86.7%	Nov-21	Driver			Note Performance
	Well Led	Statutory and Mandatory Training	85.0%	90.9%	Dec-21	85.0%	92.2%	Nov-21	Driver			Note Performance

Breakthrough Objective: Counter Measure Summary

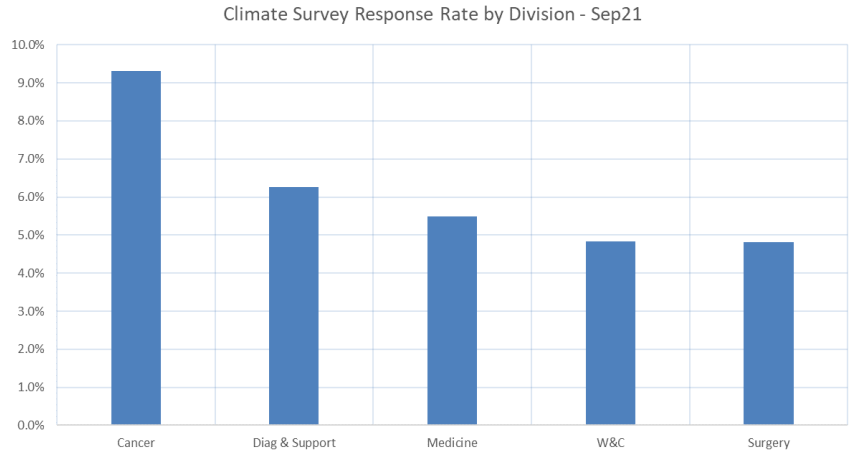
Metric Name – Increase Climate Survey Response to provide a larger sample base

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

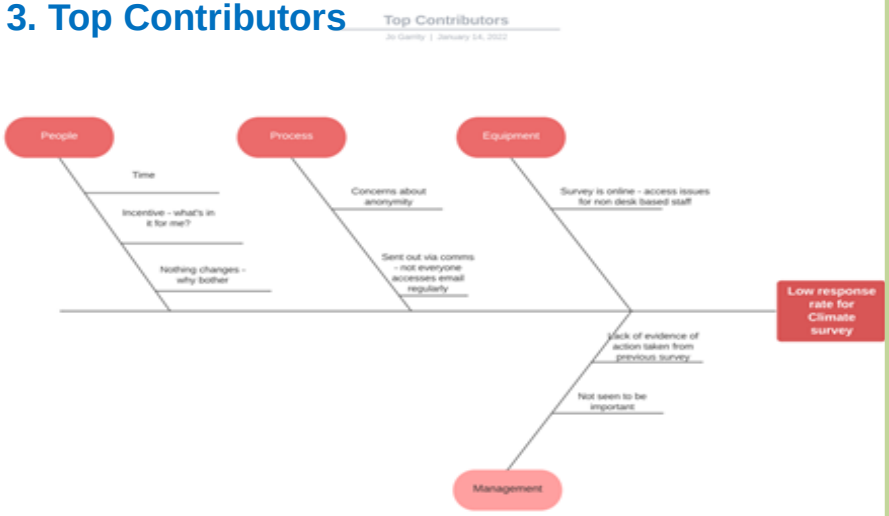
1. Historic Trend Data



2. Stratified Data



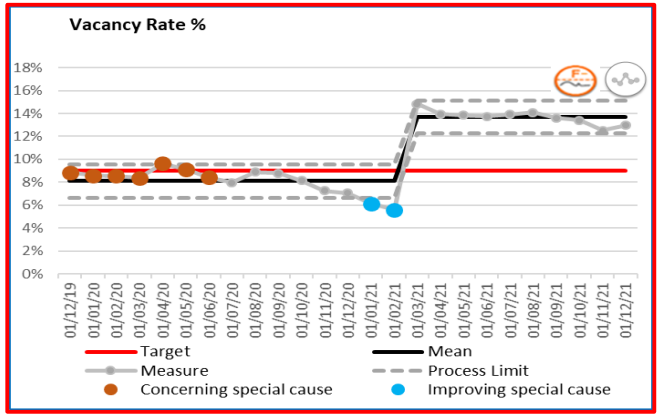
3. Top Contributors



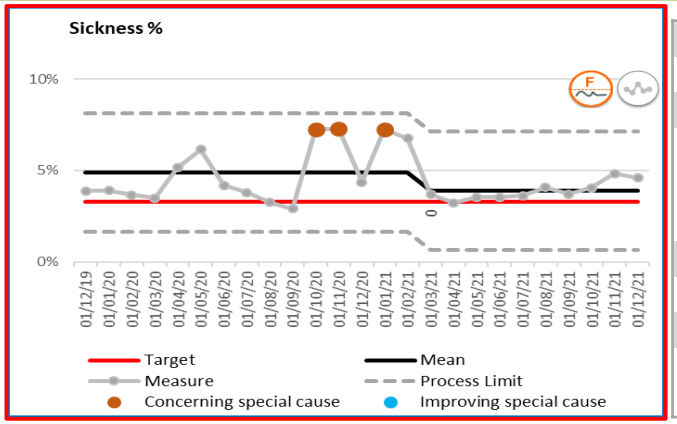
4. Action Plan

Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
Time	To be confirmed	Introduction of QR code to enable staff alternative method of responding	Head of Staff Engagement & Equality	Complete
Management	To be confirmed	Promotion of QR code in wellbeing lounges and encouragement to complete by coordinators plus promotion by wellbeing team	Head of Staff Engagement & Equality	Complete
People- Incentive – what's in it for me	To be confirmed	Introduction of incentive (2 x £50 vouchers) – prize draw for all who respond	Head of Staff Engagement & Equality	Complete
People – Nothing changes why bother?	To be confirmed	You said We did – Trust wide communications	Head of Staff Engagement & Equality/ Comms	
People – Nothing changes why bother?	To be confirmed	You said We did – Divisional comms	Head of Staff Engagement & Equality /Divisional leads	

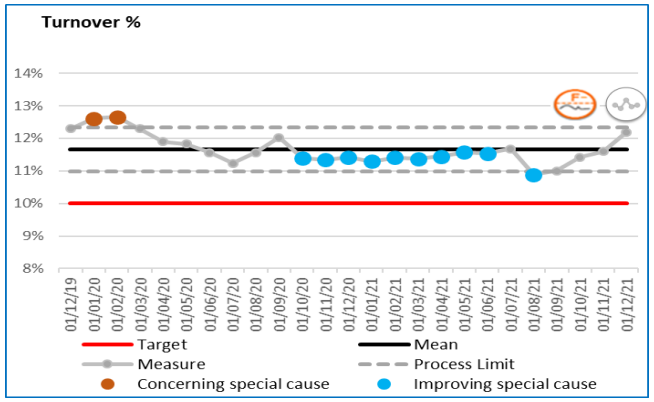
People – Workforce: CQC: Well-Led



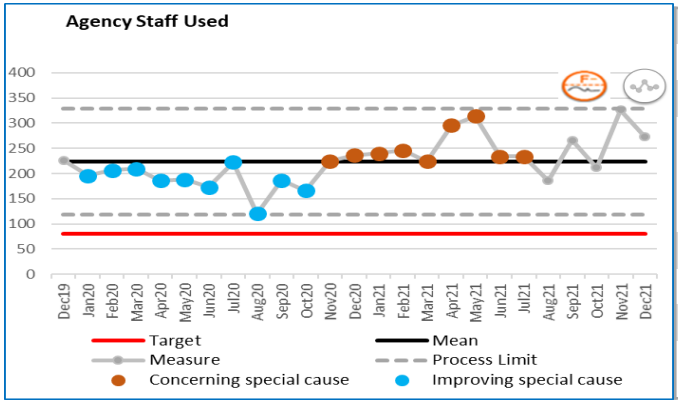
Dec-21
13.0%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and consistently failing the target
Max Limit (Internal)
9%
Business Rule
Full Escalation



Nov-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



Dec-21
13.0%
Variance / Assurance
Metric is currently experiencing Common Cause Variation consistently failing the target
Max Limit (Internal)
10%
Business Rule
For Information as linked to Vacancy Rate



Dec-21
273
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: slight increase for last period, due to people typically leaving roles in December and not starting the new one until January. Expectation this will revert in January to the trend of reduction in vacancy rate.

For wider recruitment, there is a significant coordinated response: Marketing company working with Resourcing / comms to enhance trust branding, attractions materials and lead on specific campaigns, Ongoing international nurse recruitment, National recruitment campaigns organised for nursing, New Healthcare Support Worker (HCSW) role supporting applicants new to healthcare, Allied Health Professional (AHP) Strategy Lead also supporting greater coordination and planning in this area

Sickness: Close monitoring of daily sickness absence rate due to recent increase as a result of omicron. Rates do appear to be levelling out

Assurance & Timescales for Improvement:

Fortnightly workforce supply task group- which provides pipeline for each staff group

Monthly PWR data submitted to NHSI

Nursing paper submitted to Executive team which provides pipeline/ turnover and new initiatives

Workforce planning sessions (with Strategy and Finance colleagues) taking place in January at division level with HRBPs representing HR to inform future recruitment planning

The Trust is managing the NHS Mandatory Vaccination Programme carefully and any risks to future workforce numbers are being closely monitored.

Strategic Theme: Patient Safety & Clinical Effectiveness

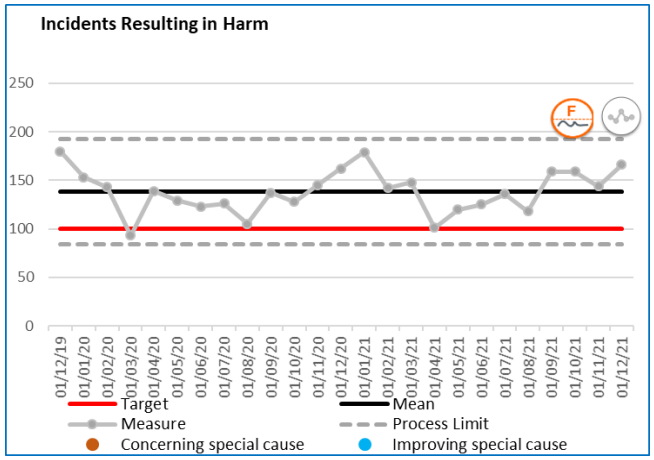
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Safe	A reduction in harm (target to be determined) by March 2022. - Incidents resulting in Harm	100	166	Dec-21	100	144	Nov-21	Driver		F	Full CMS
Breakthrough Objectives	Safe	Reduction in slips, trips and falls (Rate per 1,000 Occupied Beddays)	6.0	10.4	Dec-21	6.0	7.8	Nov-21	Driver	H	F	Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Safe	Number of New SIs in month	11	1	Dec-21	11	9	Nov-21	Driver		P	Note Performance
	Safe	Standardised Mortality HSMR	100.0	94.1	Oct-21	100.0	94.9	Sep-21	Driver		P	Note Performance
	Safe	Never Events	0	0	Dec-21	0	0	Nov-21	Driver		?	Verbal CMS
	Safe	Safe Staffing Levels	93.5%	89.0%	Dec-21	93.5%	87.7%	Nov-21	Driver		F	Escalation Page
	Safe	Infection Control - Hospital Acquired Covid	0	20	Dec-21	0	1	Nov-21	Driver		F	Escalation Page
	Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays	22.7	42.1	Dec-21	22.7	25.3	Nov-21	Driver		F	Escalation Page
	Safe	IC - Number of Hospital acquired MRSA	0.0	1	Dec-21	0	0	Nov-21	Driver	H	?	Verbal CMS

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

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

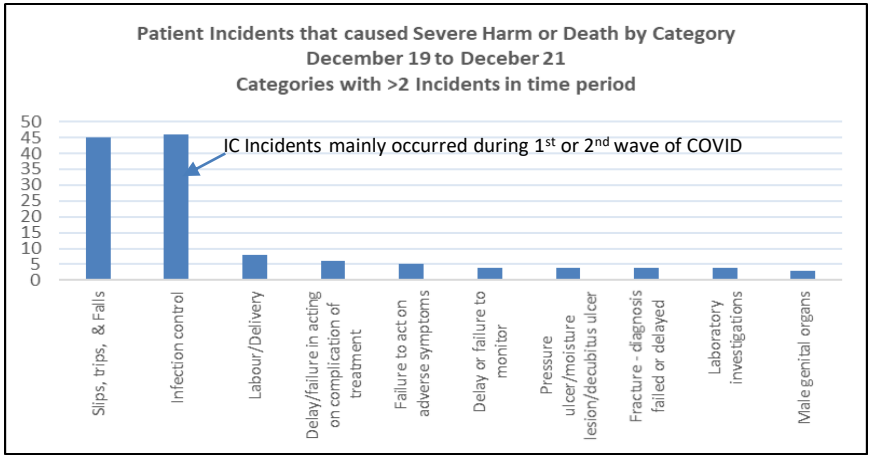
Owner: Peter Maskell
Metric: Incidents resulting in harm
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Dec-21
166
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

Reviewing the logic / process required to apply A3 thinking to multiple investigation reports

4. Action Plan

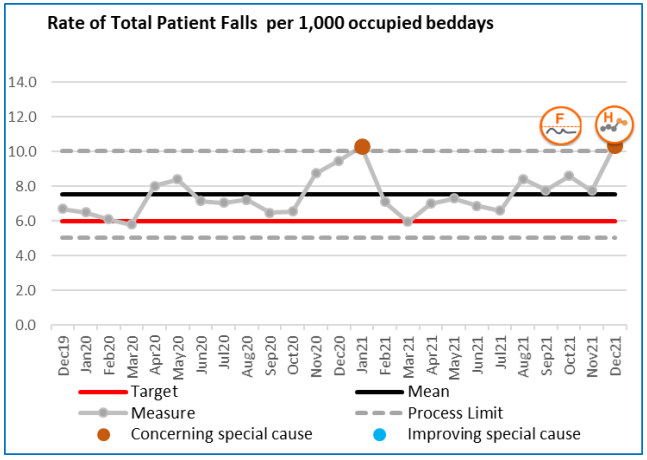
Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
Currently under review as multiple investigation reports	TBC	Action plan pending confirmation of A3 review process	Director of Quality Governance	

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

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

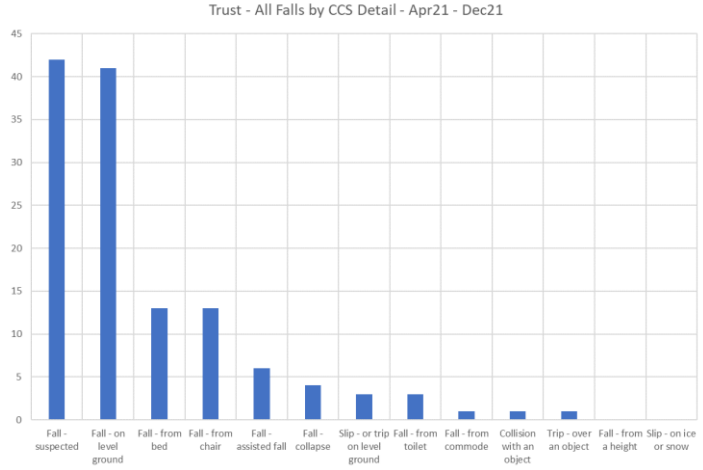
Owner: Peter Maskell
Metric: Falls Rate per 1,000 Occupied Beddays
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data

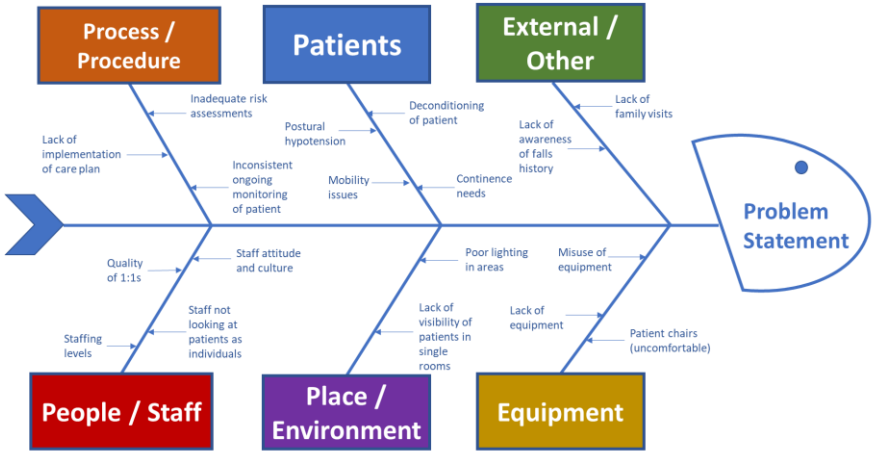


Dec-21
10.4
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has not achieved the target for more than 6 months
Max Target (Internal)
6.0
Business Rule
Full Escalation as Hit or Miss > 6 months

2. Stratified Data



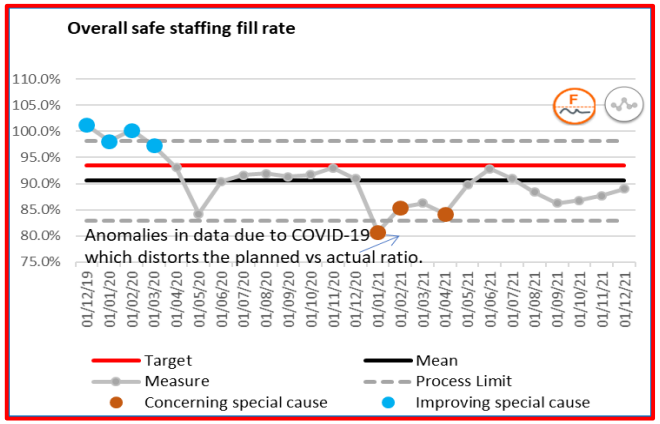
3. Top Contributors



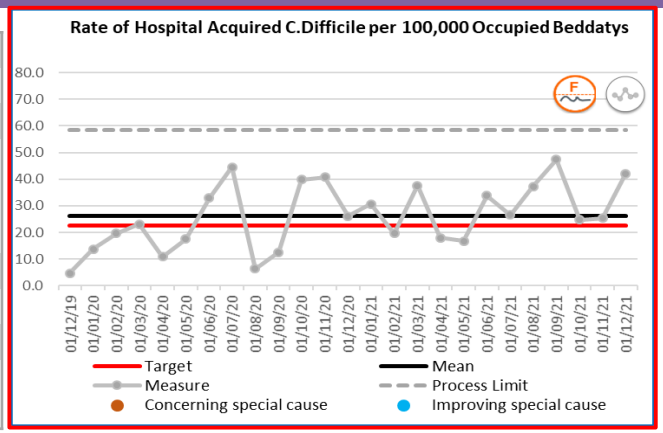
4. Action Plan

Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
Not identified yet as starting to look at process and undertaking analysis	To be Confirmed	Three Working Groups meeting fortnightly to work through all the priorities identified to scope out feasibility and actions required for each of the priorities identified.	Lead Nurse for Falls Prevention	w/c 17/01/22
		Business Intelligence to support with data analysis to provide evidence for proposed KPI.	Lead Nurse for Falls Prevention	w/c 17/01/22
		Agree proposed KPI ready for presentation to STFs Group at February 8th meet and sign off by Directorate sponsor.	Lead Nurse for Falls Prevention	w/c 31/01/22

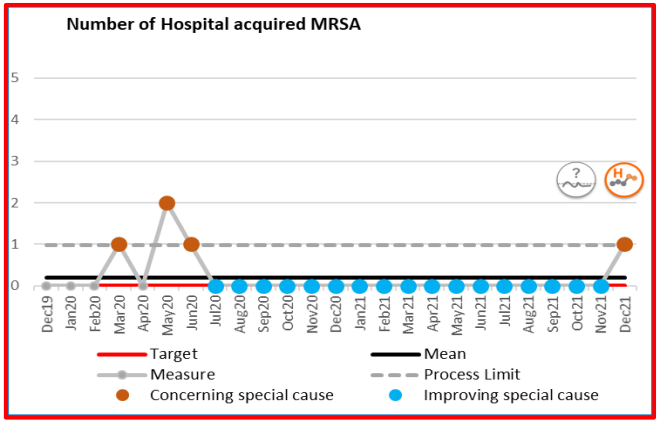
Patient Safety and Clinical Effectiveness: CQC: Safe (Hit & Miss > 6months)



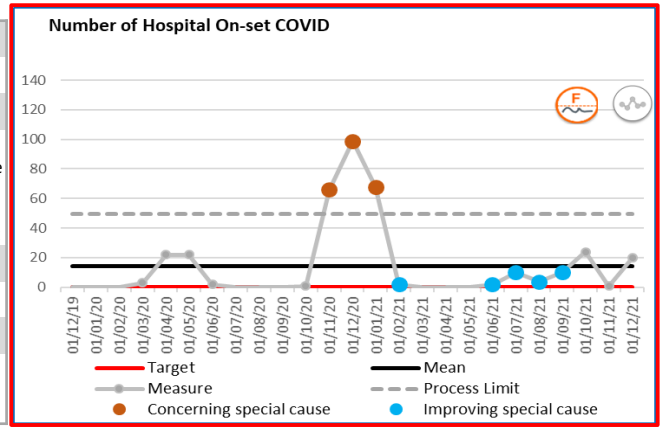
Oct-21
87.7%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has not achieved the target for >6months
Target (Internal)
93.3%
Business Rule
Full Escalation as has not achieved the target for > 6 months



Dec-21
42.1
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



Dec-21
1
Variance / Assurance
Metric is currently experiencing Special Cause variation of a concerning nature and variable achievement of the target
Max Target
0
Business Rule
Full Escalation as Hit or Miss > 6 months



Dec-21
20
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: There was one MRSA reported in December 21 and therefore this indicator is now experiencing special cause variation of a concerning nature and has been experience variable achievement of the target for more than six months. This variation and increase in alert organisms has been seen across Kent and Medway.

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 continue to review nursing and midwifery staff rosters. This enables forward planning, risk identification and action planning on projected fill rates, to ensure staffing is as safe as possible across the whole Trust. To optimise joint working between the nursing teams and the Bank team, the temporary staffing team now attend morning site meeting. Bank team members continue to liaise with Matrons at the afternoon staffing huddle to update on fill rate. Daily senior nurse staffing huddle implemented to provide oversight for areas of concern. CSW agency lines of work implemented to support clinical areas. Head of Nursing for Safe Staffing in being recruited. Retention Committee, chaired by the Chief Nurse is being implemented specifically for Nursing, Midwifery and Clinical Support Workers (CSWs).

Infection Control: 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, actions include a focus on antimicrobial prescribing policy, completion of C.Difficile risk assessments for patients on admission, and replacement of commodes identified as difficult to clean, this work is still ongoing and did see an initial improvement in October and November. A further C.difficile incident meeting was held in January which identified further actions for improvement. Root cause analysis of cases have identified a number of unavoidable cases of C.Difficile and E.Coli bacteraemia, but where learning has been identified this is disseminated. A trust attributable MRSA bacteraemia was identified in December and is currently undergoing root cause analysis.

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 for every shift, with oversight monitored by the Senior Leadership Team and appropriate redeployment to support staffing levels across the trust. Daily BI staffing data for14 days sent to all DDNQ's, senior corporate nursing team, temporary staffing team and Flow team for review. Daily senior nurse staffing huddle implemented to provide oversight for areas of concern. Incentive package agreed for holiday period and with a focus 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 6 in the implementation stages. The SafeCare forum is now active, ensuring escalation of issues and sharing of good practice. SafeCare project has been mapped to ensure all inpatient wards are live by April 2022. Retention and Recruitment activity is significant and includes and interim Matron for Retention and Recruitment to work collaboratively with Human Resources to ensure clinical areas are supported with recruitment and retention activity

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.

Strategic Theme: Patient Access

			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Responsive	We will ensure no patient waits longer than 52 week for treatment by April 2022	0	4	Dec-21	0	10	Nov-21	Driver	L	F	Full CMS
	Responsive	By April 2022 we will achieve the RTT standard	83.5%	71.7%	Dec-21	83.5%	73.7%	Nov-21	Driver	H	F	Full CMS
Breakthrough Objectives	Responsive	Ensure activity levels for theatres match those pre-Covid - Total Elective	100.0%	91.9%	Dec-21	100.0%	94.8%	Nov-21	Driver		F	Full CMS
	Responsive	Ensure activity levels for outpatients match those pre-Covid - First Outpatients	100.0%	81.1%	Dec-21	100.0%	92.4%	Nov-21	Driver		F	Full CMS
	Responsive	Ensure activity levels for outpatients match those pre-Covid - Follow Up Outpatients	100%	102%	Dec-21	100%	105%	Nov-21	Driver		P	Note Performance
	Responsive	Ensure activity levels for diagnostics match those pre-Covid - MRI	100%	100%	Dec-21	100%	107%	Nov-21	Driver		?	Verbal CMS
	Responsive	Ensure activity levels for diagnostics match those pre-Covid - CT	100%	118%	Dec-21	100%	125%	Nov-21	Driver		P	Note Performance
	Responsive	Ensure activity levels for diagnostics match those pre-Covid - NOUS	100%	95%	Dec-21	100%	95%	Nov-21	Driver		?	Verbal CMS
	Responsive	Ensure activity levels for diagnostics match those pre-Covid - Colonoscopy	70%	22%	Dec-21	70%	30%	Nov-21	Driver		F	Full CMS
	Responsive	Ensure activity levels for diagnostics match those pre-Covid - Flexi Sigmoidoscopy	70%	31%	Dec-21	70%	33%	Nov-21	Driver		?	Verbal CMS
	Responsive	Ensure activity levels for diagnostics match those pre-Covid - Gastroscopy	100%	60%	Dec-21	100%	65%	Nov-21	Driver		?	Verbal CMS

Strategic Theme: Patient Access; continued

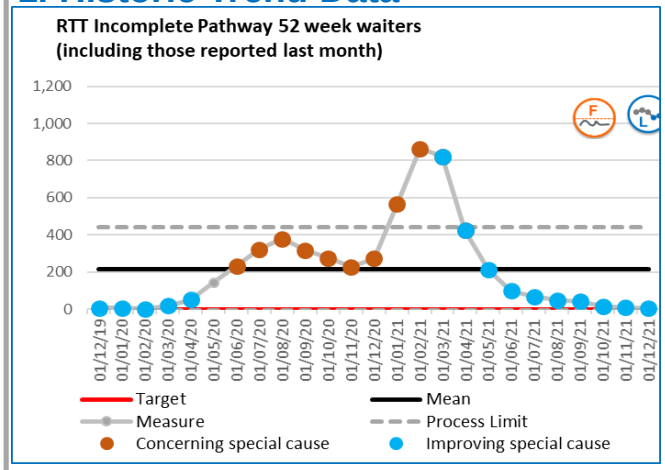
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Constitutional Standards and Key Metrics (not in SDR)	Effective	Transformation: % OP Clinics Utilised (slots)	85.0%	48.7%	Dec-21	85.0%	54.0%	Nov-21	Driver		F	Escalation Page
	Responsive	Access to Diagnostics (<6weeks standard)	99.0%	60.8%	Dec-21	99.0%	70.6%	Nov-21	Driver	L	F	Escalation Page
	Responsive	A&E 4 hr Performance	95.0%	81.1%	Dec-21	95.0%	80.9%	Nov-21	Driver	L	F	Escalation Page
	Responsive	Cancer - 2 Week Wait	93.0%	94.3%	Nov-21	93.0%	93.1%	Oct-21	Driver	L	P	Note Performance
	Responsive	Cancer - 62 Day	85.0%	85.9%	Nov-21	85.0%	85.5%	Nov-21	Driver		P	Note Performance
	Effective	Transformation: % of Patients Discharged to a PIFU Pathways	1.50%	2.03%	Dec-21	1.50%	2.05%	Nov-21	Driver	No SPC	No SPC	
	Effective	Transformation: CAU Calls answered <1 minute	90.0%	67.2%	Dec-21	90.0%	58.2%	Nov-21	Driver	H	F	Escalation Page
	Effective	Flow: Ambulance Handover Delays >30mins	7.0%	12.1%	Dec-21	7.0%	12.8%	Nov-21	Driver	H	F	Escalation Page
	Effective	Flow: Super Stranded Patients	80	0	Dec-21	80	0	Nov-21	Driver	L	?	Note Performance
	Effective	Flow: % of Emergency Admissions that are zero LOS (SDEC)	35.0%	40.3%	Dec-21	35.0%	40.4%	Nov-21	Driver	H	P	Note Performance
	Effective	Flow: % of Emergency Admissions into Assessment Areas	65.0%	58.7%	Dec-21	65.0%	59.6%	Nov-21	Driver		F	Escalation Page

Vision: Counter Measure Summary

Project/Metric Name – We will ensure no patient waits longer than 52 week for treatment by April 2022

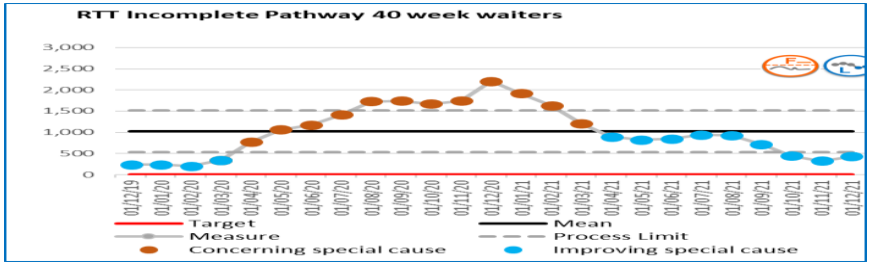
Owner: Sean Briggs
Metric: Referral to Treatment time Standard
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Dec-21
4
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Max Limit
0
Target Achievement
Metric has not achieved the target for > 6months

2. Stratified Data



	Weeks Wait					
Specialty	53	58	59	63	66	**Total**
ENT		1				1
Urology	1					1
Surgery			1			1
Paediatric T&O					1	1
Total	1	1	1	0	1	4

3. Top Contributors

- A3 thinking to be completed – February 22
- Action plan in place to monitor long waiting patients.

4. Action Plan

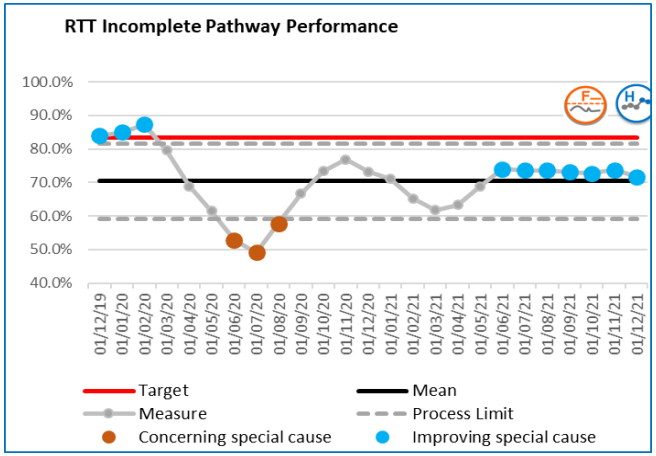
Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
Long waiting patients	Lack of OPA and theatre capacity due to NEL demand and covid restrictions	To continue with virtual OPA's. PIFU pathways to be implemented Patients monitored on a weekly basis at the weekly PTL meeting and Directorate PTL meetings.	General Managers	In progress
40+ week patients	Continuous increase in patients waiting 40 weeks for treatment	Patients monitored on a weekly basis at the weekly PTL meeting and Directorate PTL meetings. Patients tracked until treatment commenced.	General Managers /Patient Access Team	In progress
Patient referrals	Patients to be triaged in a timely manner	Patients monitored on a weekly basis at the weekly PTL meeting and Directorate PTL meetings.	General Managers /Patient Access Team	In progress

Vision: Counter Measure Summary

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

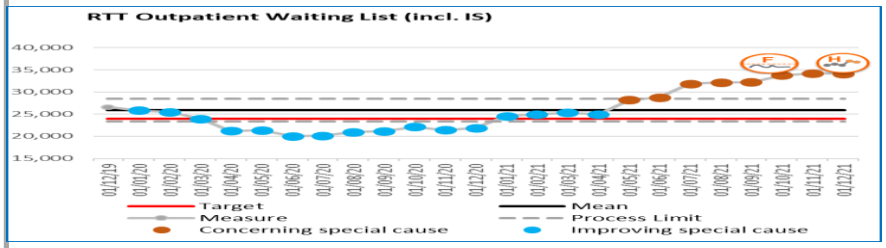
Owner: Sean Briggs
Metric: Referral to Treatment time Standard
Desired Trend: 7 consecutive data points above the mean

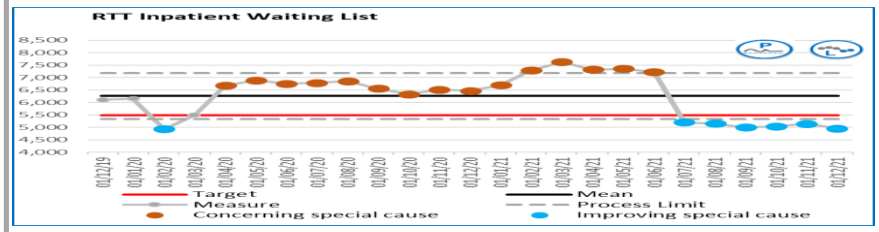
1. Historic Trend Data



Dec-21
71.7%
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Target (Internal)
86.3%
Target Achievement
Metric is consistently failing the target

2. Stratified Data





3. Top Contributors

- A3 thinking to be completed – February 22
- Currently have actions in place to monitor processes and impact.

4. Action Plan

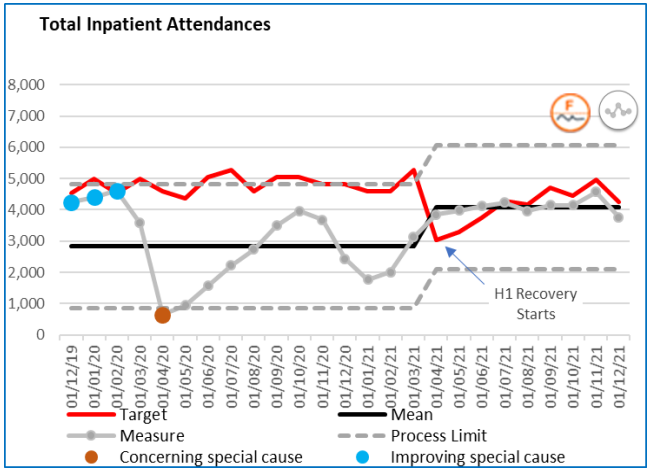
Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
Consultant availability	Consultant leave not always signed off by GM	GM to sign off all Consultant leave and to escalate to CD any issues.	Deputy Divisional Director of Operations Surgery	1/2/22
Patient not ready for surgery	POA outcome not checked prior to confirming surgery date	CAU SOP to be revisited and communicated to all CAU teams		1/3/22
Booking process not followed	Variation in booking patients for surgery	CAU policy has been circulated to the operational teams for comments.	RTT & Operational Lead	1/3/22
Lack of theatre space for new consultants	Limited free theatre slots	Theatre scenarios' have been drafted and shared with the theatre management teams. Comparison now being undertaken in line with D&C for each specialty.	Deputy Divisional Director of Operations Surgery	In progress

Breakthrough Objective: Counter Measure Summary

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

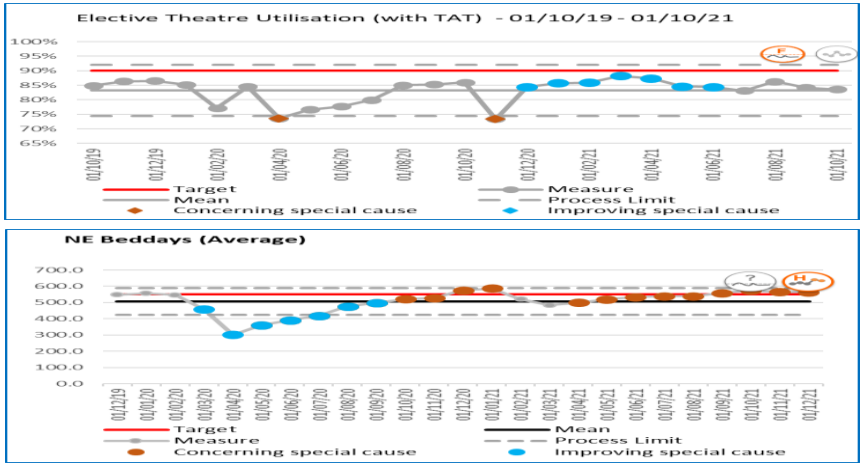
Owner: Sean Briggs
Metric: Elective Activity: Total Elective
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Dec-21
3760
Variance Type
Metric is currently experiencing Common Cause Variation
Target
4244
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

4. Action Plan

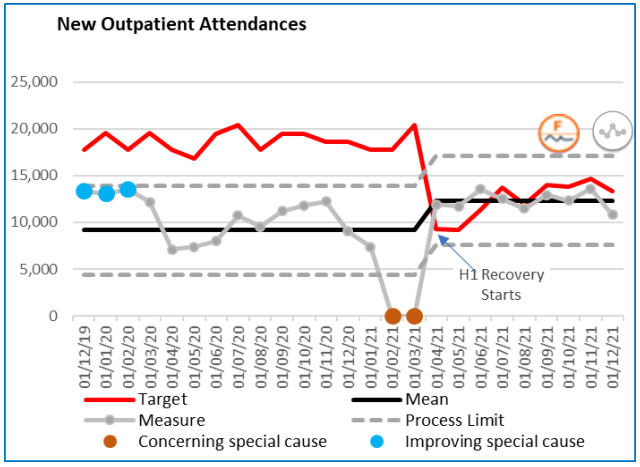
Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
Internal activity below plan	Closure of 1 theatre at TW due to staffing and increase in NEL demand.	Activity monitored weekly and day case activity increased.	Deputy Divisional Director of Operations Surgery/ Director of Operations Surgery	In progress
Outsource activity below plan	Lack of staff and capacity	Activity monitored weekly. Calls scheduled with IS Directors 17/01/22		In progress
Theatre utilization	Theatres not utilized to 85% trajectory without TAT	Monitored weekly at Directorate PTL Monitored monthly at TUB	General Managers	In progress
Cancelled operations	Increase in cancellations due to admin processes at all levels not being followed correctly	Cancellation to be monitored at weekly Directorate PTL's. Weekly monitoring at theatre scheduling meeting	General Managers	In progress

Breakthrough Objective: Counter Measure Summary

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

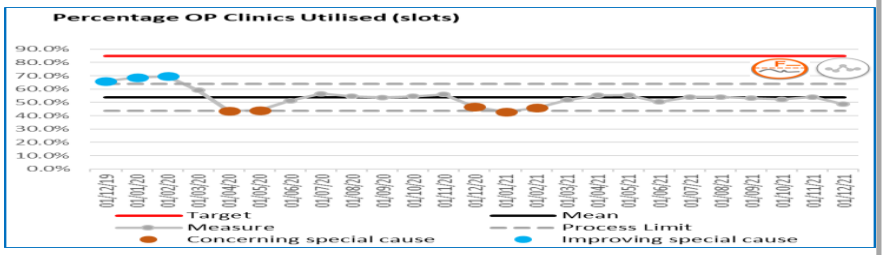
Owner: Sean Briggs
Metric: Elective Activity: New Outpatients
Desired Trend: 7 consecutive data points above the mean

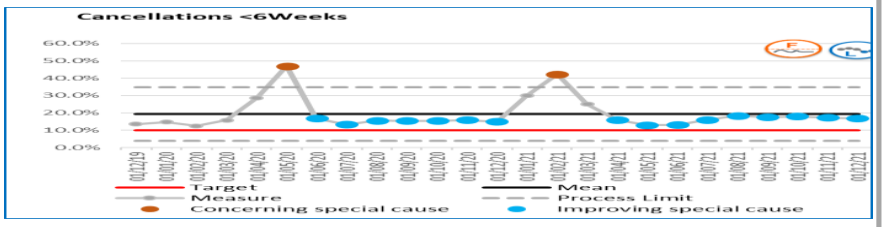
1. Historic Trend Data



Dec-21
10,824
Variance Type
Metric is currently experiencing Common Cause Variation
Target
13,339
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

4. Action Plan

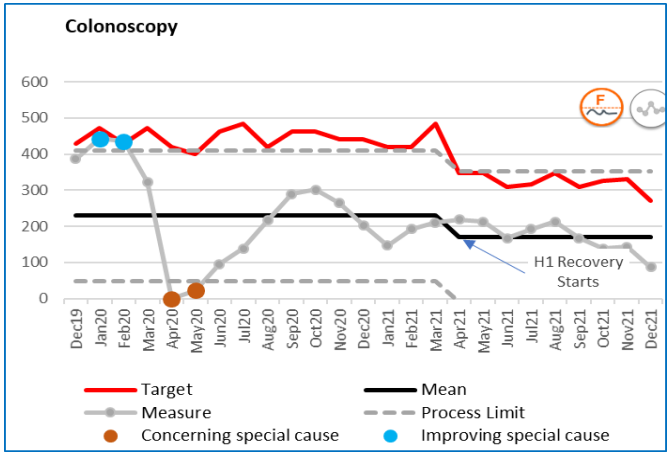
Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
Internal activity below plan	Clinics not cancelled with 6 weeks notice if specialty cant utilise	Activity monitored weekly. Weekly OPA scheduling meeting. Monitored weekly at Directorate PTL	General Managers	In progress
Outsource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

Breakthrough Objective: Counter Measure Summary

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

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

1. Historic Trend Data



Dec-21
87
Variance Type
Metric is currently experiencing Common Cause Variation
Target
271
Target Achievement
Metric has not achieved the target for >6 months

2. Stratified Data

Based on the pathway changes that have therefore reduced the demand this indicator will not achieve the pre-covid levels of activity. Now that this is understood would therefore recommend that this indicator is not escalated in future months

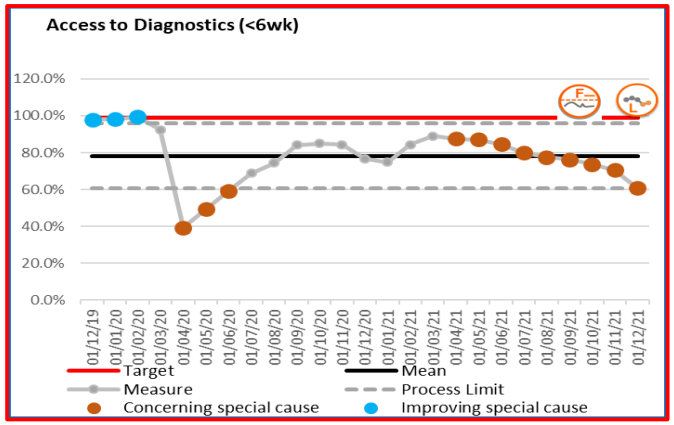
3. Top Contributors

- Current Kent & Medway capacity and demand modelling work being undertaken by Attain via cancer network – February 22
- Potential opportunity for support to other Trusts with backlog issues – based on output data from audit.
- Bowel scope was discontinued and age extension extended in Nov 21 and is the only diagnostic test that has seen a decrease in activity levels.

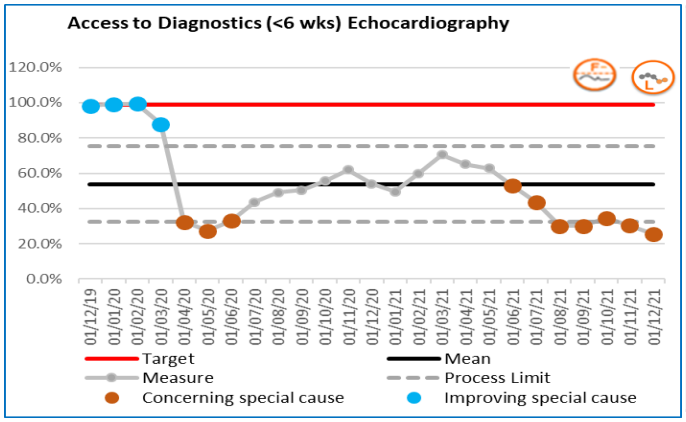
4. Action Plan

Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
Activity levels have decreased	Change of patient pathways: BSG guidelines for surveillance patients 60-70% colons removed via vetting – 3&5 years surveillance; Introduction of qFIT testing reducing 2 week demand; Colon capsule has commenced Increase in virtual colonoscopy	Monitor impact of pathway changes and adjust demand and capacity plans accordingly.	Deputy Divisional Director of Operations Surgery	In progress

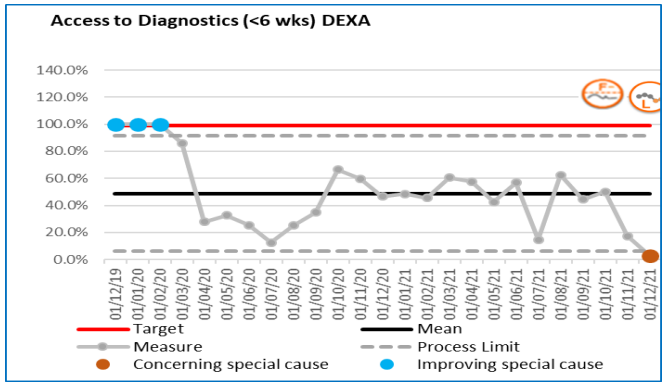
Patient Access – Diagnostics Waiting Times: CQC Responsive



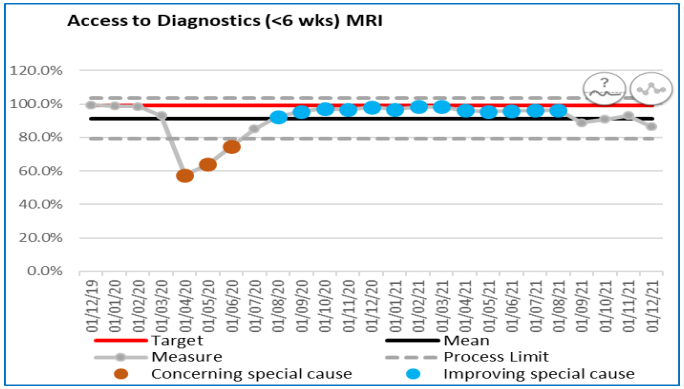
Dec-21
60.8%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of a concerning nature and consistently failing the target
Max Limit (Internal)
99%
Business Rule
Full Escalation



Dec-21
25.6%
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



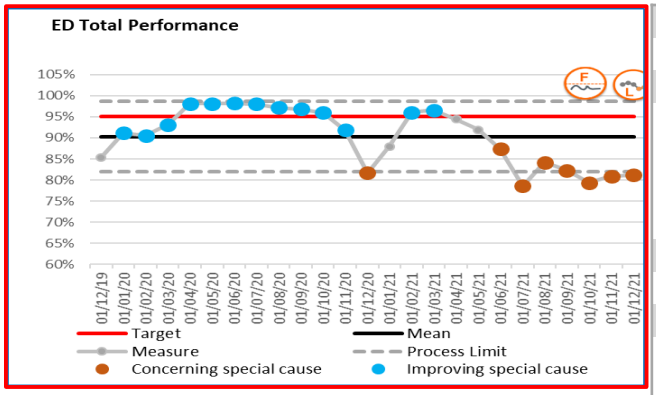
Dec-21
2.8%
Variance / Assurance
Metric is currently experiencing special cause variation of a concerning nature and consistently failing the target
Max Limit (Internal)
99%
Business Rule
For Information as Contributor to Overall



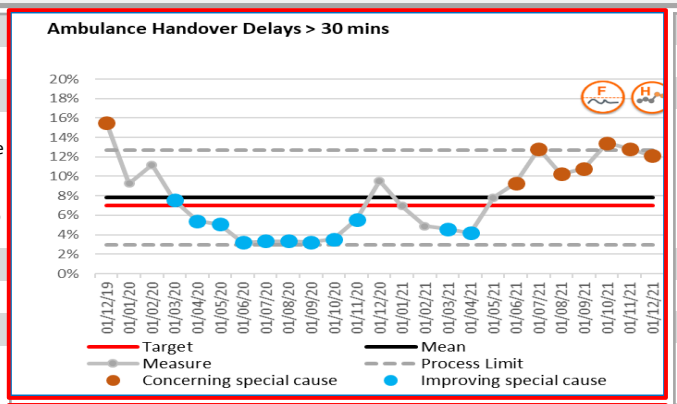
Dec-21
86.5%
Variance / Assurance
Metric is currently experiencing common cause variation and variable achievement of the target
Max Limit (Internal)
99%
Business Rule
For Information as Contributor to Overall

Summary:	Actions:	Assurance & Timescales for Improvement:
Diagnostic Waiting Times: Overall performance is experiencing special cause variation of a concerning nature and consistently failing 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. Ongoing pathway review with BI to plot through recovery trajectory and action plan. Process map the DEXA pathway and complete with an audit.	**Echocardiography:** Capital monies have been awarded for extra capacity to clear the current backlog of patients waiting more than six weeks. Staffing shortages are hugely impactful. **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. **DEXA:** continues to be outsourced to various providers to maximise capacity. However new Dexa machine has arrived and additional internal capacity has commenced. Actions - • Recovery paper in progress. • Action plan and revised trajectory to be monitored weekly • Revised operational structure to be implemented in radiology to support the recovery trajectory

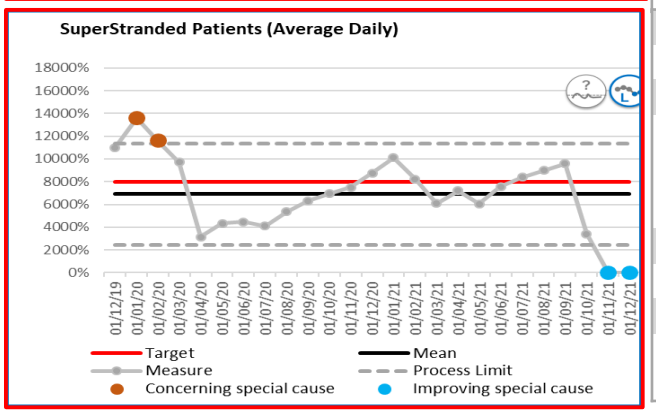
Patient Access – Hospital Flow: CQC: Responsive (Hit & Miss >6months)



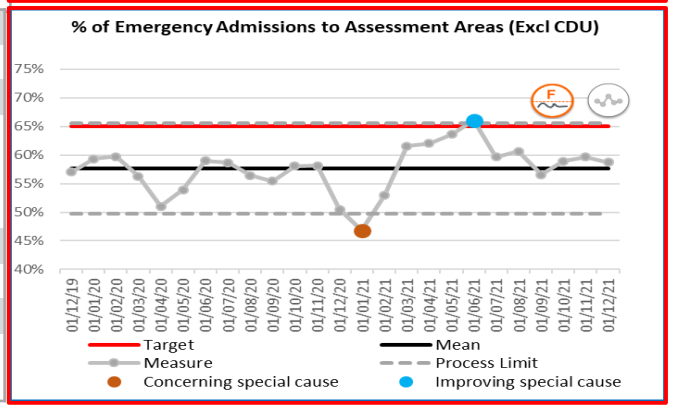
Dec-21
81.1%
Variance / Assurance
Metric is currently experiencing Special Cause variation of a concerning nature and has not achieved the target for >6 months
Target (National)
95%
Business Rule
Full Escalation as Hit or Miss > 6 months



Dec-21
12.1%
Variance / Assurance
Metric is currently experiencing Special Cause variation of a concerning nature and has not achieved the target for >6 months
Mas Limit (Internal)
7%
Business Rule
Full Escalation as Hit or Miss > 6 months



Dec-21
0
Variance / Assurance
Metric is currently experiencing Special Cause variation of an improving nature and variable achievement of the target
Max Limit (Internal)
80
Business Rule
Full Escalation as Hit or Miss > 6 months



Dec-21
58.7%
Variance / Assurance
Metric is currently experiencing Special Cause variation of a concerning nature and has not achieved 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 >15minutes is experiencing special cause variation of a concerning nature and has failed the target for more than six months

Super Stranded Patients: is now experiencing special cause variation of an improving nature and has been experiencing variable achievement of 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

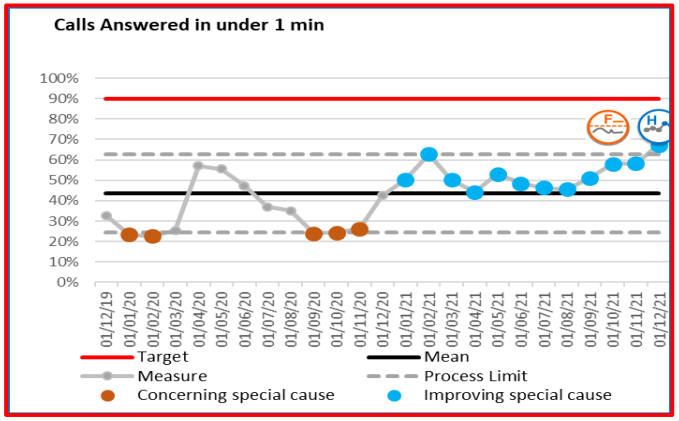
Ambulance handovers delays: Improvements expected in February. Divisional weekly performance meeting in place

Super stranded patients:

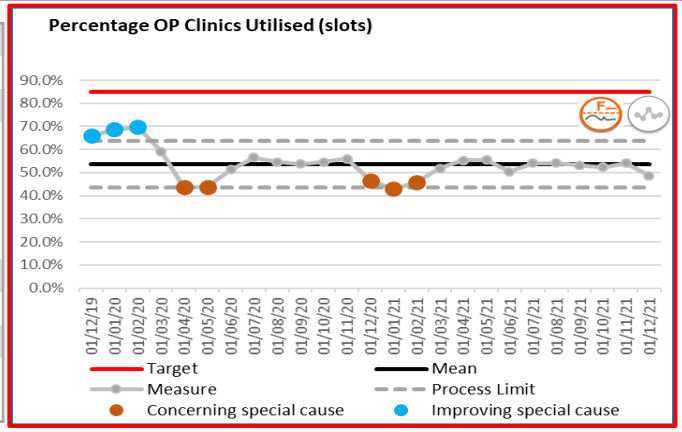
Monthly MADE events to bring an MDT approach. Improved understanding of pathways and introduction of resource packages.

% 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

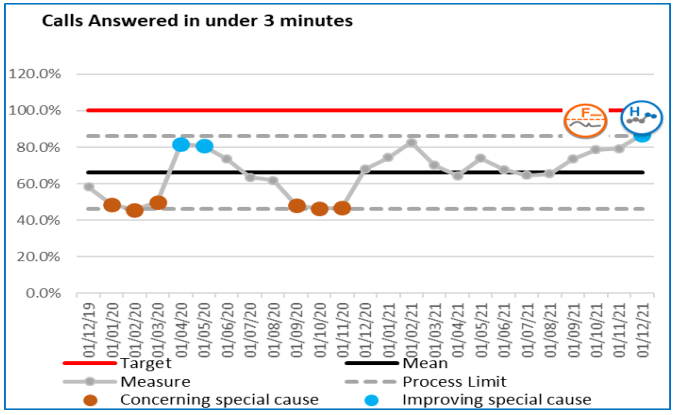
Patient Access – Transformation: Outpatients: CQC: Responsive



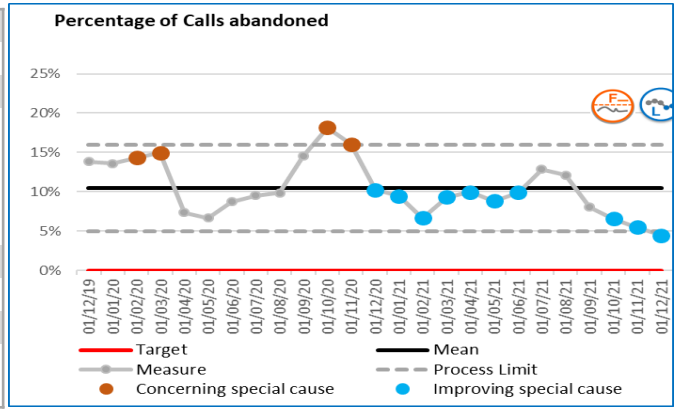
Dec-21
67.2%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target
Target (Internal)
90%
Business Rule
Full Escalation



Dec-21
48.7%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and consistently failing the target
Target (Internal)
85%
Business Rule
Full Escalation



Dec-21
87.0%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target
Target (Internal)
100%
Business Rule
For Information as linked to Calls <1min



Dec-21
4.5%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target
Target (Internal)
0%
Business Rule
For Information as linked to Calls <1min

Summary:

Calls Answered: The number of calls answered in less than 1 minute 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: Continuous weekly monitoring of the CAU's has helped to flag any long waiters and have analysed call performance to understand trends.
Future plans include in house call operatives (dependent on space) for the outpatient communication centre pilot which will improve the answer rate.

Outpatient Utilisation: The Clinical System Development Managers have reviewed all 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. Now complete further work is being completed on individual clinics affecting the utilisation report.

Assurance & Timescales for Improvement:

Calls Answered: Steep improvement due to weekly meeting with specialties to understand call performance. Still below target due to setting this high however huge improvements can be seen and more to come.

Outpatient Utilisation: Specialty clinic templates are being reviewed to ensure that all templates are correct and have received GM and CD sign off. Monthly deep dive into any clinic with low utilisation to understand cause of low %. Further look into DNA rate and the potential improvement from turning on Text reminders for patients.

Strategic Theme: Patient Experience

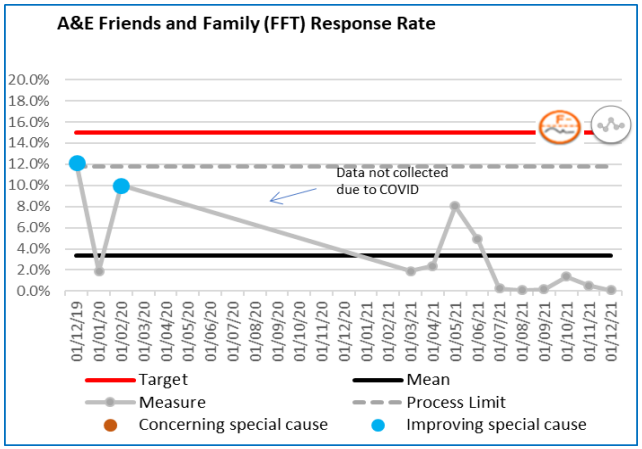
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Caring	Maintain the National FFT positive response rate. Inpatients	95.0%	98.3%	Dec-21	95.0%	97.8%	Nov-21	Driver		P	Note Performance
	Caring	Maintain the National FFT positive response rate. A&E	87.0%	100.0%	Dec-21	87.0%	100.0%	Nov-21	Driver		?	Verbal CMS
	Caring	Maintain the National FFT positive response rate. Maternity	95.0%	100.0%	Dec-21	95.0%	100.0%	Nov-21	Driver		P	Note Performance
	Caring	Maintain the National FFT positive response rate. Outpatients	84.0%	84.0%	Dec-21	84.0%	82.7%	Nov-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%	8.2%	Dec-21	25.0%	7.1%	Nov-21	Driver	L	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%	0.1%	Dec-21	15.0%	0.5%	Nov-21	Driver		F	Full CMS
	Caring	Increase response rates across all our FFT domains to meet the national target: Maternity	25.0%	2.8%	Dec-21	25.0%	5.6%	Nov-21	Driver	L	F	Full CMS
	Caring	Increase response rates across all our FFT domains to meet the national target: Outpatients	20.0%	15.6%	Dec-21	20.0%	13.4%	Nov-21	Driver	L	F	Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Caring	Complaints Rate	3.9	1.9	Dec-21	3.9	4.2	Nov-21	Driver		?	Verbal CMS
	Caring	% complaints responded to within target	75.0%	72.7%	Dec-21	75.0%	85.1%	Nov-21	Driver		?	Verbal CMS
	Caring	% VTE Risk Assessment (one month behind)	95.0%	96.1%	Nov-21	95.0%	96.4%	Oct-21	Driver		P	Note Performance

Breakthrough Objective: Counter Measure Summary

Metric Name – Increase Friends and Family Response Rates for A&E

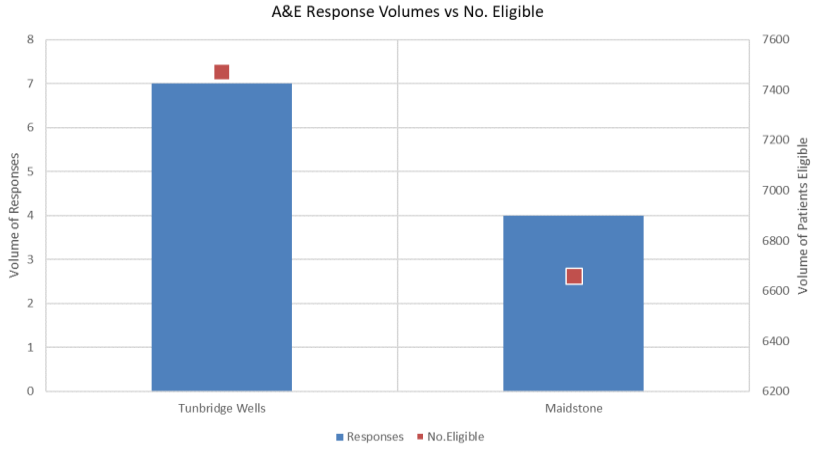
Owner: Joanna Haworth
Metric: FFT Response Rate – A&E
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Dec-21
0.1%
Variance Type
Metric is currently experiencing common cause variation
Target
15%
Target Achievement
Metric is consistently failing the target

2. Stratified Data



3. Top Contributors

A3 Thinking currently

- Problem statement completed
- Current condition completed; data that needs focus identified as a group. Targets identified in the current climate for response rates and positive responses
- Some of the goals and targets have been informed; national response identified, local targets still to be informed
- Next steps – develop wish bone. To be started W/C 24th January 2022

4. Action Plan

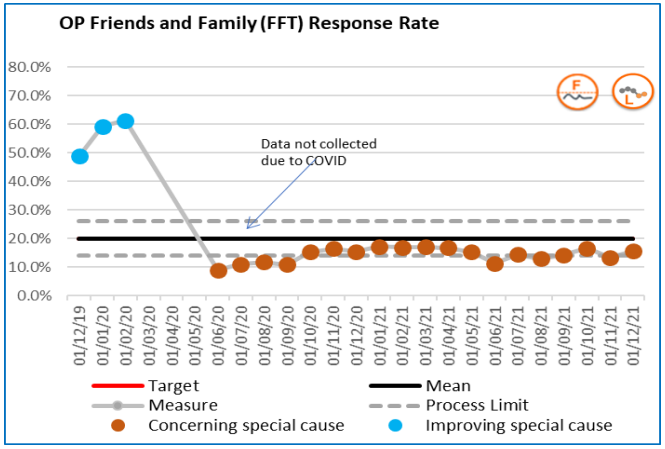
Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
Reduction in ability to collect FFT	Increasing pressures / reduction in staff	Patient partner / OTR onboarding to assist with collection	Patient Experience Lead	31/01/22
SMS Text Messaging	MTW Supplier & Budget issue	Heads of service review meeting & with IQVIA Actions for leads and IT	Patient Experience Lead	31/01/22
Poor engagement for collection	Some services not included on IQVIA	Audit to review all services	Patient Experience Lead	31/01/22
Poor submission rate	Delay in getting surveys in on time	Weekly reminders. PEA supporting distribution of posters & QR codes	Patient Experience Lead	31/01/22

Breakthrough Objective: Counter Measure Summary

Metric Name – Increase Friends and Family Response Rates for Outpatients

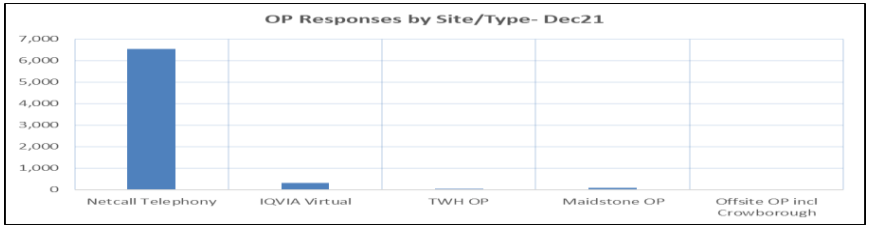
Owner: Joanna Haworth
Metric: FFT Response Rate - Outpatients
Desired Trend: 7 consecutive data points above the mean

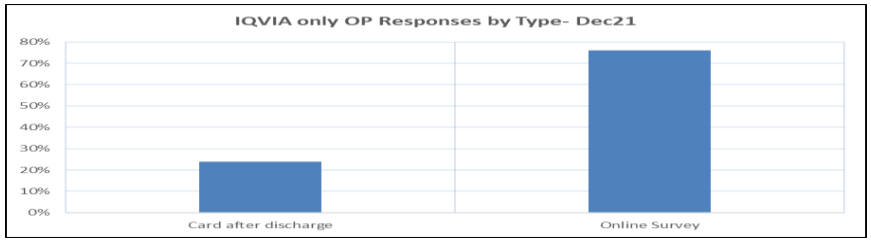
1. Historic Trend Data



Dec-21
15.6%
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Target
20%
Target Achievement
Metric has not achieved the target for >6 months

2. Stratified Data





3. Top Contributors

A3 Thinking currently

- Problem statement completed
- Current condition completed; data that needs focus identified as a group. Targets identified in the current climate for response rates and positive responses
- Some of the goals and targets have been informed; national response identified, local targets still to be informed
- Next steps – develop wish bone. To be started W/C 24th January 2022

4. Action Plan

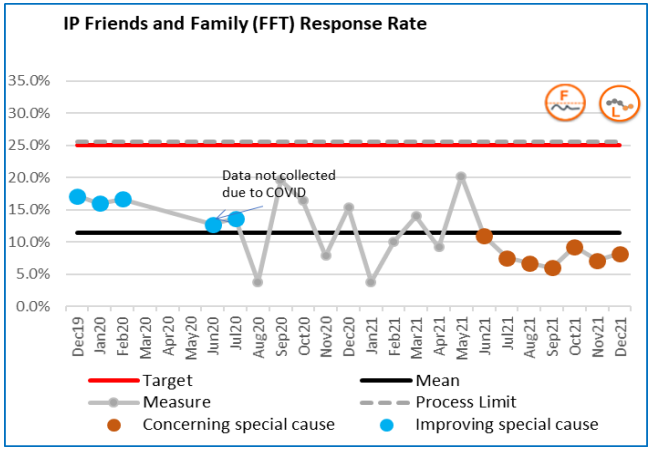
Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
Request one CMS for FFT	One for each area not needed	Have one Counter Measure Summary to cover FFT	Jo Haworth	31/01/22
SMS Text Messaging	MTW Supplier issue	Heads of service review meeting & with IQVIA	Patient Experience Lead	31/01/22
Poor engagement for collection	Some services not included on IQVIA	Audit to review all services are set up correctly	Patient Experience Lead	31/01/22
Poor submission rate	Delay in getting surveys in on time	Weekly reminders going out PEA supporting distribution of posters & QR codes	Patient Experience Lead	31/01/22

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

Metric Name – Increase Friends and Family Response Rates for Inpatients

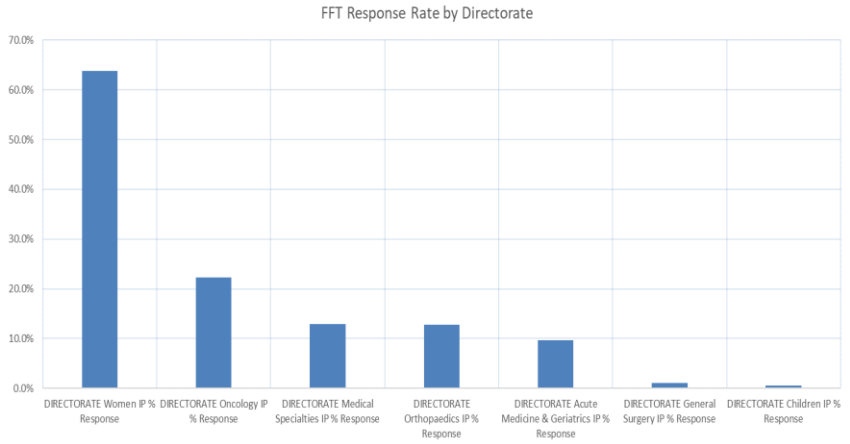
Owner: Joanna Haworth
Metric: FFT Response Rate – Inpatients
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Dec-21
8.2%
Variance Type
Metric is currently experiencing common cause variation
Target
25%
Target Achievement
Metric has not achieved the target for >6 months

2. Stratified Data



3. Top Contributors

A3 Thinking currently

- Problem statement completed
- Current condition completed; data that needs focus identified as a group. Targets identified in the current climate for response rates and positive responses
- Some of the goals and targets have been informed; national response identified, local targets still to be informed
- Next steps – develop wish bone. To be started W/C 24th January 2022

4. Action Plan

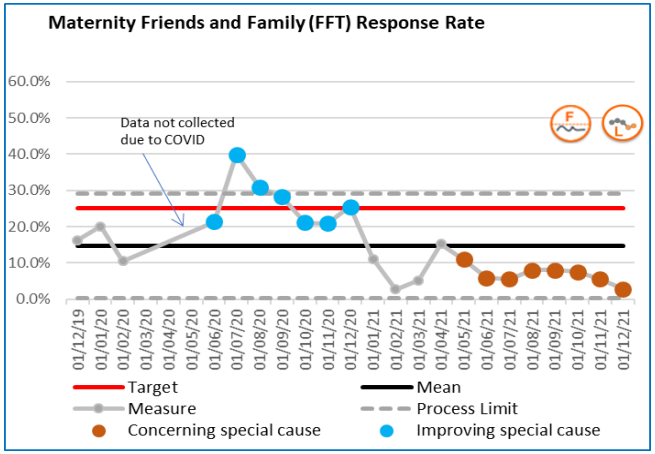
Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
Reduction in ability to collect FFT	Increasing pressures / reduction in staff	Patient partner onboarding to assist with collection	Patient Experience Lead	31/01/22
Poor engagement for collection	Some services not included on IQVIA	Audit to review all outpatient services	Patient Experience Lead	31/01/22
Poor submission rate	Delay in getting surveys in on time	Weekly reminders going out PEA supporting distribution of posters & QR codes	Patient Experience Lead	31/01/22
Fully understand root causes of engagement and FFT contribution	unknown	Start the A3 process across all areas to identify root causes & countermeasures	Patient Experience Lead	31/01/22

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

Metric Name – Increase Friends and Family Response Rates for Maternity

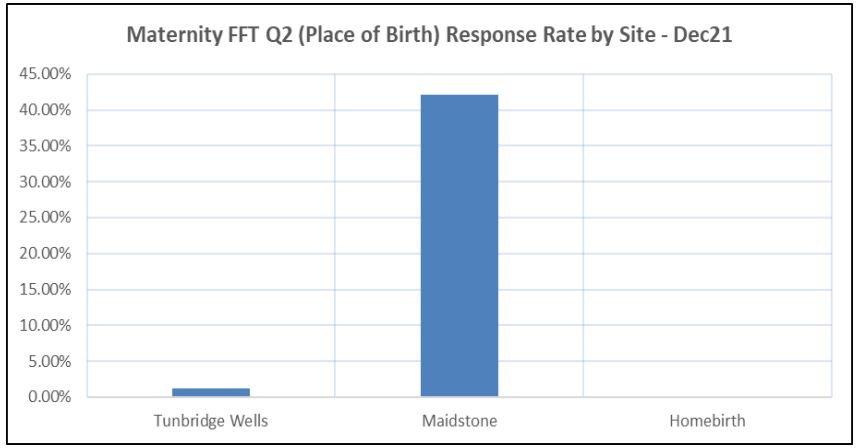
Owner: Joanna Haworth
Metric: FFT Response Rate – Maternity
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Dec-21
2.8%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target
25%
Target Achievement
Metric has not achieved the target for >6 months

2. Stratified Data



3. Top Contributors

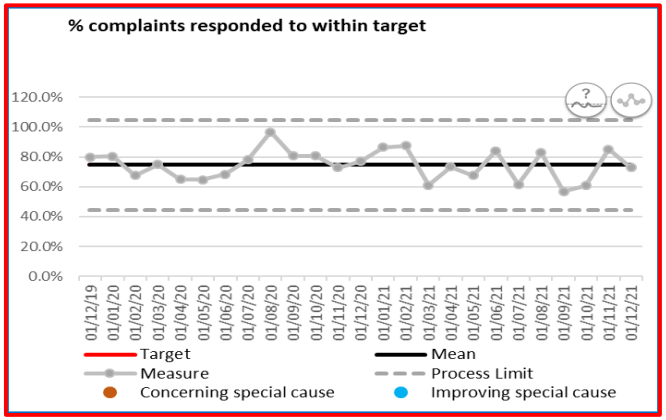
A3 Thinking currently

- Problem statement completed
- Current condition completed; data that needs focus identified as a group. Targets identified in the current climate for response rates and positive responses
- Some of the goals and targets have been informed; national response identified, local targets still to be informed
- Next steps – develop wish bone. To be started W/C 24th January 2022

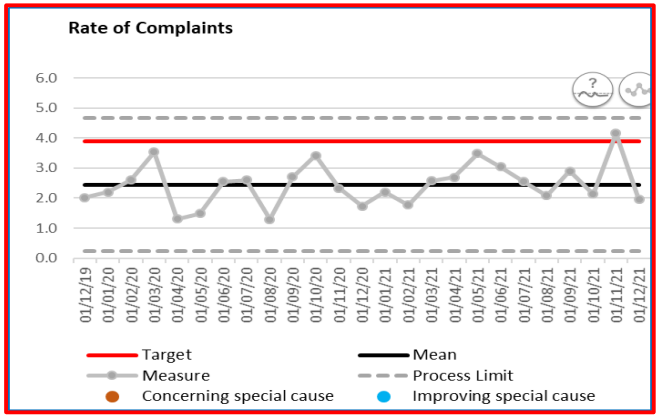
4. Action Plan

Contributor	Potential Root Cause	Solution / Countermeasure	Owner	Due by?
Reduction in ability to collect FFT	Increasing pressures / reduction in staff	Patient partner onboarding to assist with collection	Patient Experience Lead	31/01/22
IQVIA Lead times for upload	Delays in submission / historical data entry	Heads of service review meeting & with IQVIA	Patient Experience Lead	31/01/22
Poor engagement	Some services not included on IQVIA	Audit to review all in-patient & outpatient services	Patient Experience Lead	31/01/22

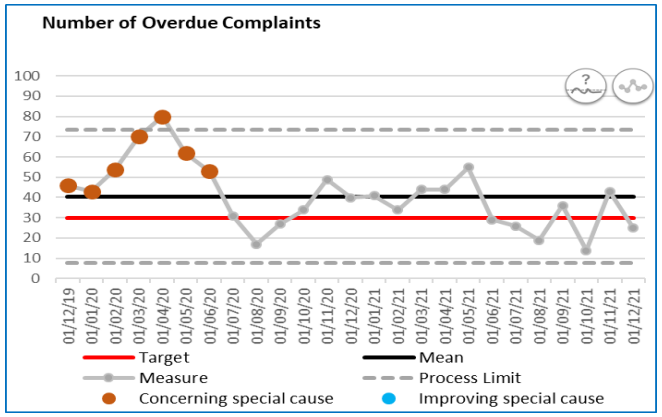
Patient Experience: CQC: Caring (Hit or Miss >6 months)



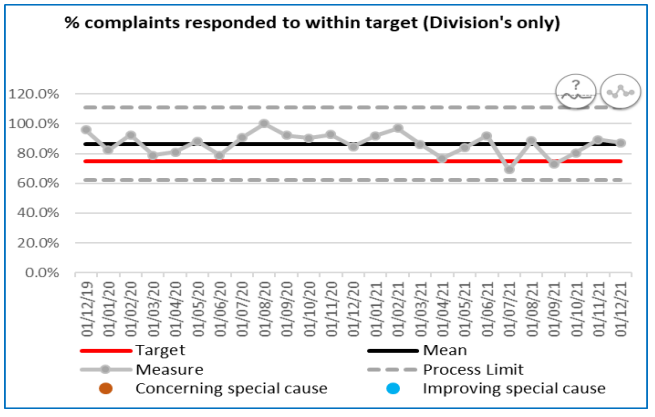
Dec-21
72.7%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Target (Internal)
75%
Business Rule
Full Escalation as Hit or Miss > 6 months



Dec-21
1.9
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



Dec-21
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



Dec-21
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 directorate teams to monitor progress on all open complaints
- Recruitment underway to replace complaints lead (interviews January 2022)

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
- Trust is not currently on track to meet 75% performance for January 2022, due to unfilled vacancies across the PALS and Complaints teams. Sustained improvement may not be achieved until all posts filled.

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	563	Dec-21	550	565	Nov-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	3.54	Oct-21	3.90	4.01	Sep-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	7	Dec-21	0	6	Nov-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	2502	Dec-21	1333	2277	Nov-21	Driver			Verbal CMS
Constitutional Standards and Key Metrics (not in SDR)	Well Led	CIP	483	228	Dec-21	483	236	Nov-21	Driver	No SPC	No SPC	
	Well Led	Cash Balance (£k)	26600	32729	Dec-21	26600	26719	Oct-21	Driver	H		Note Performance
	Well Led	Capital Expenditure (£k)	981	804	Dec-21	981	388	Nov-21	Driver	L	P	Note Performance

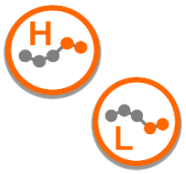
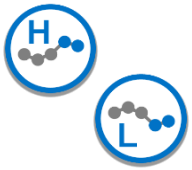
NHS
Maidstone and Tunbridge Wells NHS Trust

Appendices

MTW
exceptional people, outstanding care

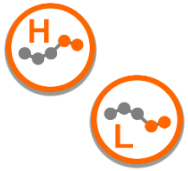
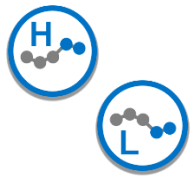
SDR Business Rules Driven by the SPC Icons

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

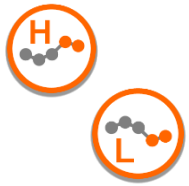
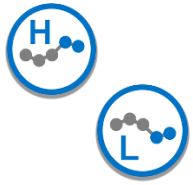
SDR Business Rules Driven by the SPC Icons

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:

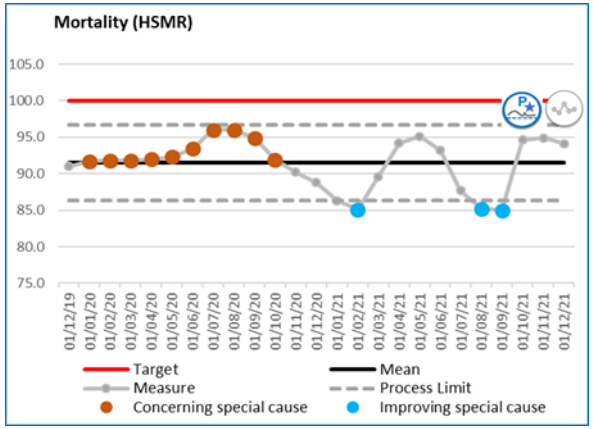
The **target** line **between** the **upper** and **lower** control limit for all metric types

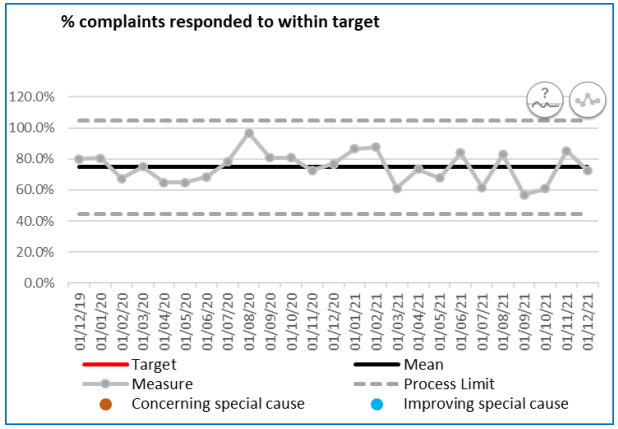
Metrics that consistently **fail** have:

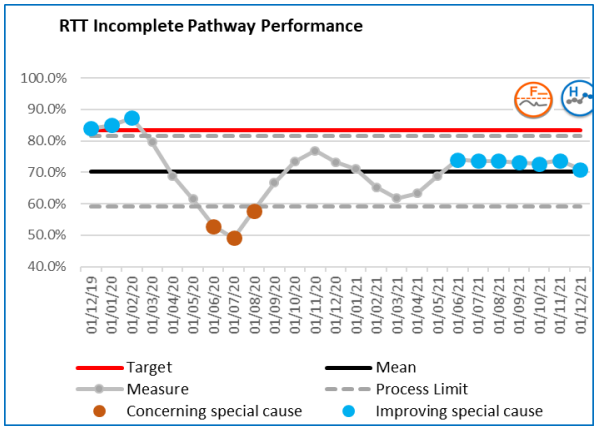
The **lower** control limit **above** the target line for metrics that need to be **below the target**

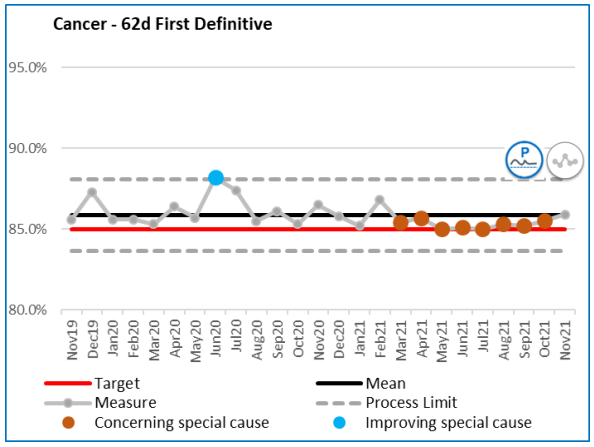
The **upper** control limit **below** the target line for metrics that need to be **above the target**

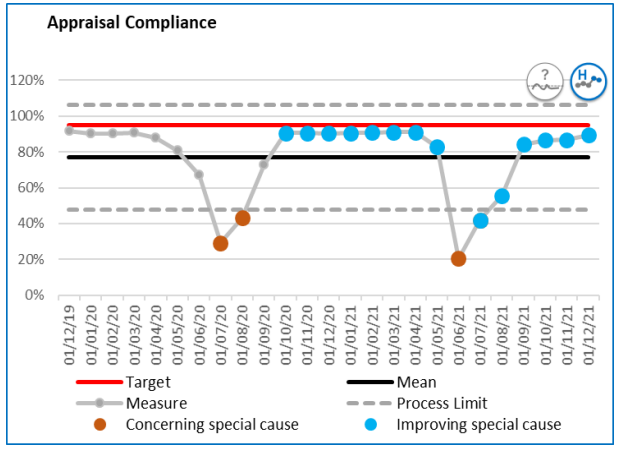
A metric not achieving the target for 6 months or more will be flagged as failing

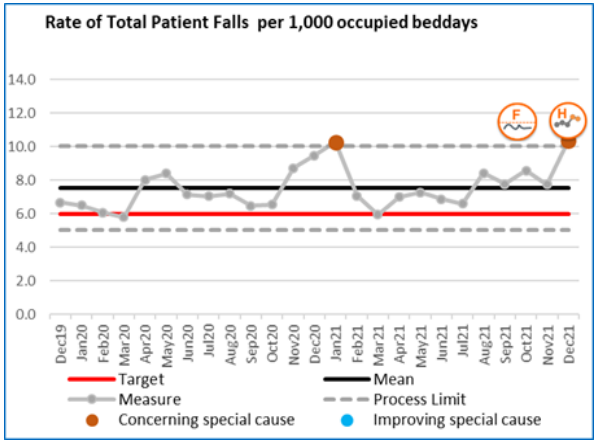












Retired KPIs

Caring	Admin and clerical office space in (sqm)
Caring	Energy cost per staff
Caring	Footprint devoted to clinical care vs non clinical care ratio
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
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

REVIEW OF LATEST FINANCIAL PERFORMANCE

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 December which was on plan.
- In line with NHSE/I guidance additional income (£4.7m) 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 (£5.2m)
    - Independent Sector usage (£4.3m),
    - Pay underspends (£2.m)
    - Clinical supplies and drugs (£1.1m) due to lower activity than funded levels
    - Elective recovery fund overperformance (£0.6m).
    - Pathology trade income (£0.5m)
  - **Adverse Variances**
    - Rephasing of top up and non-recurrent income support (£6.4m)
    - Expenditure incurred relating to Kent and Medway Medical school (£5.8m)
    - CIP slippage to stretch target (£1.5m)

Current Months Financial Position

- The key current month variances are as follows:
  - Income overperformed by £0.3m in December. The main overperformance is within other operating income which related to the release of months 1 - 8 placement support funding (£0.3m).
  - Expenditure budgets overspent by £0.2m, pay budgets overspent by £1.2m which was partly offset by non-pay underspends (£1m). The key overspends to plan were: Costs associated with Kent and Medway Medical School (£2m), pay increase (£1.3m of which £0.6m associated with the temporary increase in bank rates), clinical supplies £0.9m due to non-recurrent adjustments mainly within Theatres and Pathology and increase in security costs (£0.2m). These pressures were partly offset by the following key favourable variances: Release of contingency (£2.6m - offset Medical School costs (£2m) and increase in bank rates (£0.6m)), Independent sector (£0.9m) and non-recurrent benefits (£0.8m).

Cashflow

- The closing cash balance for December was £32.7m compared to the plan cash balance of £21.9m, the variance is primarily linked to Health Education England paying c.£5.4m and K&M CCG £1.9m of aged debt. H2 System funding envelopes, including system top-up and Covid-19 fixed allocation have been calculated based on the H1 2021/22 envelopes adjusted for inflation, efficiency requirements and policy priorities. The system funding envelope is comprises of growth funding (including 3% pay uplift), system top up (funding for free car parking and H1 efficiencies) and Covid-19 allocation.
- The capital programme for the year is currently c.£23.1m (including c£12.9m National funding); the majority of the capital spend with the cash flow forecast is within Qtr4 c.£19.9m. 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£27.1m.

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 s chemes include the Annex/Kabin Modular Development, KMMS enabling work, Paeds ED modular build and Oncology Outpatients.

- **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 STP 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. The national Target Investment Fund (TIF) bids for £2.4m 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 £23.2m, 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 £4.06m compared to the original Plan of £7.1m, 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/Kabin, 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 YTD variance relates to schemes that have either been delayed or are waiting for orders to be raised.

Year and Forecast

- The Trust is forecasting to deliver the planned breakeven position however the Trust has the following risks:
  - The forecast assumes the lease for the Kent and Medway Medical School will be agreed which will result in £4.7m of spend incurred to be recharged to the lessor therefore improving the financial position.
  - The forecast does not include any increase in spend to support winter pressures and COVID increase.

Maidstone and Tunbridge Wells NHS

1. Dashboard

December 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	51.8	51.5	0.3	450.0	456.9	(6.9)	605.2	612.0	(6.9)
Expenditure	(49.0)	(48.8)	(0.2)	(425.5)	(432.5)	7.0	(572.5)	(579.0)	6.6
EBITDA (Income less Expenditure)	2.8	2.7	0.1	24.5	24.4	0.2	32.7	33.0	(0.3)
Financing Costs	(2.9)	(3.0)	0.1	(24.9)	(25.0)	0.1	(34.3)	(34.2)	(0.1)
Technical Adjustments	0.1	0.2	(0.2)	0.5	0.6	(0.2)	1.6	1.2	0.4
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	32.7	26.6	6.1	32.7	26.6	6.1	1.5	1.5	0.0
Capital Expenditure (Incl Donated Assets)	0.8	1.0	0.2	4.1	7.2	(3.1)	1.6	20.4	18.8

Summary Current Month:

- The Trust was on plan generating a breakeven position.
- Income overperformed by £0.3m in December. The main overperformance is within other operating income which related to the release of months 1 - 8 placement support funding (£0.3m).
- Expenditure budgets overspent by £0.2m, pay budgets overspent by £1.2m which was partly offset by non pay underspends (£1m). The key overspends to plan were: Costs associated with Kent and Medway Medical School (£2m), pay increase (£1.3m of which £0.6m associated with the temporary increase in bank rates), clinical supplies £0.9m due to non recurrent adjustments mainly within Theatres and Pathology and increase in security costs (£0.2m). These pressures were partly offset by the following key favourable variances: Release of contingency (£2.6m - offset Medical School costs (£2m) and increase in bank rates (£0.6m)), Independent sector (£0.9m) and non recurrent benefits (£0.8m).
- In line with NHSE/I guidance additional income (£0.5m) has been included in the month 9 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 (£5.2m), Independent Sector usage (£4.3m), Pay underspends (£2m), underspends within clinical supplies and drugs (£1.1m) due to lower activity than funded levels, Elective recovery fund (£0.6m) and Pathology trade income overperformance (£0.5m).

Adverse Variances:

- Rephasing of top up and non recurrent income support (£6.4m), expenditure incurred relating to Kent and Medway Medical school (£5.8m) and CIP slippage to internal plan (£1.5m) .
- In line with NHSE/I guidance additional income (£4.7m) 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 quarter 3 payment 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 £1.9m which is £0.3m 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	5,058
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	438
Backfill for higher sickness absence	962
Remote working for non-patient activities	18
Existing workforce additional shifts to meet increased demand	91
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	934
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	2,754
Long COVID	656
Total 'In Envelope'	**10,938**
COVID-19 virus testing- rt-PCR virus testing	4,140
COVID-19 - Vaccination Programme - Provider/ Hospital hubs	77
COVID-19 virus testing - Rapid / point of care testing	417
COVID-19 virus testing (NHS laboratories)	0
NIHR SIREN testing - research staff costs	11
NIHR SIREN testing - antibody testing only	6
Total 'Out of Enevelope'	**4,651**
Total Expenditure (£000s):	**15,590**

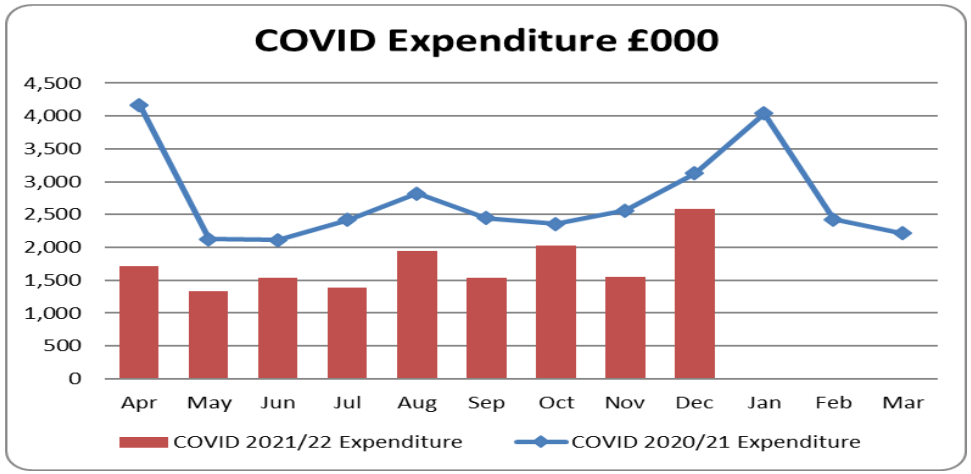
Income

Free staff car parking	427
Catering - Income loss	23
Total Income	**449**
Grand Total (£000s):	**16,039**

Commentary:
The Trust has identified the year to date financial impact relating to COVID to be £16m.

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 £4.7m income in the position to offset the costs for 'Out of envelope' which include COVID swabbing , rapid testing and vaccination programme. NHSE/I has paid in full the costs identified relating to quarter 1 and 2, the remainder is expected to be confirmed over the next few months.



Dec-21		DAY				NIGHT				TEMPORARY STAFFING						Nurse Sensitive Indicators				Financial review		
Hospital Site name	Health Roster Name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Bank/Agency Usage	Agency as a % of Temporary Staffing	Bank / Agency Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand Unfilled -RM/N (number of shifts)	Overall Care Hours per pt day	FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Stroke Unit (M) - NK551	77.2%	104.9%	-	100.0%	103.2%	106.6%	-	100.0%	27.6%	32.3%	445	18.49	168	6.5	0.0%	0.0%	13	1	275,288	277,032	(1,744)
MAIDSTONE	Cornwallis (M) - NS959	89.8%	56.0%	-	-	109.7%	190.1%	-	-	75.0%	40.2%	315	11.34	73	9.1	0.0%	0.0%	1	1	0	109,660	(109,660)
MAIDSTONE	Culpepper Ward (M) - NS551	90.3%	75.5%	-	-	108.1%	109.7%	-	-	37.1%	47.7%	126	4.75	36	4.7	37.9%	100.0%	3	0	111,333	109,312	2,021
MAIDSTONE	John Day Respiratory Ward (M) - NT151	91.2%	94.6%	-	-	101.3%	140.3%	-	-	29.9%	42.7%	256	7.90	99	6.8	19.4%	100.0%	7	1	145,571	167,771	(22,200)
MAIDSTONE	Intensive Care (M) - NA251	95.7%	107.0%	-	-	87.6%	97.9%	-	-	16.6%	7.4%	204	9.09	79	40.8	0.0%	100.0%	0	0	252,851	230,427	22,424
MAIDSTONE	Pye Oliver (Medical) - NK259	98.7%	94.5%	-	-	120.4%	103.3%	-	-	21.4%	59.5%	145	6.22	41	6.4	0.0%	0.0%	10	2	123,301	130,358	(7,057)
MAIDSTONE	Whatman Ward - NK959	91.5%	120.3%	-	100.0%	127.9%	189.3%	-	-	62.8%	40.3%	283	12.91	90	6.7	0.0%	0.0%	7	2	91,695	121,653	(29,958)
MAIDSTONE	Lord North Ward (M) - NF651	80.3%	92.4%	-	100.0%	95.7%	100.0%	-	-	7.3%	0.0%	40	1.61	16	7.3	22.2%	100.0%	2	0	112,254	102,603	9,651
MAIDSTONE	Mercer Ward (M) - NJ251	101.6%	90.5%	-	100.0%	114.4%	124.7%	-	100.0%	36.1%	60.8%	245	9.92	89	5.8	3.7%	100.0%	6	0	109,816	132,455	(22,639)
MAIDSTONE	Edith Cavell - NS459	96.7%	88.8%	-	100.0%	96.8%	90.3%	-	-	39.0%	25.5%	215	6.48	82	6.7	33.3%	100.0%	0	0	118,411	105,659	12,752
MAIDSTONE	Acute Medical Unit (M) - NG551	100.3%	95.0%	-	100.0%	135.6%	225.8%	-	-	39.0%	31.1%	273	9.82	84	10.6	0.0%	100.0%	5	0	163,153	180,035	(16,882)
TWH	Ward 22 (TW) - NG332	78.6%	82.9%	-	-	145.2%	97.9%	-	-	50.7%	56.6%	465	17.39	216	5.6	2.8%	100.0%	18	3	130,587	157,014	(26,427)
TWH	Coronary Care Unit (TW) - NP301	76.1%	37.5%	-	-	79.3%	-	-	-	12.2%	7.6%	96	4.52	69	10.3	28.0%	100.0%	0	0	69,560	58,964	10,596
TWH	Ward 33 (Gynae) (TW) - ND302	78.8%	92.0%	-	-	86.0%	90.3%	-	-	28.9%	3.7%	84	4.42	27	7.5	63.8%	98.3%	0	0	114,771	111,479	3,292
TWH	Intensive Care (TW) - NA201	99.6%	94.7%	-	-	105.7%	83.9%	-	-	11.1%	1.9%	133	7.51	12	34.1	0.0%	0.0%	0	0	383,197	337,760	45,437
TWH	Acute Medical Unit (TW) - NA901	82.4%	55.6%	-	100.0%	92.2%	68.7%	-	-	13.4%	32.5%	275	10.96	168	7.9	5.7%	87.5%	15	1	218,161	189,778	28,383
TWH	Surgical Assessment Unit (TW) - NE701	102.3%	122.1%	-	-	30.6%	45.2%	-	-	24.5%	16.5%	121	6.33	68	22.9	0.3%	0.0%	0	0	71,341	53,030	18,311
TWH	Ward 32 (TW) - NG130	85.2%	69.3%	-	100.0%	65.4%	89.1%	-	100.0%	12.7%	26.9%	133	6.84	71	7.3	0.0%	0.0%	3	0	141,039	113,070	27,969
TWH	Ward 10 (TW) - NG131	84.1%	93.0%	-	100.0%	96.8%	151.6%	-	-	48.0%	44.7%	393	14.52	154	6.1	0.0%	0.0%	6	0	137,396	148,788	(11,392)
TWH	Ward 11 (TW) Winter Escalation 2019 - NG144	59.9%	55.7%	-	100.0%	92.7%	70.2%	-	-	64.5%	27.6%	546	16.90	189	7.1	5.3%	100.0%	8	0	0	112,984	(112,984)
TWH	Ward 12 (TW) - NG132	82.5%	90.7%	-	100.0%	127.1%	97.9%	-	-	36.4%	49.1%	354	11.85	161	6.2	11.1%	87.5%	11	0	139,447	157,835	(18,388)
TWH	Ward 20 (TW) - NG230	94.1%	95.8%	-	-	149.5%	109.6%	-	-	40.0%	46.1%	391	15.81	187	7.1	3.9%	100.0%	18	0	363,810	175,862	187,948
TWH	Ward 21 (TW) - NG231	85.0%	108.6%	-	100.0%	109.1%	115.8%	-	-	26.2%	35.0%	282	11.23	149	6.8	9.9%	87.5%	10	0	147,063	150,152	(3,089)
TWH	Ward 2 (TW) - NG442	61.7%	86.0%	-	100.0%	107.6%	131.5%	-	-	40.3%	33.0%	427	13.62	241	6.1	42.4%	100.0%	18	1	162,959	159,505	3,454
TWH	Ward 30 (TW) - NG330	89.2%	82.2%	-	100.0%	122.6%	111.8%	-	-	20.4%	12.2%	196	5.94	86	5.9	1.8%	100.0%	6	1	125,393	145,549	(20,156)
TWH	Ward 31 (TW) - NG331	82.5%	86.6%	-	100.0%	81.0%	132.3%	-	-	30.0%	9.4%	294	8.26	124	6.2	2.3%	100.0%	12	1	138,962	159,838	(20,876)
Crowborough	Crowborough Birth Centre (CBC) - NP775	49.3%	67.6%	-	-	0.0%	0.0%	-	-	3.8%	0.0%	24	0.54	2	-				0	103,021	57,331	45,690
TWH	Midwifery (multiple rosters)	70.9%	49.4%	-	-	78.6%	86.5%	-	-	14.0%	5.2%	951	36.61	259	12.4	14.1%	95.4%	0	0	742,775	908,477	(165,702)
TWH	Hedgehog Ward (TW) - ND702	80.8%	50.1%	-	-	81.3%	66.3%	-	-	26.3%	69.6%	306	15.50	98	11.0	1.2%	50.0%	0	0	139,456	226,188	(86,732)
MAIDSTONE	Maidstone Birth Centre - NP751	86.7%	99.6%	-	-	73.1%	53.7%	-	-	23.1%	0.0%	59	1.92	2	63.1	42.1%	100.0%	0	0	72,115	90,042	(17,927)
TWH	SCBU (TW) - NA102	75.9%	1436.4%	-	100.0%	94.0%	-	-	-	22.7%	0.0%	126	6.55	4	15.9	7.1%	100.0%	0	0	177,929	209,046	(31,117)
TWH	Short Stay Surgical Unit (TW) - NE901	74.0%	58.9%	-	100.0%	75.8%	80.6%	-	-	7.6%	19.4%	54	1.72	20	10.2	4.7%	100.0%	2	0	75,794	72,204	3,590
MAIDSTONE	Accident & Emergency (M) - NA351	92.6%	68.8%	-	100.0%	103.3%	90.3%	-	-	39.0%	40.1%	522	29.75	111		0.1%	100.0%	7	0	283,070	416,198	(133,128)
TWH	Accident & Emergency (TW) - NA301	86.4%	67.2%	-	100.0%	85.7%	72.6%	-	100.0%	42.0%	54.7%	791	40.37	260		0.1%	100.0%	7	0	389,304	462,813	(73,509)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	88.4%	59.2%	-	100.0%	71.0%	-	-	-	26.0%	15.9%	59	2.62	10	14.2	24.7%	100.0%	0	0	67,488	58,196	9,292
MAIDSTONE	Peale Ward COVID - ND451	75.5%	110.1%	-	100.0%	106.4%	119.4%	-	-	42.3%	68.3%	222	11.66	100	10.2	8.7%	100.0%	4	0	110,447	105,974	4,473
MAIDSTONE	Foster Clark - NS251	83.9%	90.4%	-	100.0%	89.6%	89.4%	-	-	19.1%	18.8%	132	3.97	31	7.6	0.0%	0.0%	7	0	159,410	149,144	10,266
MAIDSTONE	Foster Clarke Ward - NR359	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	2,455	(2,455)
MAIDSTONE	Short Stay Surgical Unit (M) - NE751	90.7%	100.5%	-	-	78.3%	-	-	-	32.5%	6.0%	71	2.38	10	21.9	29.6%	98.9%	0	0	52,988	65,003	(12,015)
																				6,221,156	**6,721,641**	**(500,485)**
																				7,508	57,922	(50,414)
																				0	-2,432	2,432
																				0	0	0
																				4,674,132	4,767,409	-93,277
																				10,902,796	**11,544,541**	**(641,745)**

Total Established Wards
Additional Capacity beds — Cath Labs
Chaucer
Foster Clarke Winter Escalation 20
Other associated nursing costs

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%

NHS Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report (IPR) for December 2021	Chief Executive / Members of the Executive Team

Following a discussion at the Finance and Performance Committee on 25/10/22, Trust Board members are asked to consider the enclosed document when the Integrated Performance Report (IPR) is reviewed at the Trust Board meeting. While the IPR includes details of the "Retained KPIs", the enclosed document shows both current and retired metrics by Care Quality Commission (CQC) domain, for ease of cross reference to our previous IPR which was structured around the CQC domains.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Review and discussion

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

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

NHS Maidstone and Tunbridge Wells NHS Trust

To approve the Business Case for the People and Culture Structure and Operating Model

Chief People Officer

Please find enclosed the Business Case for the People and Culture Structure and Operating Model. The Trust Board is required to approve the Business Case, so the Finance and Performance Committee will therefore be asked, at its meeting on 25/01/22, to consider the Business Case and recommend that the Trust Board gives its approval. The outcome of the review by the Finance and Performance Committee will be reported to the Trust Board after the Committee's meeting.

Which Committees have reviewed the information prior to Board submission?

- 'Main' People and Organisational Development Committee, 18/11/21
- Executive Team Meeting, 18/01/22
- Finance and Performance Committee, 25/01/22

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

Maidstone and Tunbridge Wells NHS Trust

BUSINESS CASE

Title: **People and OD Directorate Investment (previously the Workforce Directorate)**

Issue date/Version number	11/11/2021 Version 4
ID reference	
Division	Corporate Services
Directorate	People & Organisational Development (OD)
Department/Site	Trust wide
Author	Sue Steen – Chief People Officer
Clinical lead/Project Manager	n/a

Approved by	**Name**	**Signature**	**Date**
General Manager/Service Lead			
Finance manager	John Coffey		
Clinical Director			
Executive sponsor	Sue Steen		
Division Board	P&OD Cttee		
Supported by	**Name**	**Signature**	**Date**
Estates and Facilities Management (EFM)			
ICT			
Deputy Chief Operating Officer			
Diagnostics and Clinical Support Services (DCSS)			
Emergency Planning			
Human Resources (HR) Business Partner			
Procurement			
EME Services Manager			
Outpatients			

Maidstone and Tunbridge Wells NHS Trust

Business Case Summary

Strategic background context and need

Summarise the background to the proposal including its relevance to strategic aims and objectives identified in Division business plan. Identify the key stakeholders. Summarise the needs or demands that are to be addressed and deficiencies in existing service.

The purpose of this business case is to respond to the identified areas of failure and underperformance of the previous Workforce Directorate primarily as a result of both historic under-investment as well as previous leadership concerns. In 2020 an independent review commissioned by the Trust Board was undertaken, this review included significant stakeholder engagement with key stakeholders across the Trust and a number of the Workforce team at that time. Key performance metrics were reviewed as well as benchmarking with other comparable NHS Trusts.

The report identified a history of underfunding with the Trust Workforce function which was estimated at that time to be 40% lower than the national average and benchmarked as the 9th lowest in the country against comparable NHS data. The ability to resource, respond and establish clear deliverables and accountability is severely undermined by the lack of resource available and the increasing demands that are being placed on the (renamed) People & OD Directorate. The Trust vision of 'Exceptional People Outstanding Care' is built on a foundation of high performing compassionate leadership which aligns with the NHS People Promise to deliver more people, working differently, in a compassionate and inclusive culture.

As described throughout this business case there are significant areas of under-investment which have resulted in the People & OD Directorate having a significant gap between what is possible to be delivered against the ambition of the Trust to be in the top quartile as a place to work. These gaps align directly to the strategic priorities that are directly influenced and led by the People & OD Directorate which includes workforce supply; health and wellbeing and e-rostering. These areas are identified as having an under resourced capacity to deliver.

This lack of resources has been evidenced and highlighted more recently with some key areas of non-compliance and an absence of organisational insight. The team are routinely only able to perform and respond at a reactive level despite the significant commitment and hard work of individual team members. The DBS project has identified a lack of compliance checking; an absence of robust standard operating procedures and a failure to maintain effective records on ESR or act on any insight and reporting in a proactive way. With the minimal additional investment in temporary staff and overtime this project continues to deliver to the level required in the Trust Policy but it will take time with the current level of resource as well as ensuring sustainable application moving forward; the project to cleanse the data for the rebuild of e-rostering has identified over 2,000 line by line establishment corrections in ESR to align to the data in the finance ledger – this level of compliance and data inaccuracy make any form of workforce planning challenging and highly unreliable as well as creating a high risk of contradictory data from different system sources; identifying and responding quickly to significant increases in establishment changes leading to high vacancy rates was difficult as data from ESR was incorrect or incomplete; the identification of significant nursing vacancies which arose when additional funded roles were loaded into the finance ledger were not identified by the HRBP's or the Head of Resourcing again highlighting deficiencies in the data integrity and capacity to partner effectively with the organisation. This work has required the engagement of an external contractor and additional team members to be in a position to start the rebuild of the rosters.

Digitalisation and transformation are areas of insufficient investment but has great efficiencies when delivered, only recently has the Trust been able to start the roll out of the employee self-service module, this not only creates the ability for thousands of paper pay slips to no longer be required which is inefficient and costly but it also enables and empowers our staff to maintain their own personal data. In the trial roll out there were tangible

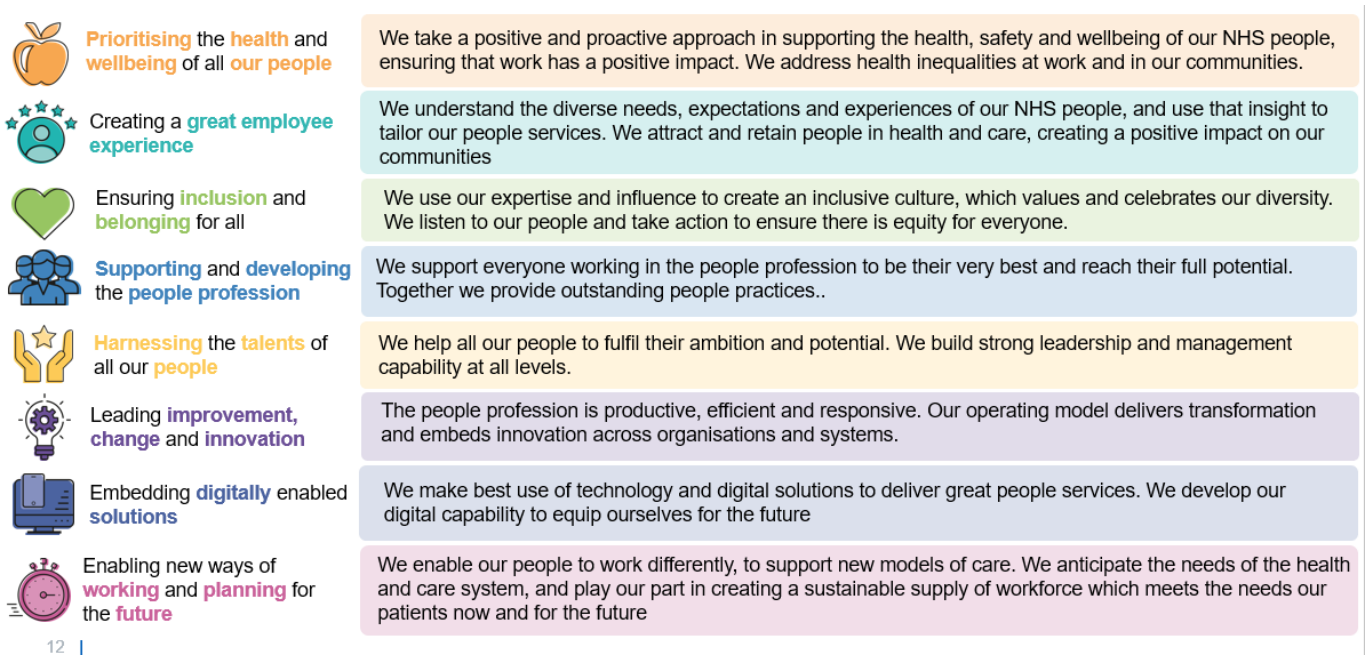
return on investment – a reduction in the first month of 18% pay queries; a reduction of over 40% of forms to change personal details; a reduction in payslips and P60's amounting to an estimated a saving of 36 hours a month in the distribution, postage and delivery of paper payslips. The scope for automation and reductions in manual processing is significant. This also then enables the workforce team to focus on value added work that contributes to the overall effectiveness of the department and the Trust.

In 2022/23 we expect to begin the digitisation of our paper HR records to a cloud-based solution, allowing for a more efficient way of maintaining and accessing staff records, as well as freeing up physical office space. We are engaging with KCHFT regarding their recent work on setting up multiple 'bots' to automate a number of processes. Examples of where this will have an immediate and positive impact includes manager notification and sift document collation immediately following the closure of an advert, automatic roster approvals and automated management report production. Although primarily focused on HR processes, there are a range of other (typically corporate) actions these bots can undertake. We would hope that the adoption of this new technology from 2022/23 onwards will free up time for colleagues in the team to focus on more strategic support to the organisation, in turn giving a better 'customer experience' for those using our services.

A number of key areas of delivery create inefficiencies in the system which also includes a cumbersome job evaluation process and limited trained individuals; a failure to focus on strategic retention and reward; no investment in the Organisational Development Team; temporary and unsustainable resources to support the overwhelming health and wellbeing agenda which is a strategic priority; and a business partner structure which does not support the operating model to align to divisions and departments strategically and support workforce planning; engagement and innovation; reward and recognition; early intervention for issues such as bullying and harassment as well as strategic commissioning of wider people functions to support change programmes.

In order for the Trust to achieve its ambitions, deliver on the findings of the independent review and be assured of a high-quality people function the business case for additional resources needs to be approved.

In addition to the need to invest in a fit for purpose newly branded People and OD function there are also increasing ambitions both for the Trust as part of the exceptional people outstanding care programme with our aim to be amongst the top performing Trust as a recommended place to work. In addition, the ICS Workforce Strategy outlines system level collaborative improvements which all feed into the vision of the NHS People Plan, the People Promise and the future of NHS human resources and organisational development launched in November 2021 which outlines 35 strategic actions across 8 domains.



Objectives - *List the project objectives. (What you wish to achieve for patients, not what you wish to purchase)*

1. Increase in the People and OD structure by 34.8(wte) to right size a function that can systematically develop the strategic objectives and delivery to where it needs to be and can then effectively lead on the transformation and ambitions that the Trust has set out in its vision, strategic objectives, goals and strategic deployment cascade.

2. Develop the People and Culture Strategy (and supporting enabling strategies) for the Trust with key deliverables and milestones to meet the ambition as a place recommended to work and an employer of choice. Aligned to the NHS People Plan and the vision of the future of NHS Human Resources and Organisational Development 2030.

3. Develop innovative ways of working to enable a flexible, empowered, well connected workforce that is fit for the future and can deliver against our clinical strategy. Aligned to this ambition is the continued delivery of the exceptional leader programme and a comparable development opportunity for middle and senior managers to create a high-performance compassionate culture.

4. Achieve the ambitions of the Trust Strategy and take the organisation to excellent leading on all the people metrics and creating a high performance engaged place to work.

The preferred option. *List exactly what is required in terms of staff (WTE and band) / equipment/estate*

The preferred and most effective option is to fully implement the People and OD structure and to develop a clear programme of delivery including a transformation programme for the service aligned to the Trust's People and Culture Strategy for 2022-2025. The ability to develop and deliver on key areas of priority is severely hampered by the lack of resources, the NHS People Plan sets out the clear ambition for the sector and this is translated into the regional and local delivery.
The strategic priority for the Trust to be amongst the top quartile for staff engagement will be determined by the ability to make improvements in key areas such as: staff wellbeing; workforce/vacancies/retention; culture and leadership development. The lack of appropriate resourcing in these areas leads to the inability to deliver on key projects.
The onboarding of the resources has been determined based on priority with the following roles identified as business critical and have been approved subject to funding. **See attached structure charts** to outline the overall structure and areas of investment across the full People and OD Structure.

Phase 1 – to be appointed and onboarded by April 2022

Head of Wellbeing (Band 8b) – whilst we have outlined a wellbeing plan for the winter as well as ongoing focus on health and wellbeing as a strategic priority we have no resources to deliver this programme or have an overview to sustain and maintain the programme. Many wellbeing offerings currently are disjointed, reactive, lack planning and funding, and logistically are unable to sustain.

Senior Business Partner (Band 8b)– to lead the Business Partnering operating model, oversee the team as well as head up the ER Advisory Team (15 in team)

HRBP (Estates and Facilities) (Band 7) – the support to this division is currently shared with other divisions leading to a limited resource available despite this area accounting for a significant workload and demand for support with a requirement for a focus on culture, transformation and leadership development

HRBP (Cancer) (Band 7)– similarly this division has no direct support from a Business Partner and has a significant ambition for transformation, change and team development.

Deputy Head of Resourcing (Band 7) – this role is a direct report to the Head of Resourcing to support the overall resourcing team (20 in total) this includes the growth in international recruitment as well as a new attraction and retention team which will ensure that we are proactively supporting the Trust to retain talent. The absence of a

deputy role has been evidenced in the areas of establishing lead workforce metrics, KPI monitoring, leadership and management support to the team and setting clear objectives for the resourcing team.

Retention Lead (Band 5) – this role is part of a new team of three roles and will lead on the MTW approach to retention. The capacity for the team to understand the data and drivers for retention, the differences and unique challenges of the two sites, a broader and deeper understanding of the feedback from the majority of people leaving the NHS including a lack of flexibility; ensuring total reward is understood; analysing data and moving on survey information; identifying interventions for divisions for flexible working; retire and return; talent programmes; bank talent pipeline review etc.

These roles should be onboarded fully by April 2022. The ideal opportunity would be to commence recruitment to the second phase of the structure by the end of June 2022 with the remaining phase three by the end of the calendar year 2022.

Phase 2 – to be appointed and onboarded by June 2022

Head of Organisational Development (Band 8c) – leading the OD function this role will ensure that interventions are developed with a 'systematic mindset' to create alignment with the Trust's goals and activities in a planned and intentional way, working in partnership with the transformation team to enable sustained organisational performance through the involvement of our people.

Principal OD Practitioner (Band 8b) – a senior qualified OD practitioner with expertise in culture diagnostics, team intervention activities, high performance leadership and development.

EDI lead (Band 7) – to support the alignment of the WRES, WDES and engagement surveys to lead and develop our EDI Strategy to ensure cohesion for longer term delivery of sustainable improvement.

Senior OD practitioners (Band 8a x2) – working in divisions to lead, design and deliver effective team interventions. Focus on high performing teams, clarity of role objectives and systems of working, organisational structure design linking back to the clinically led vision and removing silo and ineffective working.

Principal Clinical Psychologist (Band 8b) – to work with the OD team and OH as appropriate supporting complex and deeply damaging team relationships, supporting leaders and managers to implement psychologically safe environments where people are empowered and supported to manage conflict.

Wellbeing practitioners (Band 7 x2) - outreach practitioners who will lead and manage a sustainable and research-based approach to wellbeing, through activities, access to support, leading on wellbeing initiatives, focus on health and wellbeing campaigns and facilitating appropriate space for staff to rest and recharge. This links to retention and engagement strategies to ensure our staff are supported.

OH nurse (Band 5) – to add additional support to the team in order to provide timely and effective OH advice and support for the growing number of people employed.

HR adviser (Band 5) additional resources required to manage and support increasing numbers and complexities of employee relations cases and manager interventions. This focus will also be to reduce the time spent managing ER cases as well as support managers and staff earlier in the process to avoid drawn out formal processes.

Workforce team leader (Band 5) - to manage the workforce team and provide technical and operational management of key objectives, compliance, quality assurance, data management and establishment control.

Attraction manager (Band 6) - working with the communications team to build an employer of choice marketing approach for the Trust, working with external providers, social media, campaigns, job fairs, educational facilities, etc to ensure that we are maximising our offering and building an effective reward strategy.

Retention officer (Band 4) – working with key stakeholders to develop and deliver an approach to retention including clarity on total reward package, awareness of all benefits available, focus on delivering local benefits such as access to child care.

Admin E&F Staff Bank (Band 4) – to respond to the increasing demand for bank and agency fill for our high turnover lower skilled workforce where demand and supply is often fast paced and challenging.

Phase 3 – following the onboarding of Phase 1 and 2 the senior leadership team will review and ensure that the alignment to the People and Culture Strategy and the delivery plan for the NHS People Plan continues to have the focus to move into Phase 3. Phase 3 is subject to additional approval process.

Senior OD practitioner (Band 8a) - to continue to deliver and build on the emerging People and Culture Strategy and the NHS People Plan this practitioner is likely to have been commissioning through short term contract work so will be substantively appointed into the structure.

Engagement lead (Band 7) - engagement cuts across all areas of delivery in the People and OD function and an alignment of this work will develop our themed approach to engagement ensuring that our approach to communication and developing a medium - long term approach to improvement is embedded. This will include the scoping and introduction of a live engagement tool that can offer immediate hotspot feedback from our staff to inform decision making.

OD projects (Band 6) - a project lead to ensure that the strategy, interventions and follow up to action is managed. This role will also support the delivery of the overall vision of exceptional people outstanding care and support the transformation across the People and OD function.

OD Admin (Band 4) - to provide administrative support to the team including training and development as required.

Asst staff psych (Band 6) - to provide psychological support outside of the services provided by our EAP provider and KMPT for covid related mental health and psychological support. Whilst not covid related the increase in psychological harm during the pandemic and exacerbated by the impact on the NHS has had a significant impact on the overall wellbeing of our people. This is evidenced by the strong feedback and indications of access to our current mental health support services currently.

Wellbeing practitioners (Band 6 x2) – to support and deliver on the 3 stepped approach to wellbeing outlined further in the business case.

Wellbeing campaigns (Band 5) - to maintain, develop and champion wellbeing campaigns throughout the Trust with a systemic and coordinated approach to align with the wellbeing strategy to ensure that campaigns are well planed and executed as well as measured for effectiveness and return on investment.

Compliance systems manager (Band 8a 0.8 wte) - quality and compliance across the Learning and Development function.

L&D Assistant (Band 3 x3) - to support and deliver a full range of support to the L&D team to sustain and enable effective onboarding to learning, access to development material, communication and updates of relevant opportunities and alignment to corporate delivery of induction, talent management, apprenticeships etc.

Workforce assistant (Band 3) - to support the workforce team and provide a stronger customer centric approach to workforce process and payroll queries.

Retention Assistant (Band 3) - to support the retention agenda which is an emerging key priority in the backdrop of increasing turnover and a war on talent.

Absence and Incentives (Band 5) - supporting the staffing team to be focussed on driving up attendance and incentives to ensure fill rates are maximised, working inhouse as well as with agency and bank collaboratives to improve the effectiveness of our rostering system and our flexible workforce supply.

*Full structure charts are attached which outline existing and proposed new roles.

Main benefits associated with the investment *Include here the key benefits the investment would bring to the service.*

The following KPI's are some of the tangible examples of metric improvements, this is in addition to the deliverables that will be identified in the People and Culture Strategy for the Trust which is due for approval in April 2022. The Strategy is measured over a 3-year period and will identify milestone improvements to reach overall objectives.
The enablers to the delivery of the benefits are dependant on the phased introduction of additional resources and expertise to deliver. In additional there are significant ambitions in the NHS People Plan and future of HR and OD that we will need to respond to and embrace.

Key Performance Indicator (KPI) within agreed and accepted levels (Phase 1/2)	Implement a Health and Wellbeing Strategy and Plan to sustain beyond winter 2022 with psychological support and programmes of wellbeing in place. (Phase 3)	Achieve 95% compliance against recruitment KPI's (Phase 2)
Workforce – to reduce vacancy levels to 5% or less by August 2022 (Phase 1/2)	Leadership Development Programme developed for middle managers and plan delivery post Exceptional Leaders. (Phase 2)	Achieve 95% compliance against DBS checks and 3 yearly rechecks account for (sickness/maternity/absence) (Phase 1/2)
Staff Survey – to have significantly moved the engagement drivers to move towards the top quartile improvements over 2022/23 and 2023/24 (Phase 3)	Establish a retention strategy with key interventions to reduce turnover and develop career pathways. (Phase 2/3)	Achieve 100% compliance of ESR against finance ledger (Phase 2)
Turnover – to reduce to 10% including hotspot areas (Phase 3)	Implement professional development for the People & OD Team – in partnership with HPMA/CIPD (Phase 2/3)	Transformation of employee self-serve and introduction of bot to manage self-service queries 2022/23 leading to efficiencies (Phase 3)
Succession Planning – to design and agree a succession plan for all hard to fill and senior roles in the Trust by September 2022 Phase 2/3)	Review and Retender (as appropriate) SBS contract with payroll with key contract KPI improvements 2022/23 (Phase 1/2)	Deliver an OD team and culture programme for each division based on SDR catchball priorities and staff survey feedback – aligned to the Strategy Deployment Model (Phase 2)
Bank/Agency – to reduce spend proportionate to vacancies within budget provisions by August 2022 Phase 1/2)	Eliminate long term overpayments and review medical staffing contracts to ensure accuracy of payments (Phase 1/2)	Improved support for bullying and harassment/incivility complaints to introduce restorative justice / mediation (Phase 2/3)

Main risks associated with the investment *Include here the key risks if the project is not undertaken, not undertaken in the timescale you outline and key risks associated with the delivery of the project*

Risk of not doing it:- significant failure to deliver on the Trust vision of exceptional people outstanding care to be within the top quartile as a place to work; workforce and vacancy levels below acceptable safe staffing; inability to support divisions on organisational change; negative industrial relations and continued levels of bullying and incivility; turnover of senior and experienced staff due to low morale and unacceptable workloads in the People function; litigation risks and poor management decisions; inability to deliver the People and Culture Strategy; transactional only function with little capacity for innovation and change; reduced impact and influence at a system/regional level; poor outcomes from audit/CQC etc
We have already lost good staff who either have no development path or who have been frustrated with the inability to make progress on improvement and deliver high quality people services.

Delivery risk: - the structure would need to be phased in order to manage onboarding and induction to new roles. Six roles have been approved at risk for early adoption in order to minimise the initial risks to delivery and capacity.

Residual Risk: - there will be a period to build up to the capacity/capability needed and to onboard the new starters. Residual risks that capability and delivery may fall short in the current team with performance management being required.

Accountability and clarity on deliverables will hold up any issues of current underperformance. A development plan will be introduced with formal training where necessary to support the team.

Financial impact of the preferred option – full year effect – include VAT unless recoverable

Funding and affordability			The Financial Case
Capital costs of the preferred investment option			
Capital	2022-23	2023-24	2024-25
Equipment			
Estate			
IT	30,485		
Other			
VAT			
Total capital	30,485		
Notes on capital costs:			
These relate to laptops, monitors, docking station,			
Revenue changes associated with the preferred investment option			
Revenue changes	2022-23	2023-24	2024-25
Total income			
Pay	1,134,774	1,638,528	1,638,528
Non Pay expenditure	52,199	33,366	33,366
Other (non- operating) expenditure			
Capital charges & depreciation	6,630	6,630	6,630
Total costs	1,193,604	1,678,524	1,678,524
Net financial benefit			
The Financial Case relates to 34.80 additional posts highlighted by the People Function to be appointed to by March 2023 in April 2022, June 2022 and December 2022. The Case includes 6 posts approved at risk in 2021-22. The substantive pay costs based on the phasing are forecast to be **£1,134,774** in 2022-23 with the cost associated with the full implementation of the structure equating to **£1,638,528**. The non pay revenue costs relate to ICT licenses and non capitalisable equipment for the additional 34.80 additional posts.			

A) Budgetary

	Current Budget £	Proposed £	Increase £
People and Systems	2,291,820	2,826,025	534,205
Organisation Development	1,581,948	2,686,271	1,104,323
	3,873,768	**5,512,296**	**1,638,528**

B) Runrate (based on 2021-22 actual M09 annualised)

	Annualised runrate £	Proposed £	Increase £
Total People Function	**4,898,766**	**5,512,296**	**613,530**

Run rate assumption assume any pressures resolved through approval of Case

Memorandum - spend by cost centre at M09 and annualised against 2021-22 budget. Main cost drivers in Culture and Leadership, Occupational Health and Business Partner Team.

The current run rate for 2022/23 includes an additional cost pressure of £1,024,998 which has been required to deliver the demands for the basic delivery and respond to critical staffing gaps. The cost of ongoing and short notice temporary and contract staff is a significant continued risk with the under

resourced position in the team and the continued demand levels. This additional run rate cost aligns closely to the cost of implementation of Phase 1 and 2 of the Business Case. To approve Phase 1 and Phase 2 would enable all additional costs currently being experienced to be removed and replaced with substantive posts which will give greater return on investment and also security for the team.

Timetable

Include at a minimum the expected key milestones e.g. when planning will be complete, the finance approved, staff recruited, building work commenced, and completed, go live date.

Milestone	Date
Agreed Business Case	31/1/2022
Full consultation and delivery plan agreed	11/2/2022
Phase 2 recruitment to commence	31/3/2022
Phase 3 recruitment to commence	30/9/2022
Final team structure in place	31/12/2022

The Business Case

1. Strategic context

Introduce the service as if to a layperson. Summarise the background to the case including its relevance to strategic aims and objectives identified in division business plan. Identify the key stakeholders.

The People and OD function has been subject to a significant period of change and leadership challenges over the last few years. In 2020 a number of significant events led to the commissioning of an external review, this review was shared with the Chief Executive and the Trust Board and set out a range of findings and associated recommendations.

The review included interviews with 19 key individuals/stakeholders and 15 team members in 3 groups. The understanding and context of the review was mixed within the team and morale and confidence has been severely impacted as a result of the review and the criticism (perceived or otherwise) this has had on the team.

Whilst at a superficial level when reviewing the team there were a number of key performance indicators that sat within normal benchmark bands and staff survey results were average, it was only on further review that issues with direction, leadership, resources and underpinning strategy emerged. The report was challenging in the issues that it highlighted and required significant change to be taken forward. A transformation journey was identified to take the People and OD function to a place where it would be able to deliver a fit for purpose service for the Trust.

A summary of the recommendations can be divided into three themed groups; strategic, structure and resources/operational. The strategic and structure were around the development of a People and Culture Strategy that aligned the National NHS People Plan and was to be deliverable through clear accountability

and underpinned with specific and achievable plans. There were also issues of behaviour and culture that were raised within the team and from external customers.

There is a history of underfunding with the Trust People and OD function which is estimated at 40% lower than the national average cost and benchmarked as the 9th lowest funded in the country against comparable NHS data. The ability to resource and establish clear accountability/deliverables is severely undermined by the lack of resource available and the increasing demands that are being placed on the People and OD Directorate.

There have been a number of described OD programmes which have failed to be sustained due to the lack of investment and resources. In addition to the comprehensive report of the discovery findings on the Culture and Leadership Programme which have been approved by the Board. A large number of recommendations are included in the Workforce Leadership Analysis – these need to be integrated into the renewed People and Culture Strategy and leadership strategy with scheduled actions. The cultural diagnostic work and engagement events that were delivered through the Listening into Action (LiA) programme, an initiative which was not resourced and has in effect fizzled out. The engagement and feedback during the review and subsequently has demonstrated a history where financial pressures and lack of resources has meant that things do not progress. The leadership and OD elements of the cultural diagnostic work needs to be reviewed and incorporated into the designated resources in the OD team (see below). There are currently nil funded OD roles within the team and no internal resources available to deliver the leadership and culture programme.

Culture and Leadership Programme (CLP) - Phase 2 findings to inform strategy

Developing Compassionate Inclusive Leaders	Development and Performance Conversations	Collaboration and One Team Post Covid-19	Innovation and Quality Improvement	Recruitment and Retaining Talent
Leadership development (including Team Leadership Training) • Senior Leaders (Exceptional Leaders) • Middle Managers and Line Manager • New Manager Induction	**Values-based appraisal approach** • Appraisals to be conversation based • Objectives and performance aligned to MTW's values and core objectives • Behaviour that align to the values are recognised and rewarded • Wellbeing Conversations included	**"One Team" Post Covid-19** • Agree a system-wide mission statement that represents inclusive compassionate behaviour and sense of belonging • Establish One Team Scheme, development and improvement opportunities • Create sustainable One Team Runners • Create pool of One Team Project resource	**Developing cultures of innovation** • Continue partnership with University Hospitals Sussex to deliver Patient First Improvement System, Exceptional Leaders Programme, Cultural Change, Strategy Deployment and Digital Transformation • Establish Innovation Hub and develop cross boundary partnerships	**Establish fair and inclusive recruitment** • Establish a trained list of CLP members to be included in interview panels • Implement values based recruitment • Implement values based induction • Regular analysis of workforce information reports
Inclusive Environment For All • Prioritise under-represented or minority groups in leadership development especially for WRES/WDES purposes • Civility, dignity and respect • Listen to all voices • Develop integrated strategy to respond to inappropriate actions e.g. BLESS • All staff – compassionate and inclusive behaviour training • Promote Allyship programme, anti-racism • Training to indicate skill sets rather than banding	**Developmental assignments** • One Team Runner (shop floor, non-clinical staff link to patient experience) • Coaching and mentoring • Secondments • Shadowing	**Collaboration** • Improve inter-team collaboration and patient handovers as part of EPR rollout enabled by One Team Runners	**Leading for quality improvement** • Continue to rollout continuous improvement methodology • Identify innovations and learning from the pandemic and build on these – co-design with patients • Capture improvement opportunities from One Team Runners	**Retention** • Launch "Stay Interviews" – high priority as a result of the pandemic • Actively ensure Exit Interviews are completed
Board and Executive Team Development • Continue Western Sussex coaching • Develop future board members using the NED programme • Rollout reverse mentoring	**Goal setting** • Cascade of trust core objectives • Goal setting and goal reviews	**High performing teams** • Developing high performing, compassionate and inclusive teams • Team based wellbeing priorities for Covid recovery to meet the challenge of burnout • Building team-based working • Team appraisal to review effectiveness • Share leadership in teams	**Visibility and enablement of change** • Improve visibility of all projects to reduce duplication • Create a contingency pot to allow for scope change for projects that cross boundaries	**Succession planning** • Clear succession strategy, that reinforces equality & diversity principles, to improve morale & performance
Managers Essentials • All managers and aspiring managers to undertake training in Recruitment, Rostering, Financial Management, skills to implement HR policies and procedures	**Performance** • Providing feedback on behaviour linked to values and performance • 360 degree feedback (for all staff including patient feedback) **DPC cycle and timing review** • Recommend greatest number of appraisals • Review frequency, timing and alignment to start date	**Improve communication and engagement** • Improve engagement with managers & staff • Increase awareness of different teams • Recognise compassionate and inclusive behaviour and make it easier to say thanks • Improve how information is shared (introduce virtual sharing tools, reduce emails and number of meetings)		**Talent management** • Talent panels established for all divisions • Recognise and develop talent that is fair for all • Managers use appraisals to discuss opportunities in development to achieve career progression • Improve leadership diversity demographics • Pilot specific staff groups
HR policies and procedures • Full review of the HR policies & procedures • Improve understanding and access to policies, procedure and online toolkits	**New DPC product** • Design new DPC system • Source potential new product • Re-brand appraisals to DPC • Implement new cycle	**System leadership** • Integrate compassionate leadership across boundaries with West Kent ICP		**Fair and equal career progression** • Review job title, role and specification redesign to ensure they are more inclusive • Develop career pathways - include variety and opportunity to develop at all levels • Career options promoted

The Freedom to Speak up agenda was also specifically raised as an area of concern in the review where there was little confidence that issues of bullying, harassment and levels of incivility were addressed and responded to appropriately. The feedback included concerns of poor experience when raising concerns, being told by other colleagues of poor experiences and to avoid it, or having raised concerns with HR being disillusioned with the process – often regarded as being directed down a route of raising a formal grievance and being taken through a process. The investment and relationship between the FTSU and the developing OD team (currently engaged through fixed term contractor at risk with no funding stream) has demonstrated the organisational value of commissioning holistic culture diagnostics; team designed leadership interventions; mediated and supported conversations and increased investment in restorative practice.

In response to the inadequate structure of the leadership team two Deputy Chief People Officer roles have been created, reporting to the Chief People Officer, with leadership responsibility for Organisational Development and People & Systems. These deputy roles have significant senior leadership experience and capability to lead and develop the key programmes of work to deliver on the Trust Strategy (providing they have the resources and capacity to meet the demand). There are a number of key areas of focus across these two functional areas.

1. **Organisational Development**

As the people function takes on an increasingly transformational culture change role, the OD function leads the design and development to support managers in major change and organisation design projects at a people/behavioural level. Organisational Development (OD) needs to manage interventions which are developed with a 'systematic mindset' – to ensure that they create alignment with the Trust's goals and activities in a planned and intentional way, with a view to bringing about a particular result that will improve the overall performance of the team/organisation. Organisational development specialists play a critical role in working with leader, line managers and HR/people practitioners to develop the organisation to achieve its goals. The specialists have expertise in navigating complexity to unpick what the organisation is trying to achieve; diagnose underlying issues, challenges, opportunities; and to select the best approaches to develop the team/organisation moving forward.

The four key areas identified from the Culture Diagnostic include.

The limited OD capacity that we currently have are heavily invested in diagnostic and interventions at a divisional level, this has given insight into some of the key drivers for future OD focus and strategy.

High level diagnostic themes from current OD Partner interventions with Divisions

Exceptional Leaders	Themes	Diagnostics
Compassionately Supportive, Always Learning, Conscious Collaboration, Big Picture , Positive Impact , Learning.	Strategy	• Strategic decisions e.g moving services /staff not adequately communicated/understood. • Lack of time given to bringing staff on the journey to understand and agree shared values and create better understanding, joint working and engagement. • Strategy needs to be more consistently linked to patient outcomes. • Divisions often lacking their own strategic agenda mapped to wider MTW strategy. • Staff unclear of priorities and direction of their Division beyond the immediate focus on delivery/targets.
	Structure	• Being 'Clinically Led' is inconsistent in Divisions and Care groups resulting in confusion, lack of cohesion and shared goals. • The organisational structure chart around senior teams is unclear, creating at times a lack of accountability within divisions. In several areas this has led to conflict between individuals as well. • Regular team meetings, clear shared objectives and 1:1s are the exception rather than the rule in many areas. • As a result of the above communication can be poor and collaboration suffers. At Divisional level it has been observed that senior staff are not working to shared agendas which leads to waste and frustration.
	Systems	• Systems and equipment are often implemented without full consultation and collaboration, resulting in operational issues and staff frustration at feeling 'out of the loop' • In some areas lack of structure, shared objectives and collaboration has led to poorly implemented or ineffective systems. • Continuous and Quality Improvement processes are rarely used and more significantly poor communication and lack thought into the practicalities of behavioural change has led to additional work being created as the result of how new systems and processes are implemented.
	Staff	• Issues with staff numbers and redeployment processes cause staff stress and upset • Difficulties in recruitment and retention have resulted in low morale, exhaustion, raised stress levels, increased sickness absence. • The directive leadership style driven by the necessity of the pandemic in the first wave, is still evident in many areas, with a lack of focus on distributed leadership and collaborative engagement with staff. • Decisions are being made about staff and their roles, without staff, and this is negatively impacting their wellbeing and motivation. • Basic management fundamentals that are important for performance, quality and wellbeing are being missing as managers are increasingly under pressure or are covering shifts, e.g. 1:1's, team meetings, development conversations etc. This results in staff not feeling valued, heard or cared for. • In some areas there is a lack of visible leadership • In some areas issues that staff have raised are not being acted on.
	Style	• In some areas Trust values are acknowledged but not lived, so staff do not feel valued and are not seeing or experiencing good leadership practice. • Management/leadership style is still perceived as hierarchical/autocratic in many areas, and the culture of referring to colleagues AfC grade rather than their job title/responsibilities reinforces that. Compassion is often lacking in leaders who believe that compassion is not being afforded to them.
	Skills	• Allocating staff to areas or patients that they don't feel adequately skilled for is causing stress for staff and concerned for some about the potential threat to their professional registration.
	Shared Values	• The Trust values while they may be implicitly in play in many areas, are not explicitly used in decision-making processes. The lack of clarity in the value hierarchy also creates tension e.g. teams wishing to focus on patients first, others on delivery. Comms in the Trust also demonstrate different views of what the values actually mean in practice e.g. Excellence - being the best or, enhancing reputation? • With no clear hierarchy, behavioural framework or explicit reference to the values in how decisions are made, values are of limited in their effectiveness.

Employees are often at the centre of the changes to the organisation that follow, and people professionals need to have a solid understanding of the relationship between organisational development, organisational strategy and the HR agenda. They should leverage their expertise and knowledge of the organisation to question assumptions, help surface non-obvious problems/issues, diagnose barriers/enablers to execution, and manage change effectively.

Increasingly there is better understanding and priority on the investment in employee wellbeing which can lead to increased resilience, better employee engagement, reduced sickness absence and higher performance and productivity. However, as we have experienced, the Trust wellbeing initiatives often fall short of their potential because they stand alone, isolated from the everyday business. To gain real benefit, employee wellbeing priorities must be integrated in the Trust, embedded in our culture, leadership and people management. In line with OD the Trust currently has no dedicated wellbeing capacity and has in-sourced contract/bank (at risk) which is not sustainable.

Through the alignment of the strategic deployment of the Trust Strategy each division has identified a number of driver metrics which link directly to the ability of the People and OD function to support and lead activity. A strategic driver is to take the Trust to the top performing quartile as a great place to work. This metric is driven by the annual staff survey and pulse survey feedback and is delivered through the key engagement metrics in areas such as belonging; bullying and harassment; workforce – feeling that the job is do-able, wellbeing and clear engaging communication. All of these areas demand support from the People function to work at a strategic level as well as alongside the divisional leaders to create a sustainable plan to improve the lived experience of staff.

The current resource within the team has no functionality for OD support and has minimal resource for EDI and engagement – as outlined in the HR review the ability to design, deliver and sustain organisational programmes of delivery is severely compromised. The outline of the Culture and Leadership Programme with outlined areas of improvement that are currently under resourced for delivery.

2. **Health and Wellbeing**

The current and emerging psychosocial health and wellbeing programme for staff will be built on an evidence-based model that was developed during previous COVID-19 surges. Underpinning the programme is a stepped-care model designed to, where possible, prevent trauma by helping staff to develop self-awareness and self-care practices and an awareness of where to access appropriate help and support. It's encourages the growth of a culture of wellbeing through establishing and reinforcing good management practice – regular team meetings, check-ins, 1:1's and wellbeing conversations. This approach is designed to as far as possible prevent the pathologising of natural adjustment to difficult experiences and situations. A peer-based response to support organisation-wide adjustment to high levels of anxiety and uncertainty.

The first tier of the model is designed give staff tools, knowledge and skills to be aware of their own wellbeing, those of others and to develop good wellbeing practice. It is also designed to encourage staff to be aware of and respond to the wellbeing needs of others, including how to access and sign post others to support. Delivered via communications, easy to access to information and easy access to wellbeing support. Trust-wide communications #onlyhuman campaign Wellbeing Wednesdays Divisional communications channels, supported Wellbeing lounges - a space to recharge, connect with others, access support staffed by trained Wellbeing Hub staff/One Team Runners, signposting to appropriate self-management resources and mental health and wellbeing pathways, wellbeing partners supporting managers and teams with preventative good practice providing navigation to appropriate resources and/or support resources NHS &, Kent Hub & MTW well-being and self-management resources developed for individuals, teams & managers EAP benefits and resources platform.

Tier 2 - Outreach and ward based in-reach to those with more persistent issues or acute distress. The second tier involves a named Wellbeing Partner being assigned to divisions and departments. These partners will work where required with managers to support them in creating a culture of good wellbeing practice, these will be based on the #onlyhuman practice criteria. Partners will support managers to identify and support staff that may need additional support. This tier is delivered via the development wellbeing partners deployed into the Trust, initially one per division/ department. This can be stepped up if necessary. Wellbeing Partners identify and bring support into teams where needed, bespoke in-reach team sessions with psychological staff support to professional groups, team Wellbeing Inbox & Phone number staffed Inbox to monitor and respond to requests for support for teams / managers, telephone number for managers and leaders to request support

Tier 3 - Systems to provide staff with rapid access to evidence-based psycho-social treatments. This tier is based on clear mental health navigation pathways that will be shared with staff and managers so that treatment interventions can be accessed in a timely way by staff. Escalation is to mental health services supplied via out EAP provider, via the Kent Wellbeing Hub and via the Trust internal psychology OH team. Staff can access support via managers, the wellbeing lounges and their wellbeing partner. There will also be clear comms via the intranet and posters. Access to online resources signposting and comms to raise awareness of NHS staff support phone and text lines to offer confidential support and signposting. EAP support, access to up to 6 sessions of counselling/ coaching and welfare support, MDT and psychology service for limited number of staff with more complex needs, SIS debriefs available when needed.

Tier 4 –Rapid escalation of areas and issues of concern to be addressed at organisational level. There are likely to be departments and teams that are more heavily impacted by the upcoming pressures than others. The wellbeing team will put in place process to ensure that these are escalated to relevant command structures, divisional and professional groups to enable improvement in how we are operating. Escalation to operational and divisional meetings.

3. **Business Partnering**

The role of the HR Business Partner is key to the effectiveness of the service, business partners should be closely aligned to the division and work effectively to understand the strategy, aspirations and areas of support needed and commissioned from the wider People and OD function. The Business Partners should

also work closely with other enabling and support services such as finance and communications to enable a holistic set of support to enable high performance and achievements of organisational goals.

Through feedback in the review there was a sense that the HR Business Partner model was a 'blocker' to what the divisions want to achieve and did not operate in order to improve other parts of the overall people functions – examples would be understanding workforce pressures and commissioning recruitment support; facilitating movement through change programmes and job evaluation/structure design support; as examples.

The essence of true business partnering is context. It is the ability to understand the organisation's strategy and goals, appreciating people demographics, the organisational culture, and developing people solutions that help achieve business objectives while enabling employees to flourish. This is achieved through developing meaningful relationships with key people and teams across the organisation, using data to be more evidence-based in practice, and delivering a portfolio of business relevant solutions that meet the evolving needs of the organisation.

There are four key areas to consider in developing an effective business partner model:

- Understanding the organisational strategy – getting to know and understand how the trust operates, how it creates value, its strategic drivers and its purpose.
- Generating insight from data and evidence – using and applying evidence to support business cases or strategies, as well providing insight, inspiration and the opportunity to validate and qualify the impact of their work.
- Connecting with curiosity, purpose and impact – asking the right questions, crafting networks and understanding where HR can identify opportunities to create the most value.
- Leading with integrity, consideration and challenge – having the courage and confidence to challenge the business and its leaders.

The investment in a senior strategic HR Business Partner in the operating model can be developed in the Trust, this model will outline the role of the Business Partner, clarify and determine the key accountabilities and deliverables, support the divisions to engage and involve the business partner in strategic design, develop an internal commissioning relationship with wider parts of the people function and develop a competency framework and development programme to upskill the team.

To enable this partnering model to be effective two additional HRBP are required to ensure that there is the capacity to deliver outside a purely transactional level. In discussions with the existing HRBP's their time is spent mainly dealing with payroll queries, performance discussions, and the typically described firefighting. There is little evidence of data driving insights or of leadership in the people space across the business partnering team.

4. **Additional Roles across the team**

Across the wider People function there are additional roles that have been identified which support a number of key functions including.

Resourcing – there is increasing demand and increasing challenges to meet current and future workforce needs. The ability for the Trust to develop robust strategy approaches to retention, marketing and attraction, talent pipelines and initiatives to create new career pathways is limited by the transactional demands on the team. Through the resourcing and workforce supply A3 thinking it is clear that different approaches to role design, national/regional skill shortages and structure/reward strategy needs to be a key focus. There is an over dependency on the traditional approaches to resourcing and role design, this also cascades through to approaches to job evaluation and reward initiatives and a lack of focus on different and successful approaches and case studies outside of the Trust.

Compliance – as experienced recently with the project for DBS checking, the ESR / ledger alignment and workforce/KPI's there is a serious gap in ensuring that the Trust has robust standard operating procedures, compliance and quality assurance and strong contractor assurance with our payroll provider SBS. Overpayments have caused damaging employee relations issues as well as litigation risks, also compliance with employment legislation on rolled up bank holiday rates, variable and inconsistent agency rates, limited assurance on ESR recording also leads to inadequate and incorrect data reporting which undermines effective decision making and timely escalation of key risks.

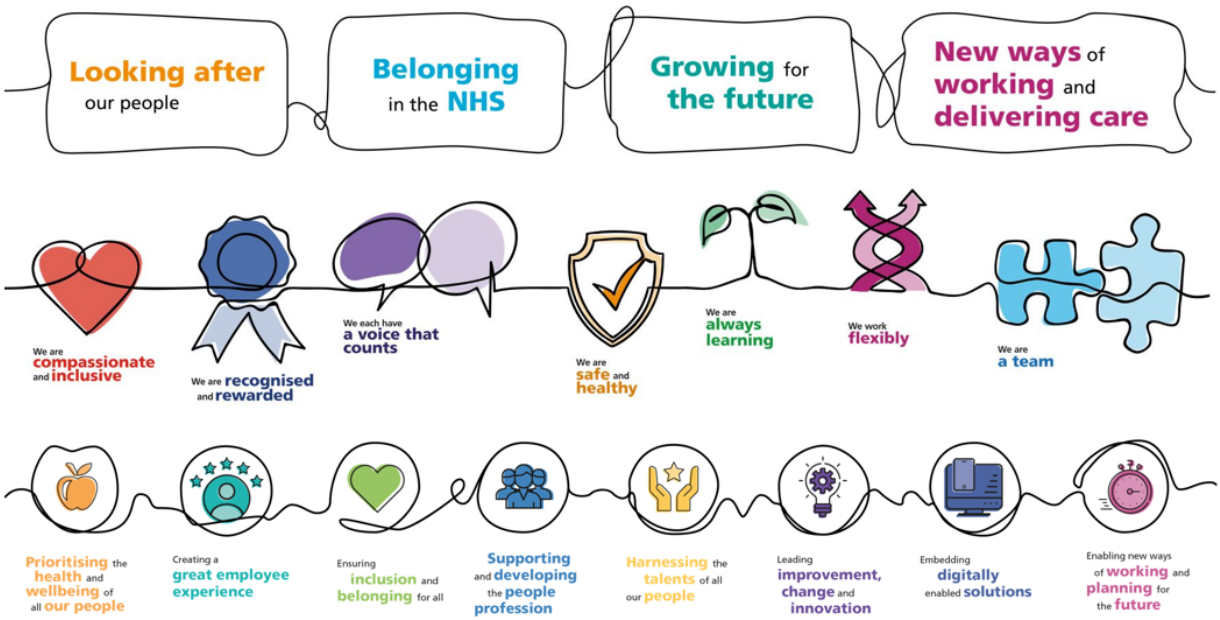
To appropriately support the Trust the key areas of focus need to be reflected in the investment in the People and OD Function.

1. Priority on health and wellbeing – currently no dedicated resources.
2. Organisational Development – culture and diagnostic with no dedicated support – this will include major change initiatives; engagement; team development; leadership development; talent and succession planning; support to the strategic projects.
3. Resourcing – limited capacity for workforce planning, initiatives for retention and reward. Ensuring we are able to retain our staff is a key priority particularly in some hotspot/hard to fill areas. Developing a retention strategy is key to ensure that we focus and sustain our employer of choice status, describe the total reward package and also develop meaningful career development.
4. Temporary Staffing – additional capacity for Admin/E&F to enable key areas of focus on patient facing roles to be managed through e-rostering. Over the last 12 months there has been a 59.86% increase in demands for nursing and midwifery bank/agency with no additional resources to respond to this increase.
5. Workforce Data and Establishment Control – including workforce returns; maintenance of ESR; key performance reporting; payroll relationship and contract management; transformation such as 'employee self-serve' – a recent project working through all the key data in ESR identified over 2,000 line by line inaccuracies against the finance ledger, our ability to run out key projects such as employee self-serve and stop producing thousands of payslips per month is severely hampered by a lack of resources and led to the engagement of a contractor to complete this work.
6. Business Partnering – the increase in activity and to support the clinically led operating model requires a dedicated HRBP for each division. Building this capacity will ensure the delivery of key corporate objectives.

The NHS Promise and the Future of HR and OD in the NHS. The eight areas for the NHS vision are outlined below and within these sit 35 actions that will need to align to the professionalism and delivery plan for our People function. The introduction of integrated care systems (ICSs) brings not only new structures but also a new emphasis on collaborative working. There will be increased opportunities to scale up what works, sharing learning and resources.

Ways of working are changing beyond just healthcare, with major transformation in the nature of work and what people expect from their employment, the Trust needs to adapt and transform to meet these changing expectations. The way we have always worked will not serve us well into the future. The pandemic has accelerated the move towards more novel approaches to care and remote working.

The Trust will need to flex its approach to ensure that we are relevant in the market, to ensure that we can attract and retain passionate and motivated people who put our patients at the heart of everything they do.



2. Objective(s) and case for change of the proposed investment

*List the project objectives succinctly. (What you wish to achieve for patients **not** what you wish to purchase)*

This is covered in other aspects of the business case.

Relating to each objective; describe the current situation and problem and risks associated with the current situation, the gap from where we are to where *we need to be i.e. the required change and the benefits of achieving the change.*

3. Constraints and dependencies

Describe any constraints and dependencies e.g. financial resources, ability to recruit and support from other departments etc.

The structure is wholly dependant on funding which currently has no identified stream. It is anticipated that the Trust reputation and the investment in the People and OD function will demonstrate an attractive proposition for recruitment.

The area of OD and Health and Wellbeing is a core element of investment in many organisations including NHS Trusts locally and regionally, whilst MTW is an attractive place to work and has a compelling vision – this is a competitive market and a strategy for bringing high quality individuals will be critical. We have been successful in attracting short term contracting staff in some areas which should give us a good platform to work from.

Space is a challenge for the Trust and the People & OD team that are located at Maidstone have mainly now been relocated off site at the Roundall. Additional space would be required to accommodate the additional team although a high level of remote and agile working is used across the team – the visibility and connection of the Business Partners; wellbeing team and OD practitioners would be particularly important as well as more geographically agnostic team roles. This is being worked through with the space group and initially the room at the Roundall will accommodate the phase 1 and 2 starters with some flex on agile working.

4. Short list of options

Show the short list of alternative ways to meet the objectives you have considered e.g. Variations in scale, quality, technique, location, timing

Option 1 Title: The do-nothing option

Description

A brief description including exactly what would be purchased in staffing, equipment and estate

The ambitions of the People and Culture Strategy and the needs of the Trust from a strategic perspective can not be delivered with the existing structure. The leadership in OD and wellbeing will be non-existent. The function would remain a largely transactional team and risks of underperformance would remain.

Responding to the Future of HR and OD vision of the NHS to 2030 which has just been released places significant investment into improvement, change and innovation. This places a requirement to work in a collaborative space across the integrated care system at a regional level as well as into the wider NHS agenda. Currently senior leadership is driving forward system level change across recruitment, retention, rostering, wellbeing and a number of other key areas. This collaboration is not sustainable and would not be a priority if the structure remained as it is currently. MTW would not be influencing, delivering or leading in the people agenda across the sector.

The key actions and priorities to March 2023 are outlined below.

Action	ICS and organisation priorities to March 2023
• All trusts to ensure that they have appointed a director of human resources/chief people officer as a member of their board.	
Supporting and developing the people profession Actions 2 and 3 	• Develop professional development plans for their teams, optimising use of apprenticeship levy
Leading improvement, change and innovation Action 6 	• Review allocation and distribution of people function resources to ensure alignment with the People Plan, NHS Long Term Plan and local system priorities • Create plans for system-level consolidated and simplified transactional people services
Embedding digitally enabled solutions Action 8 	• Optimise the adoption of current people digital solutions • Create plans and commence action to align and harmonise digital strategies and solutions, across providers wherever possible, to enable more joined-up

Prioritising the health and wellbeing of all our people Actions 13 and 15 	• Build health and wellbeing metrics into performance dashboards and consider them with the same scrutiny as operational and financial performance • Review and baseline the current health and wellbeing offer, including identifying which areas to enhance or evolve
Ensuring inclusion and belonging for all Actions 17 and 18 	• Embed the overhauled recruitment processes to take account of EDI considerations • Ensure that all individuals, teams and organisations have measurable objectives on equality, diversity and inclusion, including all board members
Creating a great employee experience Actions 21 and 24 	• Build employee experience metrics into performance dashboards • Develop strategies to make health and care the first choice for local employment
Harnessing the talents of all our people Action 29 	• Proactively set the direction for talent management and start embedding the approach
Enabling new ways of working and planning for the future Actions 31 and 35 	• Develop system workforce plans that align with local service and financial planning, HEE plans and the responsibilities set out in the guidance on the ICS people function • Lead action to address local supply issues, using the benefit of scale wherever possible and innovative approaches that broaden access to roles for the local community

A further risk to doing nothing is the ability to retain senior and/or highly skilled and experienced people which would be significantly impacted and we would likely lose a number of people, again negatively impacting the ability to deliver on key areas of HR and OD.

The operating model for the function is to work in partnership with the divisions and create a side by side high performance approach with business partnering and internal commissioning of bespoke interventions, this model would be compromised by this option with limited capacity to engage any development partners and engagement would be transactional and transmit rather that side by side.

Key activity and financial assumptions

The investment would be offset against other financial costs which currently include ongoing and high cost interim and short-term appointments. These costs are significant compared with the costs of ongoing substantive roles.
Additional costs would be incurred in agency and bank costs aligned to an inability to deliver on our resourcing demands.
Litigation and ET costs would continue and likely increase due to poor employee relations responses and an inability to create improvement in our positive culture.
Turnover in the Trust would continue to impact the wider divisions again with high agency costs and regretted loss to the skills and experience of the workforce.

What changes in capital and revenue, income and expenditure are expected from this option and why?

Non-financial risk associated with the option

Risk		Baseline risk score	Summary mitigation/ contingency	Mitigated risk score	Lead
Workforce and resourcing would be below safe staffing levels with limited capacity for innovation		High risk	Some mitigation in recruitment and ongoing focus on filling vacancies. Engaging external support and additional bank and agency work to enable flow of recruitment	High risk	Rob Henderson
Divisional plans for culture and team transformation would have limited OD support and compromised success		High Risk	Contract and high cost consultancy would need to be engaged – however would not be integrated with the Trust vision and culture. Engagement scores would continue to be low resulting in high turnover and employee relations cases.	High risk	Ainne Dolan
Health and Wellbeing programme could not be sustained or maintained beyond current temporary investment – leading to low staff engagement		High Risk	Transactional wellbeing to continue with little ability to provide sustainable wellbeing services and support to staff. Bank staff could be engaged to offer some overview and contingency but with limited sustainable delivery.	High risk	Ainne Dolan
Leadership development programme would not be delivered unless through additional funding and external delivery.		High Risk	Leadership Development would be outsourced and delivered – high cost model	Medium risk	Ainne Dolan
ER and litigation claims at risk due to low quality contract management of SBS payroll provision.		High Risk	Re tendering of contract with SBS to deliver better service delivery and quality. Would need to outsource the support to tender the current contract	Medium risk	Rob Henderson
Significant burn out and turnover of key staff in the team.		High Risk	Little mitigation possible	High Risk	Sue Steen

Non-financial benefits associated with the option

Benefit	Baseline value	Target Value	Measure	Timing	Responsibility
No benefits other than reduced continued					

Benefit	Baseline value	Target Value	Measure	Timing	Responsibility
investment in the People & OD function.					

Option 2 Title: Reduced Implementation – 50% investment

Description

A brief description including exactly what would be purchased in staffing, equipment and estate

To develop a 50% investment model the emphasis of the structure would be to ensure that the function was sustainable and delivering the core services. This would focus on transactional and functional delivery - HRBP operating model would be compromised to a more advisory and transactional relationship with less focus on transformation and commissioning of wider OD interventions to support change.

The investment in OD and Wellbeing could be significantly reduced to accommodate financial constraints which would leave a small function to respond to design and facilitation of core corporate activity such as leadership, talent and some commissioning of wellbeing support but would not have any capacity to work with the divisions on bespoke and team level work. This would reduce the capacity to support change and behaviour programmes and would require divisions to fund and commission external support to enable local OD work to continue.

Resourcing would remain at a transactional level with little investment into retention and attraction, as well as developing new pathways.

An area of innovation is for the team to have capacity to look beyond MTW and reach out to high performing and successful NHS Trusts to learn and adopt good practice to enable growth and improvement. This wider ability to translate good practice into our way of working is not possible due to restricted capacity, and also inhibits collaboration at a sector level – this could lead to an inability to influence and develop regional solutions that benefit and support MTW.

The current consultation on the People and Culture Strategy has highlighted the need for the people agenda to be more agile, flexible, outcomes driven and less policy driven – this ambition would be diluted under this option due to reduced capacity to design and deliver bespoke solutions.

Key activity and financial assumptions

What changes in capital and revenue, income and expenditure are expected from this option and why?

All capital and revenue costs would be reduced by 50% however there would be additional costs that would need to be factored back in to take account of additional resourcing that would be engaged on a case by case basis to deliver the ambitions of the Trust.

Non-financial risk associated with the option

Risk	Baseline risk score	Summary mitigation/ contingency	Mitigated risk score	Lead
Wellbeing programme would be limited to EAP and some wellbeing practitioners. Psychological support would be out-sourced which could lead to higher costs and lack of quality interventions.	High risk	Outsourced support	High risk	Ainne Dolan
Divisions would be required to fund OD interventions and sourced from contractors and external providers, hidden costs of delivery in divisions and lack of corporate connection and potential quality.	High risk	External support to be sourced and onboarded for each OD and change programme – this could be difficult to source and would not align to our organisational culture and would need support form the limited OD provision	Medium risk	Sue Steen
Morale and lack of investment would lead to turnover of senior and qualified staff who are unable to deliver the interventions needed to improve the culture of the organisation.	High risk	Limited provision to mitigate this risk which will also be exacerbated with external temporary staff doing the high-quality interesting work.	High risk	Sue Steen

Non-financial benefits associated with the option

Benefit	Baseline value	Target Value	Measure	Timing	Responsibility
Reduced investment leading to benefits of overall funding – however hidden costs emerge with additional contractors, divisional costs, litigation potential, turnover and lack of leadership investment.					

Benefit	Baseline value	Target Value	Measure	Timing	Responsibility

4a. Summary of non-monetary benefits and risks of each option

Non - monetary benefits and risks of each option - *Summarise the non-monetary benefits and risks of each option*		
Option	**Benefits and risks**	**Option benefit and risk score and/or rank**
Option 1 Do nothing	Outlined above	High risk
Option 2 50% investment	Outlined above	High risk

4b. Summary of information on each option

Category	**Option 1**	**Option 2**	**Option 3**	**Option 4**
Capital costs *(One off upfront costs)*				
A) Annual revenue income				
B) Annual costs/ expenses (pay and non-pay)				
Net annual income = (A –B)				
Benefits *(non-financial)* score *and or rank of option*				
Risks score *and or rank of option*				
Summary of option (Preferred / discounted/ deferred)				

4c. Directorate decision on which option is preferred and why

Has the cost, benefit and risk been identified?

Whilst this is a significant investment into the People and OD team there are a number of factors that have led to this business case. This case is based on a historical and ongoing failure to invest appropriately in the service therefore on many levels this business case is one of rightsizing rather than investing. However, it is also expected that many areas of development will also be possible as a result of an appropriately resourced team.

When the senior leadership team was recruited to it was on the basis that the function had vision and a direction of improvement, this has been evidenced from the review that was commissioned and approved at the Trust Board. Through the strategic resetting process, it was outlined that 'people' are amongst the

strategic priorities and are identified as a key enabler to the Trust achieving its ambitions. To be amongst the top quartile as a place to work – where our people can thrive and bring their best self to work. This ambition requires a focus on innovation, flexibility and agility in managing our people practices and developing our leaders to be compassionate and exceptional communicators.

There will be a need to phase the onboarding of the team to enable sound integration and clear accountability, also to manage the financial impact to the Trust. This phasing will also enable the People and Culture Strategy to align the deliverables and outcomes to the capacity and capability of the People and OD Directorate.

NOTE: From this point onwards the sections should be completed for the preferred option only.

5. Commercial considerations (preferred option)

5.a. Services and/or assets required

Clear list of, equipment IT and estate requirements and impact of preferred option

5.b. Procurement route

Proposed sourcing option, with rationale for its selection; key features of proposed commercial arrangements (e.g. tendering, framework agreement, contract terms, contract length, payment mechanisms and performance incentives).

n/a

5.c. Activity and service level agreement (SLA) implications. Commissioner involvement and input.

Include a clear list of expected activity changes and commissioner involvement in the proposal to date. Include statements of support from commissioners in an appendix if relevant.

n/a

5.d. Workforce impact preferred *option*

Summary of workforce changes (WTE and band) workforce issues. Include any necessary arrangements for training.

See attached Structure charts showing new and revised roles.

		Additional Posts by March 2022-23		
		People and Systems	Organisational Development	Total additional
New post start date		WTE	WTE	WTE
Phase 1	Apr-22	5.00	1.00	6.00
Phase 2	Jun-22	5.00	9.00	14.00
Phase 3	Dec-22	3.00	11.80	14.80
		13.00	21.80	34.80

6. Financial impact of the preferred option –

Full year effect – include VAT unless recoverable

		Additional Posts by March 2022-23			
		People and Systems	Organisational Development	Total additional	Recurring
New post start date		£	£	£	£
Phase 1	Apr-22	269,928	70,920	340,848	340,857
Phase 2	Jun-22	146,510	455,793	602,303	722,789
Phase 3	Dec-22	29,476	162,147	191,623	574,882
		445,914	688,860	1,134,774	1,638,528

Phase 1 and 2 combined (start dates April 2022 and June 2022)

	Additional Posts by March 2022-23			
	People and Systems	Organisational Development	Total additional	Recurring
New post start date	£	£	£	£
Phase 1 and 2	416,438	526,713	943,151	1,063,646
	416,438	526,713	943,151	1,063,646

Funding and affordability			The Financial Case
Capital costs of the preferred investment option			
Capital	2022-23	2023-24	2024-25
Equipment			
Estate			
IT	30,485		
Other			
VAT			
Total capital	30,485		
Notes on capital costs:			
These relate to laptops, monitors, docking station,			
Revenue changes associated with the preferred investment option			
Revenue changes	2022-23	2023-24	2024-25
Total income			
Pay	1,134,774	1,638,528	1,638,528
Non Pay expenditure	52,199	33,366	33,366
Other (non- operating) expenditure			
Capital charges & depreciation	6,630	6,630	6,630
Total costs	1,193,604	1,678,524	1,678,524
Net financial benefit			
The Financial Case relates to 34.80 additional posts highlighted by the People Function to be appointed to by March 2023 in April 2022, June 2022 and December 2022. The Case includes 6 posts approved at risk in 2021-22. The substantive pay costs based on the phasing are forecast to be **£1,134,774** in 2022-23 with the cost associated with the full implementation of the structure equating to **£1,638,528**. The non pay revenue costs relate to ICT licenses and non capitalisable equipment for the additional 34.80 additional posts.			

7. Quality Impact Assessment (preferred option)

Clinical Effectiveness	
Have clinicians been involved in the service redesign? If yes, list who.	
Clinicians were involved in the review as stakeholders and are also involved in the consultation on the revised People & Culture Strategy.	
Has any appropriate evidence been used in the redesign? (e.g. NICE guidance)	
Benchmark information – such as 9th lowest cost HR function	
Are relevant Clinical Outcome Measures already being monitored by the Division/Directorate? If yes, list. If no, specify additional outcome measures where appropriate.	
Are there any risks to clinical effectiveness? If yes, list	
Workforce risks	
Have the risks been mitigated?	
Have the risks been added to the departmental risk register and a review date set?	
Health and wellbeing Turnover and workforce metrics Each division has workforce and culture as a driver metric on their catchball priorities.	
Are there any benefits to clinical effectiveness? If yes, list	
Yes – workforce, culture, morale, turnover, team effectiveness, health and wellbeing of staff, Trust reputation and attraction.	
Patient Safety	
Has the impact of the change been considered in relation to:	
Infection Prevention and Control?	Y/N
Safeguarding vulnerable adults/ children?	Y/N
Current quality indicators?	Y/N
Quality Account priorities?	Y/N
CQUINS?	Y/N
Are there any risks to patient safety? If yes, list	
Staff engagement has evidenced direct links to patient outcomes and safety. Workforce levels are a significant risk to safe staffing for our people as well as adverse outcomes for patients.	
Have the risks been mitigated?	
In part	
Have the risks been added to the departmental risk register and a review date set?	
Yes	
Are there any benefits to patient safety? If yes, list	
The ability to staff our Trust at a safe level and with well trained and motivated people will have a direct impact on patient safety.	

Patient experience					
Has the impact of the redesign on patients/ carers/ members of the public been assessed? If no, identify why not.					
Staff morale and engagement has direct impact on patient care. The ability to delivery on the NHS People Plan is critical to the effectiveness of the Trust as a provider of health care.					
Has the impact of the change been considered in relation to: • Promoting self-care for people with long-term conditions? • Tackling health inequalities?					
Does the redesign lead to improvements in the care pathway? If yes, identify					
Are there any risks to the patient experience? If yes, list					
Have the risks been mitigated?					
Have the risks been added to the departmental risk register and a review date set?					
Are there any benefits to the patient experience? If yes, list					
Equality & Diversity					
Has the impact of redesign been subject to an Equality Impact Assessment?					
No					
Are any of the 9 protected characteristics likely to be negatively impacted? (If so, please attach the Equality Impact Assessment)					
No there is an opportunity to improve the impact to equality.					
Has any negative impact been added to the departmental risk register and a review date set?					
Service					
What is the overall impact on service quality? – please tick one box					
Improves quality	X	Maintains quality		Reduces quality	
Clinical lead comments					

8. Project management arrangements

Timetable

Include at a minimum the expected key milestones e.g. when planning will be complete, the finance approved, staff recruited, building work commenced, and completed, go live date.

Milestone	Date

9. QSIR Methodology

10. Arrangements for post project evaluation (PPE)

The following template will be used after the project is completed, to assess issues and lessons learned with the planning for the investment and to what extent the expected benefits were achieved.

Complete the following section now

Name of Division/Directorate
Evaluation manager
Project Title & Reference
Total Cost
Start date
Completion date
Post project evaluation Due Date

Complete this section by PPE due date

Section 1 INTRODUCTION

Background (a brief description of the project and its objectives)
Please give details of commencement of scheme, when staff were appointed and when full capacity was achieved.

SECTION 2: PROJECT PROCESS EVALUATION

Project documentation issues
Project execution issues
Project governance issues
Project funding issues
Human resource issues
Information issues
What worked well in developing case?
What could be improved in developing a case?
Summary of recommendations for developing a case

SECTION 3: ACHEIVEMENT OF OBJECTIVES

Did this Investment meet objectives?

Objective 1
Objective 2
Objective 3 How were they achieved?

SECTION 4: BENEFITS
Benefits planned in original Business Case (See benefits profile – attached below)
Benefit 1
Benefit 2
Benefit 3
Actual Outcome
(Please comment on variances or delays etc.)
How were benefits and outcomes evidenced? Please give details of such.

SECTION 5: VALUE FOR MONEY
What methodology was used to assess quality, funding and affordability and value for money of service provided? What were the conclusions?

SECTION 6: RECOMMENDATIONS AND LESSONS LEARNED
What problems were encountered during implementation of the project, and how where such resolved? What was learned, how has this been disseminated, and to whom? Please provide supporting evidence.

11. Appendices

Add any additional supporting information here. Include detail of activity and financial information as appropriate. Please do not embed files into this document.

HR Structure Charts
HR Review 2020

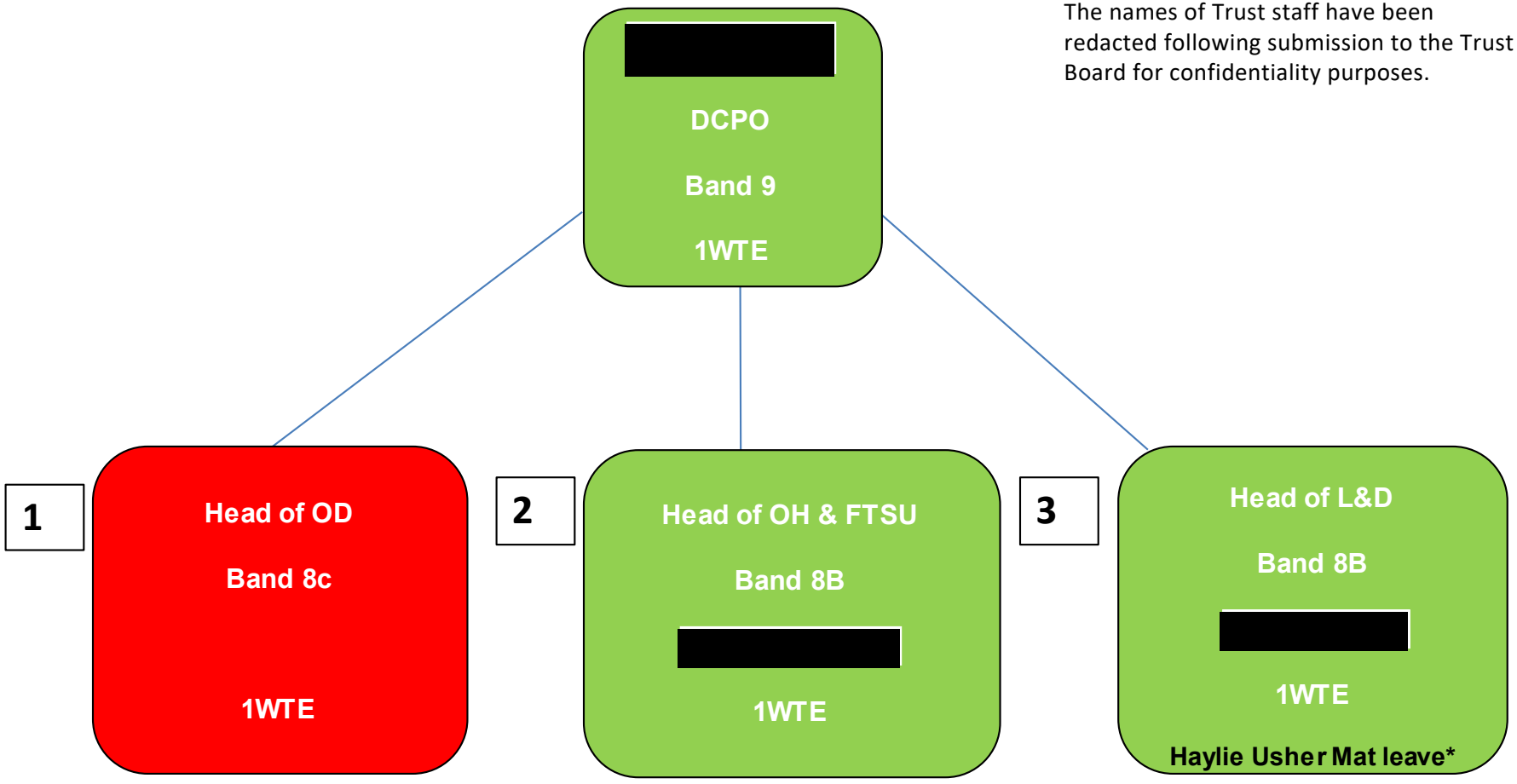
Financial Modelling Excel

Version history

Version	Issue date	Brief Summary of Change	Owner's Name
1	14/11/2021	First draft	Sue Steen
2	13/1/2022	Second Draft following initial consultation and feedback from POD Cttee; Business Case Review Panel; CEO and Deputy CEO; further financial information.	Sue Steen

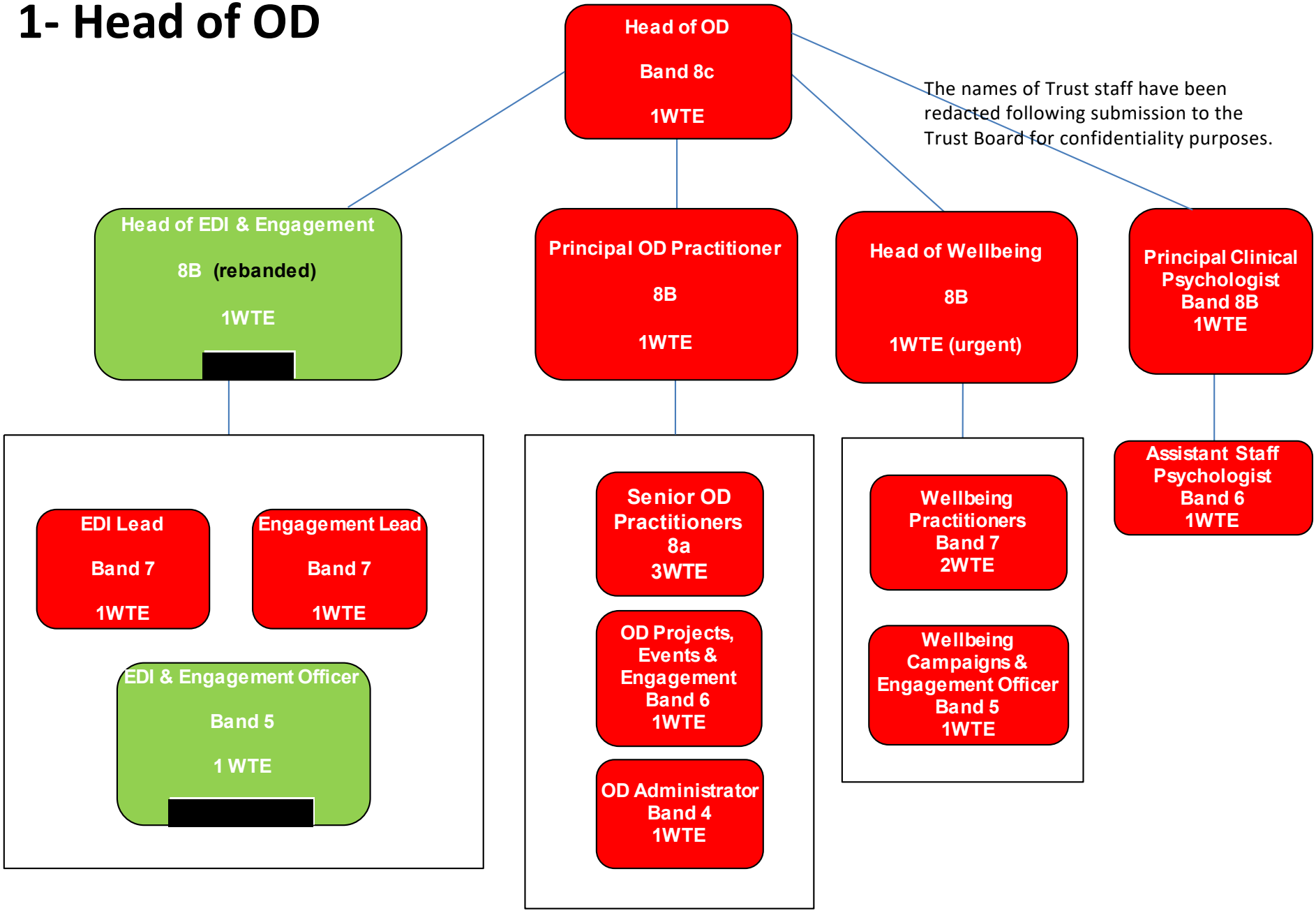
Deputy CPO - OD Top Structure

The names of Trust staff have been redacted following submission to the Trust Board for confidentiality purposes.

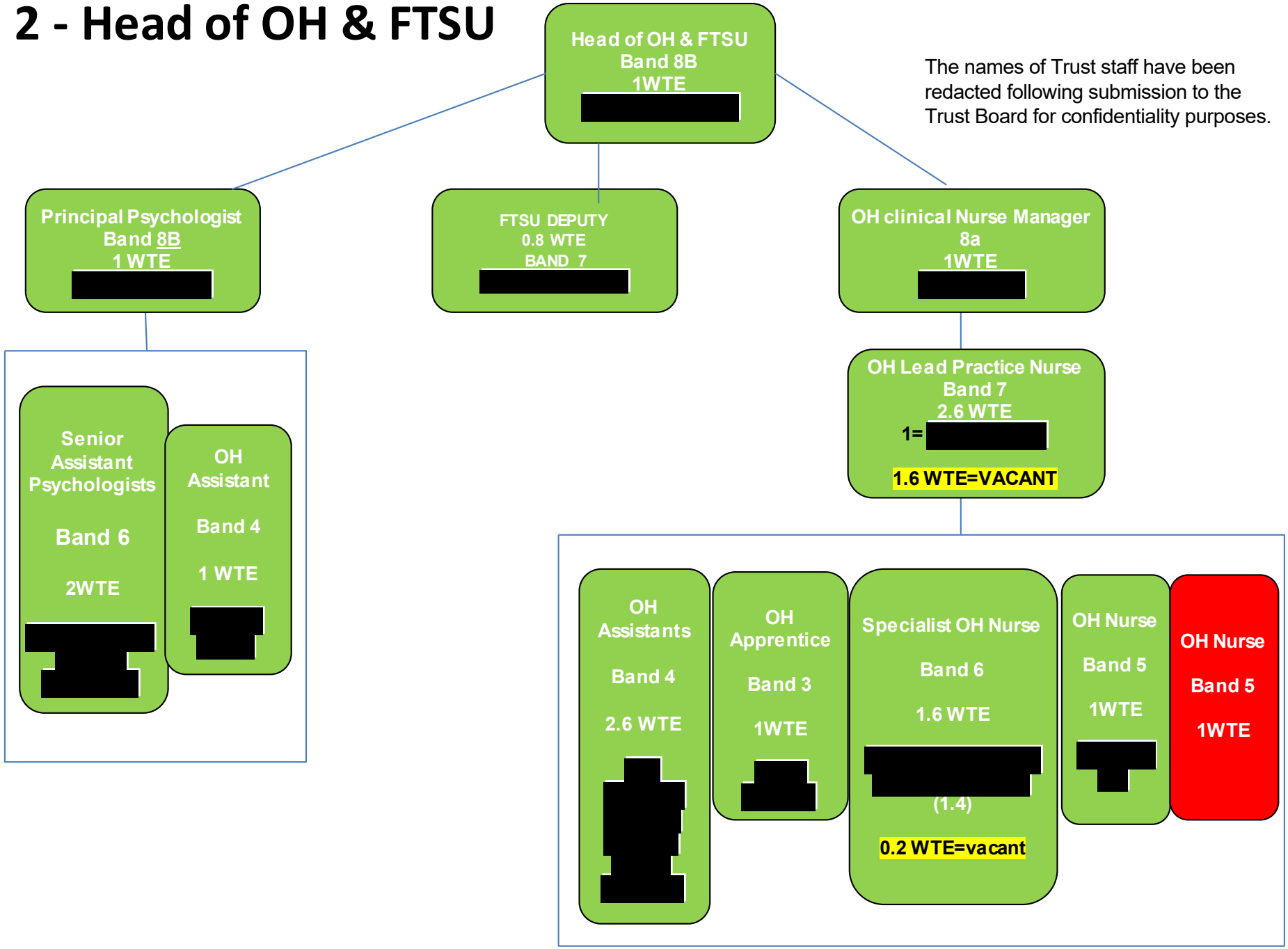


Existing Posts
Existing posts -vacancies
Proposed posts

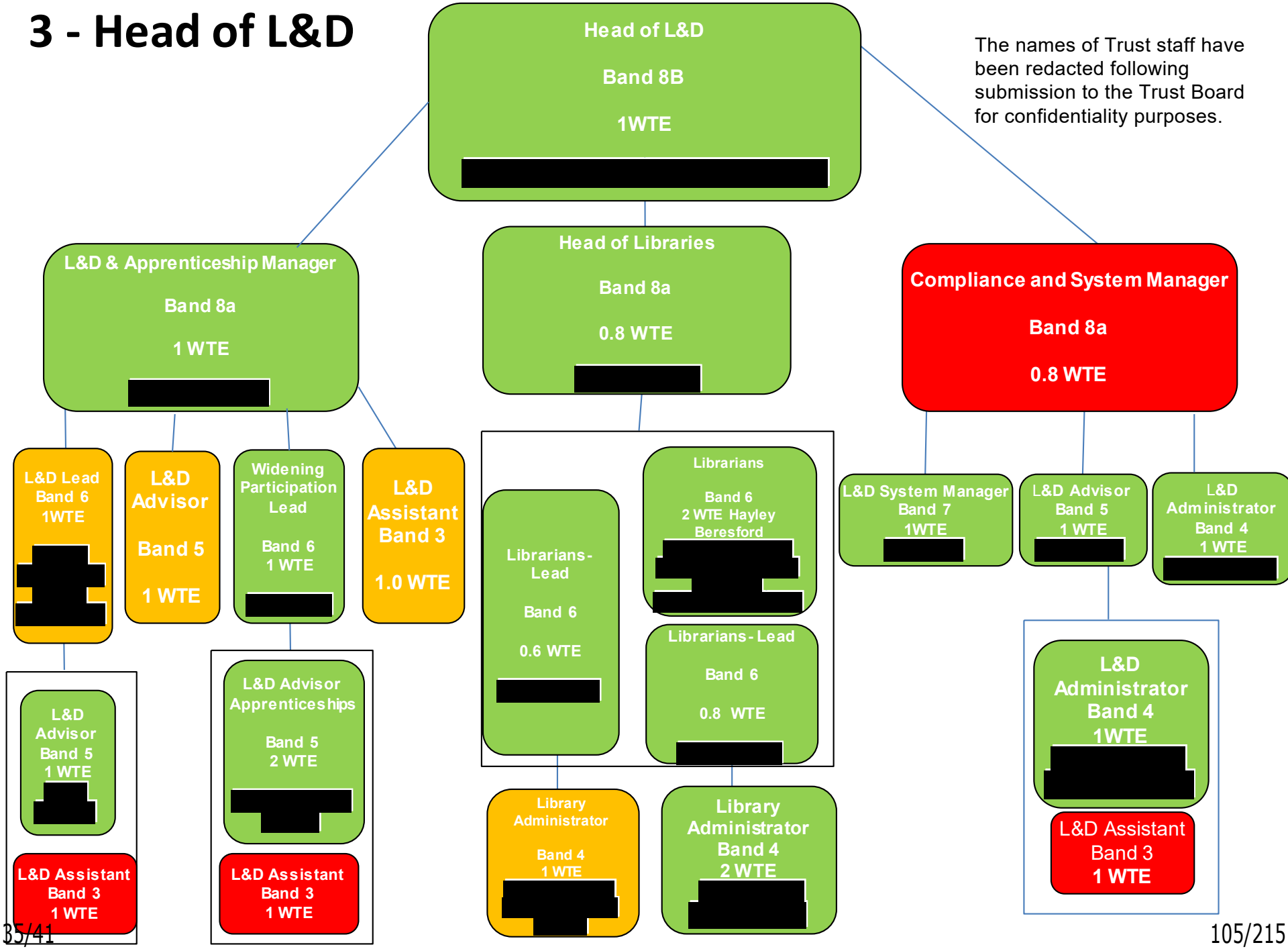
1- Head of OD


Head of OD
Band 8c
1WTE
The names of Trust staff have been redacted following submission to the Trust Board for confidentiality purposes.
Head of EDI & Engagement
8B (rebanded)
1WTE
[redacted]
Principal OD Practitioner
8B
1WTE
Head of Wellbeing
8B
1WTE (urgent)
Principal Clinical Psychologist
Band 8B
1WTE
EDI Lead
Band 7
1WTE
Engagement Lead
Band 7
1WTE
EDI & Engagement Officer
Band 5
1 WTE
[redacted]
Senior OD Practitioners
8a
3WTE
OD Projects, Events & Engagement
Band 6
1WTE
OD Administrator
Band 4
1WTE
Wellbeing Practitioners
Band 7
2WTE
Wellbeing Campaigns & Engagement Officer
Band 5
1WTE
Assistant Staff Psychologist
Band 6
1WTE

2 - Head of OH & FTSU

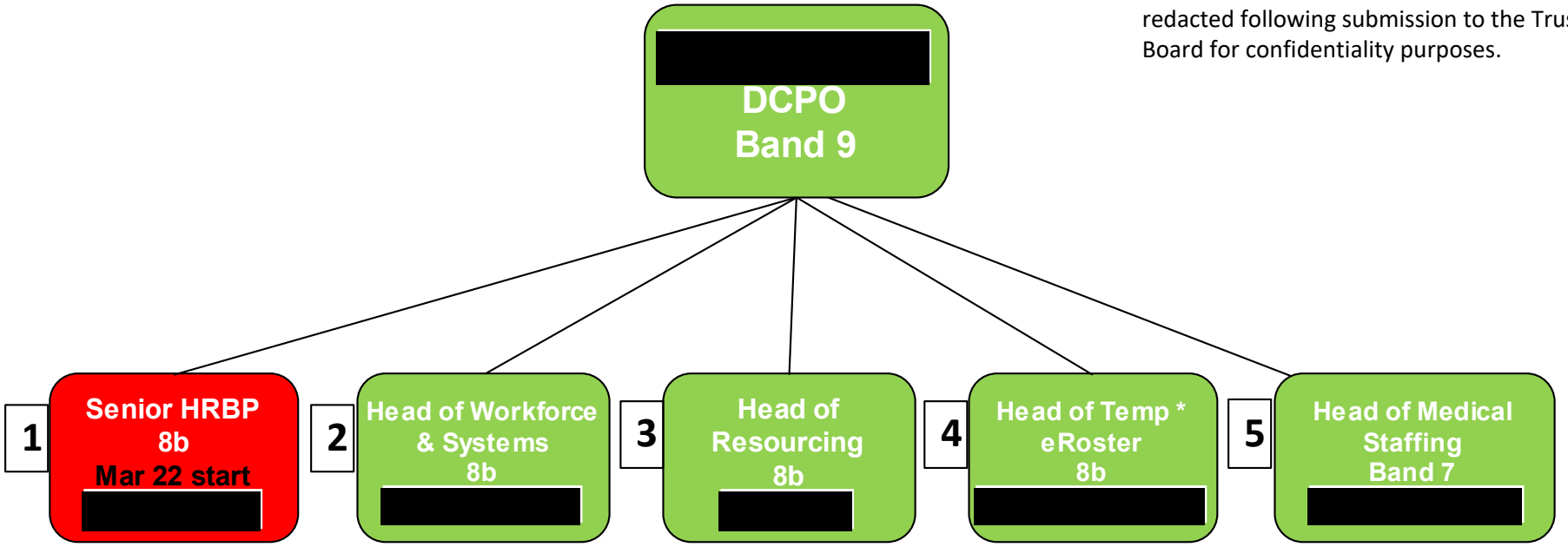


3 - Head of L&D


Head of L&D
Band 8B
1WTE
[redacted]
The names of Trust staff have been redacted following submission to the Trust Board for confidentiality purposes.
L&D & Apprenticeship Manager
Band 8a
1 WTE
[redacted]
Head of Libraries
Band 8a
0.8 WTE
[redacted]
Compliance and System Manager
Band 8a
0.8 WTE
L&D Lead
Band 6
1WTE
[redacted]
L&D Advisor
Band 5
1 WTE
Widening Participation Lead
Band 6
1 WTE
[redacted]
L&D Assistant
Band 3
1.0 WTE
L&D Advisor
Band 5
1 WTE
[redacted]
L&D Assistant
Band 3
1 WTE
L&D Advisor Apprenticeships
Band 5
2 WTE
[redacted]
L&D Assistant
Band 3
1 WTE
Librarians-Lead
Band 6
0.6 WTE
[redacted]
Librarians
Band 6
2 WTE Hayley Beresford
[redacted]
Librarians-Lead
Band 6
0.8 WTE
[redacted]
Library Administrator
Band 4
1 WTE
[redacted]
Library Administrator
Band 4
2 WTE
[redacted]
L&D System Manager
Band 7
1WTE
[redacted]
L&D Advisor
Band 5
1 WTE
[redacted]
L&D Administrator
Band 4
1 WTE
[redacted]
L&D Administrator
Band 4
1WTE
[redacted]
L&D Assistant
Band 3
1 WTE

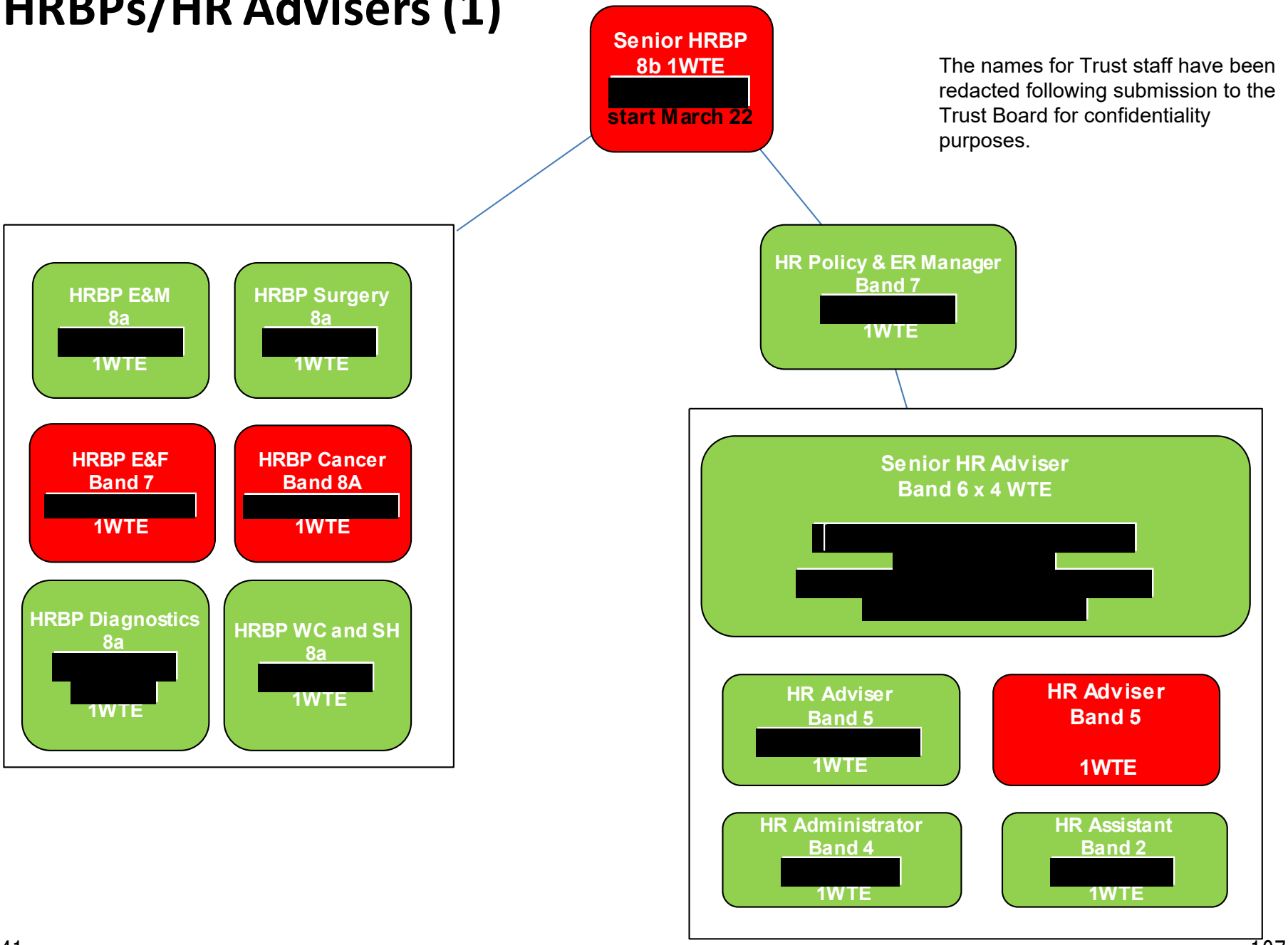
Deputy CPO People & Systems top structure

The names for Trust staff have been redacted following submission to the Trust Board for confidentiality purposes.



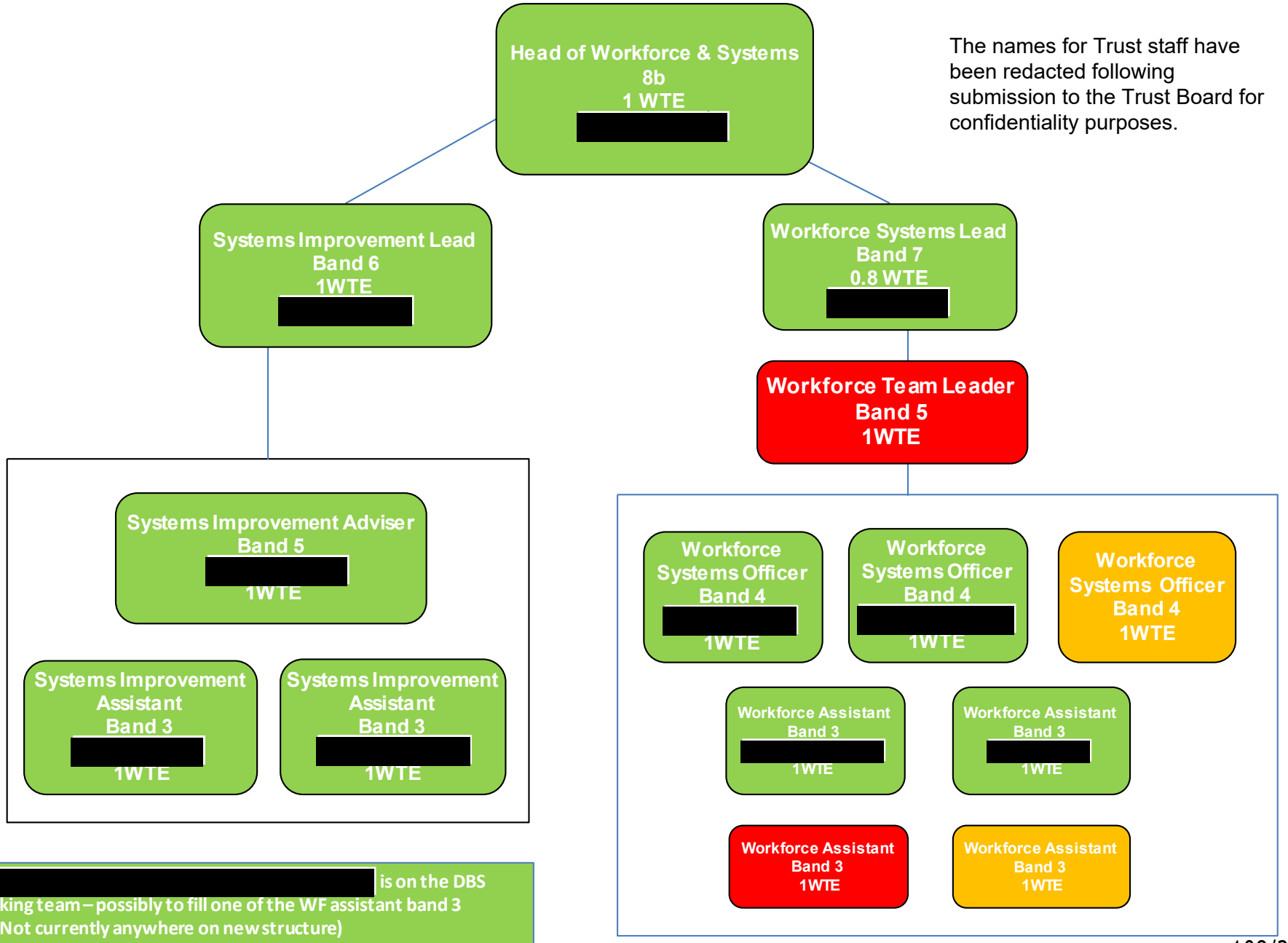
Existing Posts
Existing vacancies
Proposed posts

HRBPs/HR Advisers (1)



The names for Trust staff have been redacted following submission to the Trust Board for confidentiality purposes.

Workforce & Systems (2)

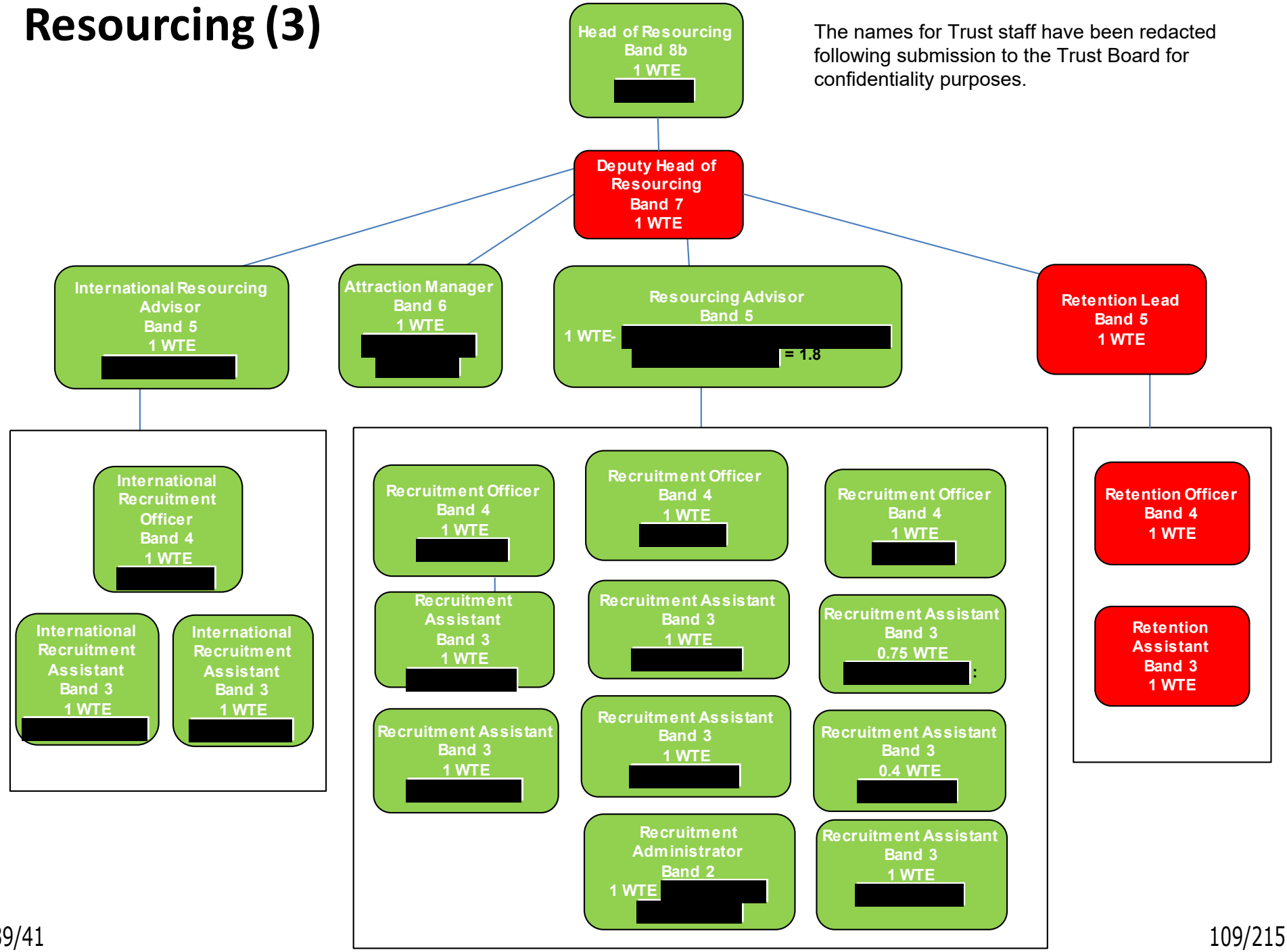


[redacted] is on the DBS rechecking team – possibly to fill one of the WF assistant band 3 posts.(Not currently anywhere on new structure)

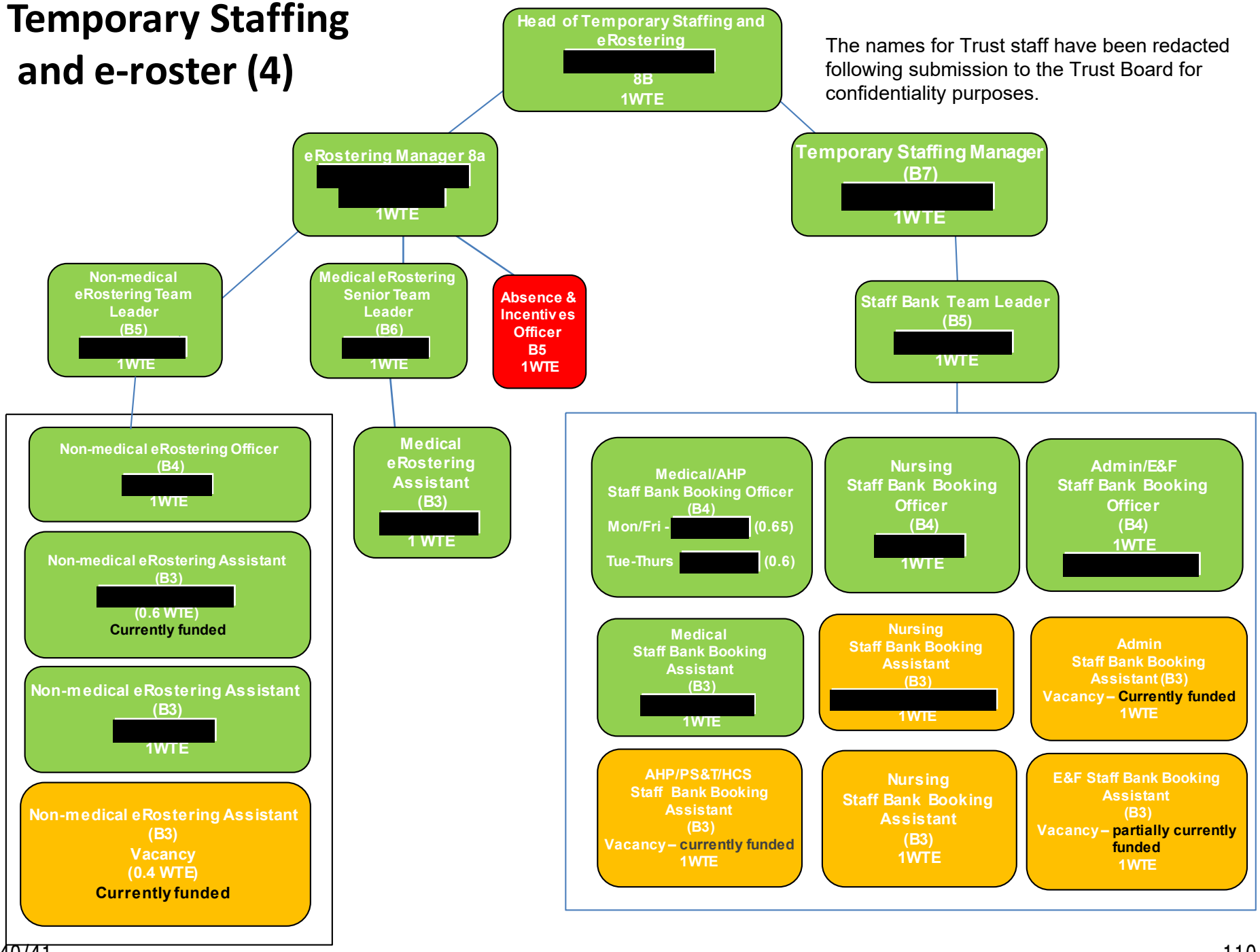
The names for Trust staff have been redacted following submission to the Trust Board for confidentiality purposes.

Resourcing (3)

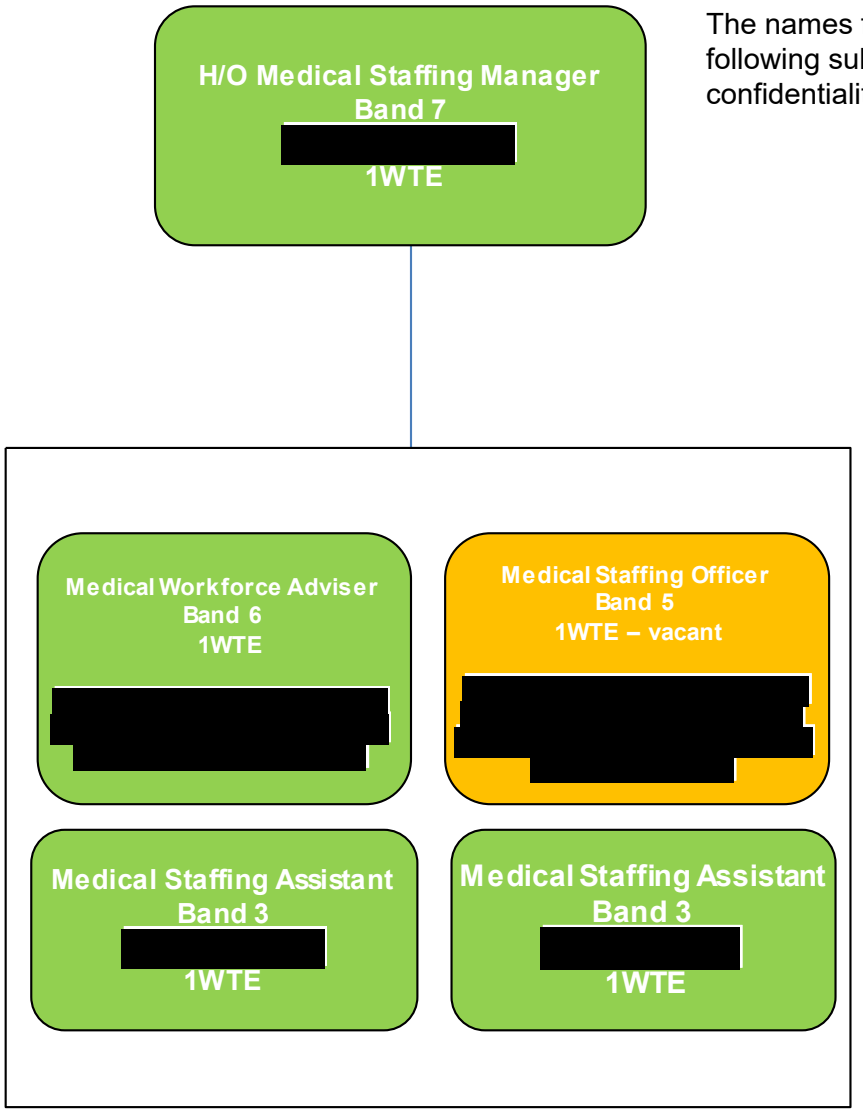
The names for Trust staff have been redacted following submission to the Trust Board for confidentiality purposes.



Temporary Staffing and e-roster (4)



Medical Staffing (5)



The names for Trust staff have been redacted following submission to the Trust Board for confidentiality purposes.

Quarterly maternity services report **Chief Nurse**

The enclosed report provides information about safety issues in Maternity, the themes and trends and the identified learning and action plans, including:

- The number and summary of Serious Incidents declared for Maternity Services **
- The number of Health Service Investigation Bureau (HSIB) cases reported **
- The number of Perinatal Mortality Review Tool (PMRT) case reviews*
- The key themes
- Learning
- The recommendations and actions
- The progress in implementing Saving Babies Lives Care Bundle v2*
- A Maternity staffing review summary

The report also provides assurance of progress in meeting the requirements of the Ockenden Report and Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme which each recommend that this information is shared with the Trust Board on at least a quarterly basis

*Clinical Negligence Scheme for Trusts (CNST) - Maternity Incentive Scheme requirement
**Ockenden recommendation requirement

Which Committees have reviewed the information prior to Board submission?

- 'Main' Quality Committee, 12.01.22, Executive Team Meeting, 18.01.22

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

Maternity Services Quarterly Update Report

Report to: Trust Board

Report from: Maternity Services

Date: January 2022 (reporting period October to December 2021)

Summary

This report provides an overview of the following for October to December 2021:

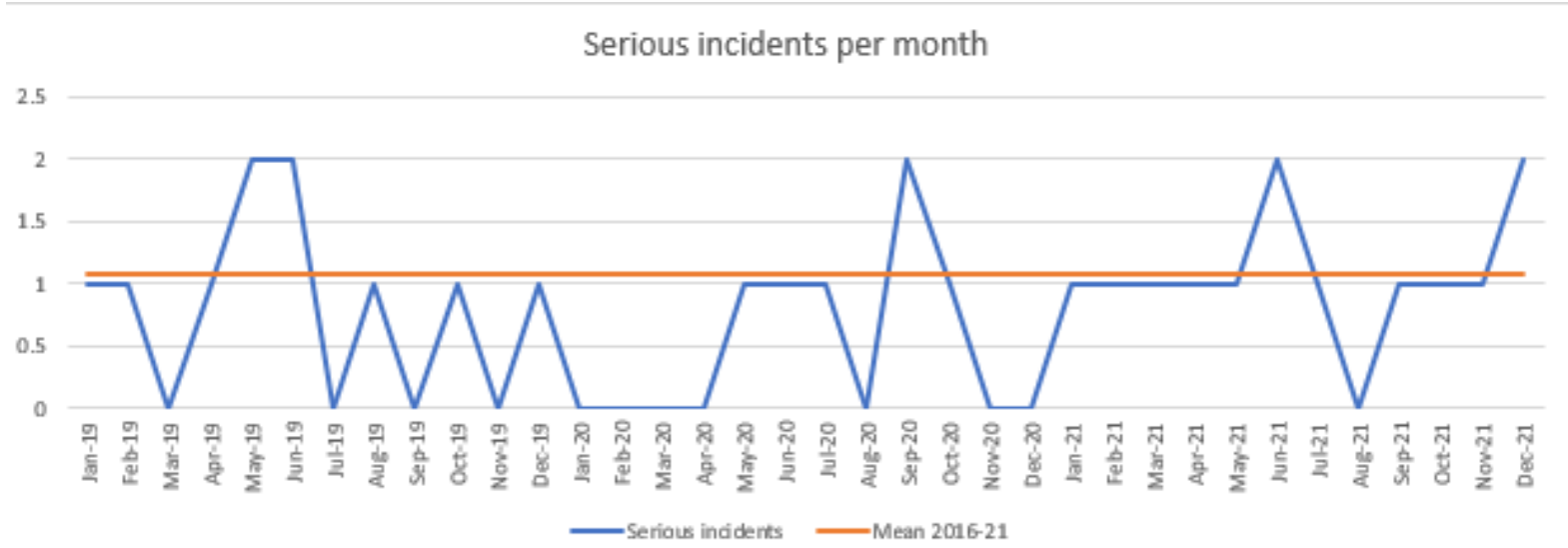
- Number and summary of Serious Incidents (SIs) declared for Maternity Services **
- Number of Health Service Investigation Bureau (HSIB) cases reported **
- Number of Perinatal Mortality Review (PMRT) case reviews*
- Key themes
- Learning
- Recommendations and actions
- Progress in implementing Saving Babies Lives Care Bundle v2 (SBLCBv2)*
- Staffing review summary*

*Clinical Negligence Scheme for Trusts (CNST) – Maternity Incentive Scheme requirement

**Ockenden recommendation requirement

Number of Internal Serious Incident's Declared: 3

STEIS Ref	Clinical Area	Synopsis
2021/152773	Delivery Suite, TWH	HSIB investigation – see below No care issues identified at 72 hour review
2021/153961	MBC / Delivery Suite, TWH	HSIB investigation – see below Immediate learning identified in collaboration with SECAmb and Children's Directorate
2021/TBC	Maternity Triage, TWH	28 week Neonatal Death following unplanned home birth Immediate learning identified in collaboration with SECAmb and Children's Directorate Investigation in progress

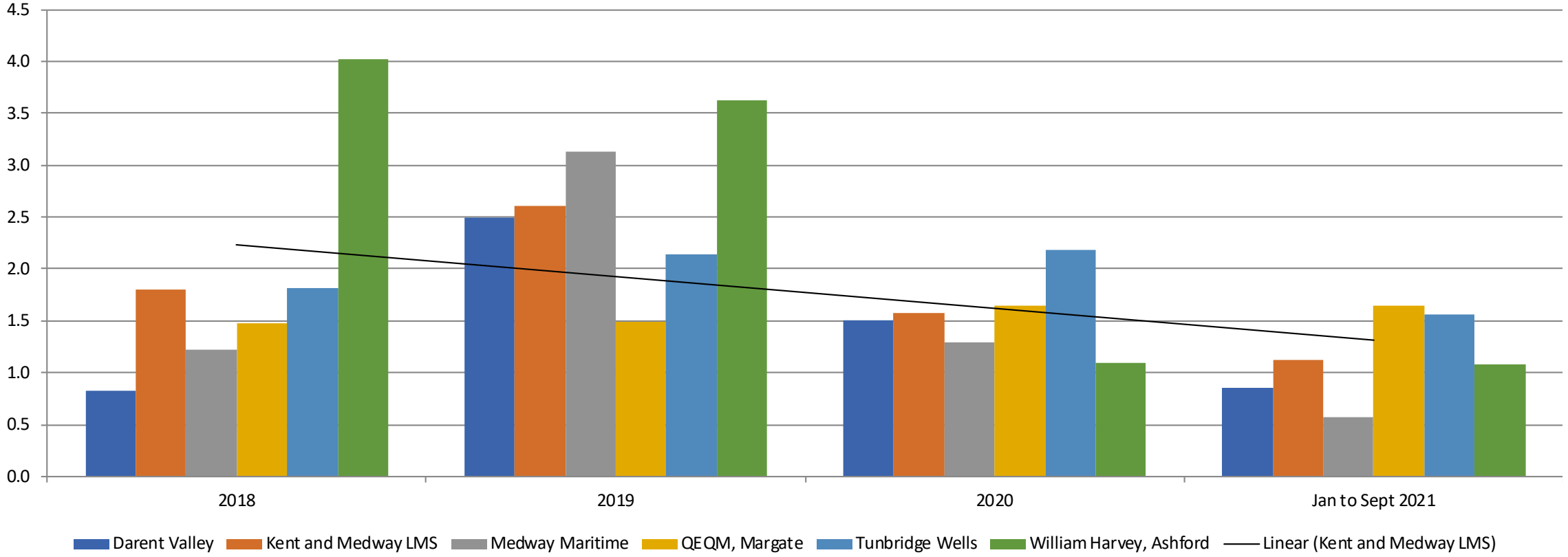


MTW Maternity
exceptional people, outstanding care

Number of Health Service Investigation Bureau Reported cases: 2

Ref	Clinical Area	Synopsis
2021/152773	Maternity Triage, TWH	G3 39+6wks gestation, Low risk pregnancy Attended Triage twice with abdominal pain and reduced fetal movements, discharged home following reassuring investigations Fetal growth measuring along the 97th centile Attended Triage with possible early labour and reduced fetal movements. Intrauterine death diagnosed HSIB investigation in progress
2021/153961	Delivery Suite, TWH	G2P1 41wks gestation. Low risk pregnancy. Labour and birth at MBC with shoulder dystocia Baby born in poor condition admitted to NNU sent to William Harvey for cooling HSIB investigation in progress

Comparative data for Hypoxic-ischaemic Encephalopathy (HIE) rates across Kent and Medway LMNS



In view of comparatively high rates at MTW, a task and finish thematic review is currently in progress, led by neonatologist Dr Park Hypoxic-ischaemic encephalopathy

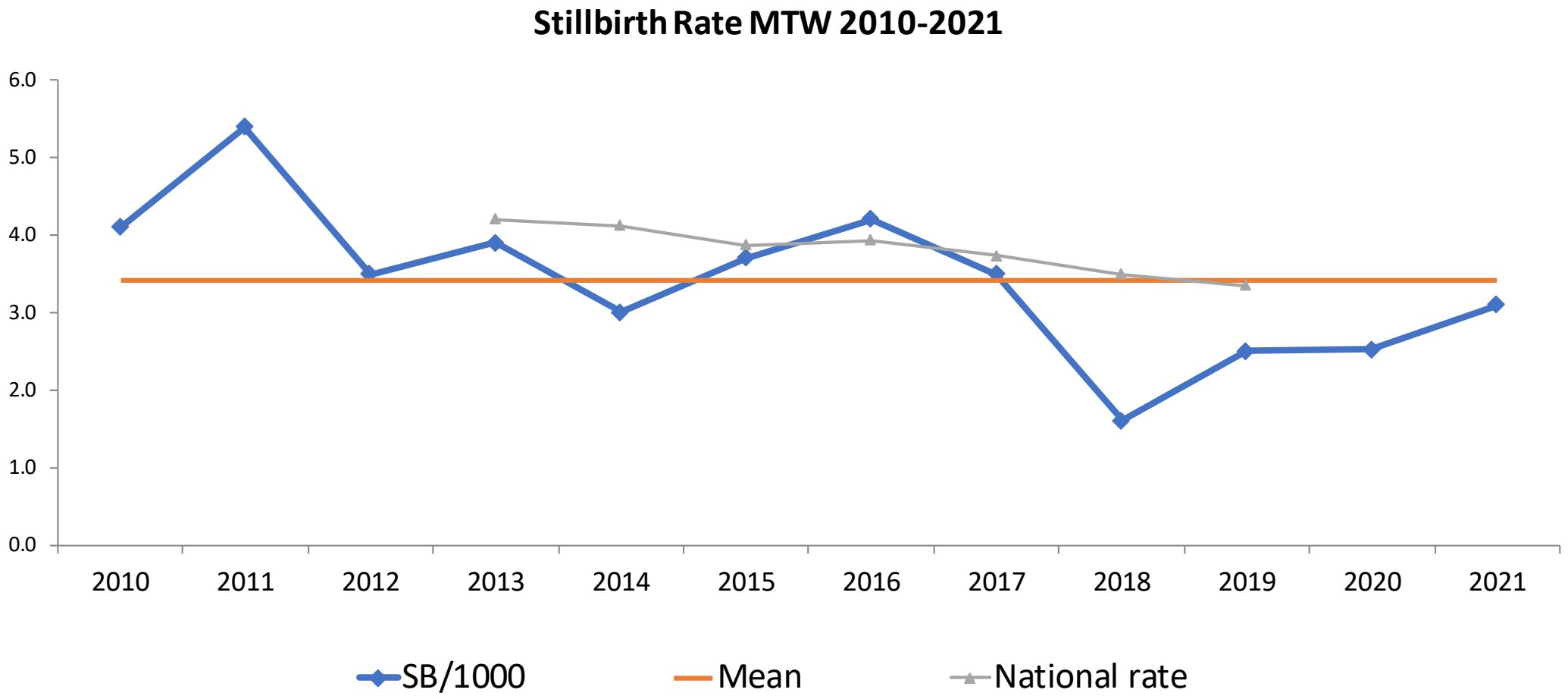
HSIB report received – findings and actions

Ref	HSIB Recommendations	Trust Actions
MI - 003862	No safety recommendations	Learning from incidental findings shared: • Fundal heights not plotted and need for growth scan not identified • Not invited in for assessment when contacted MBC with pv bleed • IOL not offered following SRM (inline with trust guideline, but not national guidance) • Fetal heart not monitored for a prolonged period during siting of epidural
MI - 003724	No safety recommendations	Learning from incidental findings shared: • Not referred for serial growth scans at booking or when serial fundal height measurement identified reduced growth

Number of Perinatal Mortality Review Tool (PMRT) case reviews: 3

PMRT ref	Clinical Area	Synopsis
ID776491	Maternity Triage, TWH	Ante partum stillbirth at 37 weeks G3 Low risk - growth scans in pregnancy, normal growth Presented with second episode of reduced fetal movements – IUD diagnosed Cause of death not determined at post mortem
ID77917	Delivery Suite, TWH	Early Neonatal Death at 28 weeks G5 P1 High risk pregnancy. Previous pregnancy loss at 22 weeks + 24 weeks. Smoking in pregnancy Spontaneous labour, breech presentation, delivered by caesarean section Neonatal resuscitation attempted, severe fetal abnormality, RIP 30 mins after birth Cause of death – fetal hydrops, lymphatic malformation
ID78351	Delivery Suite, TWH	Ante partum stillbirth at 35 weeks G3 P1, low risk pregnancy Attended Maternity Triage at 35/40 in early labour with reduced fetal movemnets. IUD diagnosed. Cause of death not determined at post mortem

Trends in stillbirths since 2010



Themes and Trends from investigations and case reviews

- Poor compliance with growth assessment protocol
- Failure to follow fetal monitoring guidelines
- Communication - SBAR handover
- Difficulty accessing 2nd obstetric theatre when required
- Staff shortages impacting services – home births and labour care at CBC suspended, specialist midwives and managers diverted to support clinical activity

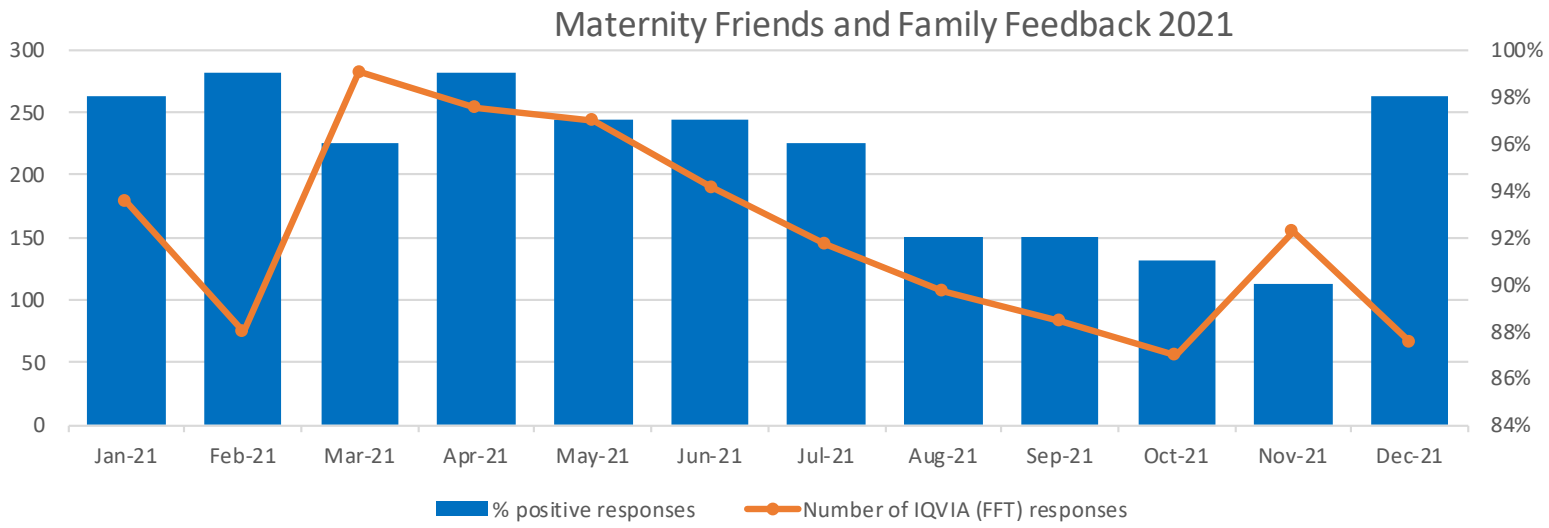
Recommendations and Actions

- Annual "deep-dives" – rolling programme of areas to review
- Safety summit to be launched to share outcomes of deep dive
- Thematic review of HIE cases, led by neonatologist Dr Park
- Recruit fetal surveillance midwife to support learning and decision making
- Continued support of junior staff to embed best practice and encourage good communication

Themes and trends from patient feedback

Complaints	
Number of new and themes from new formal complaints	▪ 12 complaints received ▪ Main theme is Communication
Key themes identified from closed complaints	▪ Complaints regarding mismanagement of labour but not upheld ▪ 3 complaints regarding damage to baby's head and face following instrumental delivery – not upheld

Friends and Family feedback



The number of responses collected varied from 55 to 282 per month. High rates were achieved during the pilot of a patient experience post

Positive feedback range 92-99%

Work in progress to improve response rates

Analysis of CQC Maternity Survey 2021 results in progress to inform quality improvements

Progress with Implementation of Saving Babies Lives Care Bundle version 2

Element	Compliance data		Actions
Smoking in pregnancy	CO monitoring at booking	95%	
	CO monitoring at 36 weeks	79%	SiP midwife working with community and ANC teams to improve compliance
Fetal growth restriction	Pregnancies where a risk status for fetal growth restriction is identified at booking and 20 week scan	100%	
Reduced fetal movements	Women who receive information about reduced FMs by 28 weeks	100%	
	Women attending with RFM who have a computerised CTG	94%	
Fetal monitoring	Staff attended annual MDT fetal monitoring training	52%	Training challenges due to staffing issues and increased activity. Action plan in place
	Lead midwife (0.4 wte) and Lead obstetrician (0.1 wte) are appointed	50%	Obstetrician appointed Midwife recruitment in progress
Preterm births	Live births <34 weeks having full dose of steroids within 7 days of birth	67%	All cases reviewed to ensure steroids given appropriately
	Live births occurring more than 7 days after first course of steroids	0%	All cases reviewed to ensure steroids given appropriately
	Singleton live births < 30 weeks receiving MgSO4 within 24 hours before birth	100%	
	Women giving birth in an appropriate care setting for their gestation	95%	All cases reviewed to ensure transferred considered appropriately

Progress with clinical workforce planning

Workforce	Latest review	Progress with actions
Maternity workforce	Birthrate plus review October and Decemebr 2020 and Nursing and Midwifery Staffing Review April 2021 Senior management safety review October 2021	Ockenden money is supporting some of the identified shortfall with a further business case being developed to support remaining shortfall Midwifery Challenges Workforce Report update, November 2021
Obstetric medical workforce	Review September 2021	New consultants appointed and job plans reviewed to increase weekend cover to meet Ockenden recommendations
Anaesthetic medical workforce	Obstetric anaesthetic cover meets national recommendations	
Neonatal medical workforce	Neonatal medical cover meets national recommendations	
Neonatal nursing workforce	Nursing and Midwifery Staffing Review April 2021	Business case for NNU BCP to meet BAPM recommendations

Perinatal Quality & Safety Dashboard	This is included as an Appendix in the monthly Trust-wide Integrated Performance Report (IPR)
Related Regulatory Requirements	Response to the Ockenden Report, December 2020 CNST Maternity Incentive Scheme – year four, August 2021 Transforming perinatal safety, December 2020
Author:	Sarah Blanchard-Stow, Divisional Director of Midwifery, Nursing and Quality Rachel Thomas, Deputy Head of Midwifery and Gynaecology Susan Powley, Matron for Governance, IT & Projects
Paper reviewed by:	
Action Required by the Trust Board	

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

The Annual Report from the Director of infection Prevention and Control (including Trust Board annual refresher training) is enclosed.

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

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
Assurance (and to provide Trust Board members with the annual infection control refresher training)

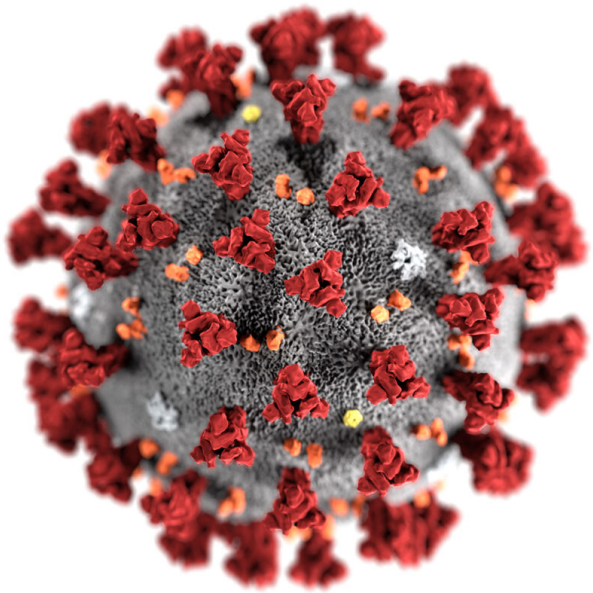
[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making;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

Maidstone and Tunbridge Wells NHS Trust

2020/21 Infection Prevention and Control Report

and

2021/22 Healthcare Associated Infection Reduction Plan



2020/21 Annual Infection Prevention and Control Report and 2021/22 Healthcare Associated Infection Reduction Plan

Introduction

This is a two-part document; a report on the developments and performance related to Infection Prevention and Control (IPC) during 2020/21 and the broad plan of work for 2021/22 to reduce the risk of healthcare associated infections (HCAIs). The report outlines the challenges faced in-year and the Trusts approach to reducing the risk of HCAI for patients.

A zero tolerance approach continues to be taken by the Trust to all avoidable HCAIs. Good IPC practice is essential to ensure that people who use the Trust services receive safe and effective care. Effective IPC practices must be part of everyday practice and be applied consistently by everyone. The publication of the IPC Annual Report is a requirement to demonstrate good governance and public accountability

The report acknowledges the hard work and diligence of all grades of staff, clinical and non-clinical who play a vital role in improving the quality of patient and stakeholder experience as well as helping to reduce the number of infections. Additionally, the Trust continues to work collaboratively with a number of outside agencies as part of its IPC and governance arrangements including commissioning CCGs, SECAMB, other local NHS Trusts and the members of the Kent and Medway ICS HCAI and antimicrobial stewardship steering group and its subcommittees

Executive Summary

The annual report for Infection Prevention and Control outlines the Trust's IPC activity in 2020/21. In addition it highlights the role, function and reporting arrangements of the Director of Infection Prevention and Control (DIPC) and the Infection Prevention and Control Team (IPCT).

The report also provides a briefing and training for Board members on the key information they need to fulfil their duties with respect to infection prevention and control.

Prevention and control of healthcare associated infections (HCAIs) is a key priority for Maidstone and Tunbridge Wells NHS Trust which has an infection prevention and control strategy and programme of activities including national initiatives for the reduction of infection rates.

The Infection Prevention and Control Team (IPCT) advises and co-ordinates activities to prevent and control infection; however, it is the responsibility of all staff in the organisation to comply with Trust policies and implement guidelines in their local area. The IPCT also works closely with other stakeholders in relation to strategies for

prevention of infection including NHSI, Commissioning CCGs, Public Health England and Regional Specialist Laboratories.

There are national contractual reduction objectives for *Clostridium difficile* infections and there are five other infections for which mandatory reporting to Public Health England is in place.

Clostridioides difficile infections

Meticillin Resistant *Staphylococcus aureus* (MRSA) bloodstream infections

Meticillin Sensitive *Staphylococcus aureus* (MSSA) bloodstream infections

Eschericia coli (E. coli) bloodstream infections

Klebsiella spp blood stream infections

Pseudomonas aeruginosa blood stream infections

In March 2020, SARS-CoV2 (COVID-19) was added to the list of reportable infections mandated by Public Health England.

In addition, MTW is a Sentinel site for reporting Influenza infection and also reports on cases of Respiratory Syncytial Virus (RSV) through the same reporting route.

The COVID-19 response has dominated the infection prevention work across the Trust for 2020/21 however all other activity has continued throughout the year

The structure and headings of the report follows the ten criteria laid out in the 2015 edition of the Health and Social Care Act 2008; Code of Practice in the prevention and control of infections and related guidance (also known as the Hygiene Code). A compliance statement is available on the Trust website.

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them

Governance and Monitoring

1.1 IPC Governance

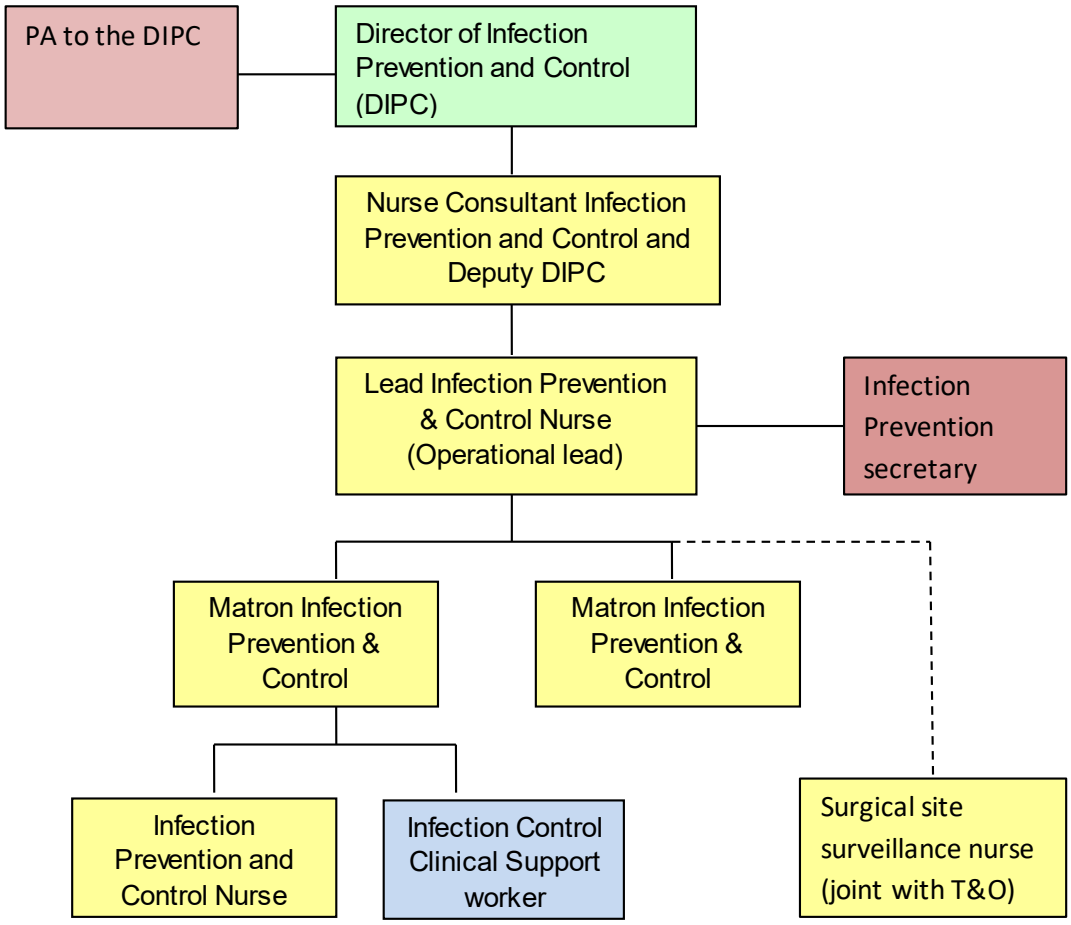
The Trust Board has collective responsibility for overseeing IPC arrangements in the Trust. The Chief Nurse is the executive lead for quality within the Trust

The Director of Infection Prevention and Control (DIPC) is a consultant microbiologist with specific training and experience in infection prevention and control and reports directly to the Chief Executive Officer. The DIPC was seconded to a neighbouring Trust on a half-time basis for an eight-month period commencing in August 2020.

The DIPC is supported by the Deputy DIPC (Nurse Consultant in Infection Prevention and Control) and the IPCT (Fig 1). Lesley Smith, Nurse Consultant left the Trust for a 16-month secondment to Public Health England in November 2020 and we were joined in January 2021 by Joanne Green who has taken on the roles of Nurse consultant and Deputy DIPC for one year. Jacqui Griffin, lead infection prevention nurse acted up in the interim period.

During the pandemic the PPE officer and PPE fit testing team joined the IPCT on a temporary basis.

Fig 1: Structure of the Infection Prevention and Control Team 2020-2021



The DIPC delivers an Annual Report to the Board of Directors and the forthcoming HCAI Reduction Delivery Plan based on the national and local quality goals.

The Trust Board receives a monthly IPC report, more frequently or on an ad hoc basis if required. *C. difficile* and MRSA and *E. coli* blood stream infection numbers and rates are detailed on the Board level dashboard together with MRSA screening rates. Since June

2020, the board has also received the COVID-19 IPC Board Assurance Framework on a monthly basis.

Directorates report to the Infection Prevention and Control Committee on IPC matters. The structured reports delivered by the directorate representatives include ward audit results, triangulation audits provided by the infection prevention team and antimicrobial audits provided by the antimicrobial pharmacist. The reports are also used to feedback to directorate clinical governance meetings on infection prevention matters.

Kent and Medway CCG was MTW's main commissioning organisation during 2020/21. IPC is a key element of quality commissioning and forms part of the joint commissioning quality schedule.

The *C. difficile* and MSSA review panel meets monthly on each hospital site and reviews root cause analysis reports from all Trust attributable cases of *C. difficile* and MSSA blood stream infections. The panel reports to the main Learning and Improvement (Serious Incident) panel and also sends a bi-annual summary report to the IPCC. Learning is shared through directorate clinical governance meetings

MRSA blood stream infections and outbreaks are declared as Serious Incidents and reports go directly to the main Learning and Improvement Panel

During the first and second waves of the pandemic, COVID-19 outbreaks were declared as Serious Incidents.

1.2 Infection Prevention and Control Committee

The Infection Prevention and Control Committee (IPCC) is chaired by the DIPC and meets bi-monthly. The committee has wide representation from services within the Trust and has external representation from West Kent CCG and Public Health England. The Chief Nurse is the Executive Director member of the committee

There was no meeting in April 2020 and all other meetings during this year have been held virtually due to social distancing rules. The requirement for written reports was relaxed in June due to pandemic pressures

The IPCC reports to the Quality Committee, a sub-committee of the Board

The clinical directorates report to the IPCC on all aspects of infection prevention and antimicrobial stewardship. Additional reports are received from estates and facilities, the vascular access team, the antimicrobial pharmacist, occupational health, risk manager, decontamination lead and others as required.

The objectives of the IPCC include:

- To advise and support the Infection Prevention and Control Team.
- To provide assurance to the Quality Committee with respect to infection prevention and control structure, processes and outcomes and compliance with CQC requirements as set out in the 'Hygiene Code' (The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance).

- To inform the Quality Committee in a timely manner of any serious problems or hazards relating to infection control.
- To receive reports from the Infection Prevention and Control Team.
- To monitor Healthcare Associated Infection against key performance indicators including receiving reports on compliance data from Directorate representatives.
- To discuss and approve Infection Prevention and Control policies.
- To review the annual infection control programme and audit programme.
- To ensure the implementation of national guidance, and action plans arising from Patient Safety alerts relating to Infection control
- To monitor progress against CQUIN targets related to infection control

The IPCC reviews the IPC related risks in the risk register and receives reports from the risk manager three times per year.

Healthcare Associated Infection Statistics and Targets

1.3 Surveillance

The IPCT undertakes continuous surveillance of target organisms and alert conditions. Patients with pathogenic organisms or specific infections (see list of alert organisms and conditions below), which could spread, are identified from microbiology reports or from notifications by ward staff. The IPCT advises on the appropriate use of infection control precaution for each case and monitors overall trends.

The IPCT uses the ICNet surveillance system.

The IPCT actively participates in national surveillance schemes, submitting epidemiological data on all *C. difficile* cases, MRSA, MSSA, *E. coli, Klebsiella* and *Pseudomonas* blood stream infections and selected surgical site infections to Public Health England (PHE).

MTW is a Sentinel site for reporting Influenza infection and also reports on cases of Respiratory Syncytial Virus (RSV) through the same reporting route.

The IPC team visit patients at regular intervals according to their infection or possible infection. Such infections/conditions are listed below:

1.3.1 Alert organisms

MRSA

Clostridioides difficile infection (CDI)

Group A *Streptococcus*

Salmonella spp

Campylobacter spp

Mycobacterium tuberculosis

Glycopeptide-resistant *Enterococci*

Multi-resistant gram-negative bacilli e.g. extended spectrum beta-lactamase (ESBL)producers

Carbapenem resistant and Carbapenemase-producing Enterobacteriaceae (CRE/CPE)

Neisseria meningitidis

Aspergillus

Hepatitis A

Hepatitis B

Hepatitis C

Influenza

Norovirus

1.3.2 Alert Conditions

Measles

Mumps

Chicken pox and Shingles

Scabies

Two or more possibly related cases of acute infection e.g. gastroenteritis such as norovirus

HCAI Reduction Priorities for 2019/20

The national HCAI objectives for MTW for 2019/20 set by NHSE were:

- MRSA – a continued zero tolerance to all MRSA blood stream infections
- CDI – to have no more than 55 patients with Trust-attributable CDI.

In addition the HCAI action plan set out to:

- To achieve no avoidable hospital acquired MSSA blood stream infection
- Reduce gram-negative blood stream infection (national target for 50% reduction in healthcare associated infections by 2024/25

1.4 *Staphylococcus aureus*

All *Staphylococcus aureus* blood stream infections, whether sensitive to Meticillin (MSSA) or resistant to Meticillin (MRSA), are reported on a mandatory basis through the Public Health England (PHE) HCAI Data Capture System (DCS). The Trust's incidence of MSSA and MRSA cases is publicly reported on the fingertips data base together with other HCAI data https://fingertips.phe.org.uk/profile/amr-local-indicators/data#page/0/gid/1938133070/pat/158/par/NT_trust/ati/118/are/RWF

The incidence of these cases is reported publicly as acute Trust attributable or otherwise. The reduction of all avoidable blood stream infections including MSSA and MRSA continues to be an aim of the Trust

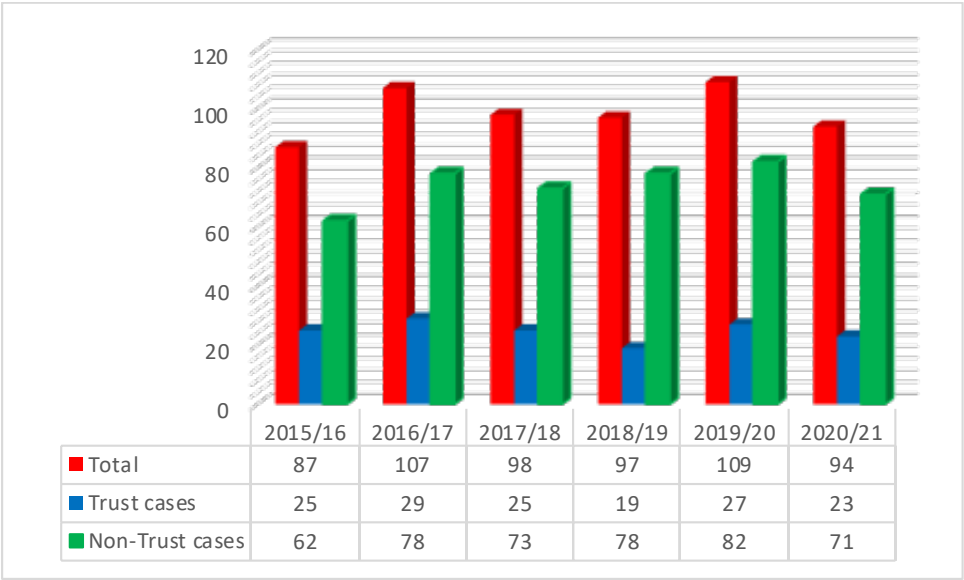
1.4.1 MSSA

There is no national objective set for MSSA bacteraemia.

All Trust-attributable (those occurring from day 2 after admission) cases of MSSA blood stream infection have a post – infection review including root cause analysis and presentation of the case at the Infection Control Review Panel.

During COVID waves the process was changed; the infection prevention team collected data and chronology for each case and the DIPC and deputy DIPC reviewed the cases to determine root cause, feeding back learning to ward teams and matrons. The panel meetings were reinstated during the summer months in 2020.

Fig 2: MSSA bacteraemia cases

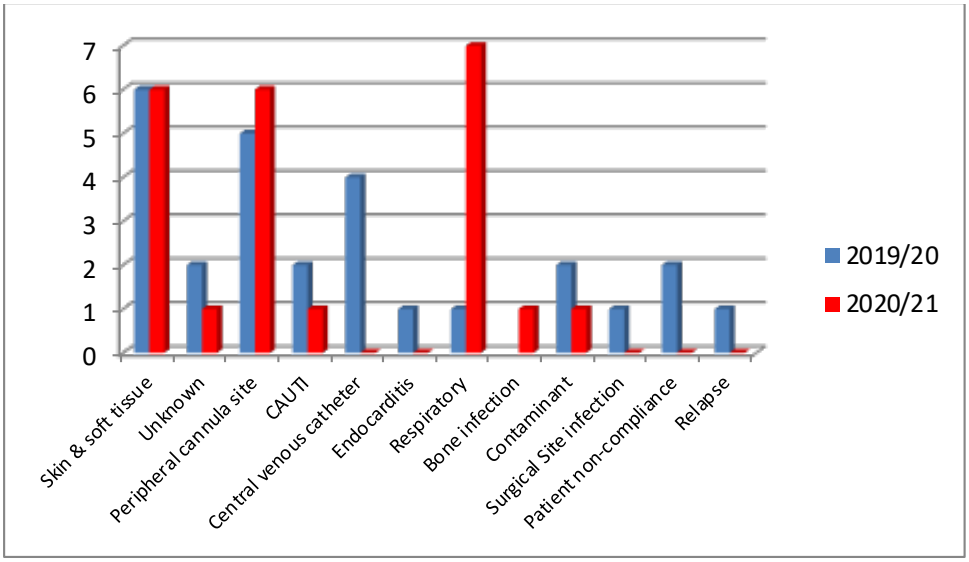


	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Total	87	107	98	97	109	94
Trust cases	25	29	25	19	27	23
Non-Trust cases	62	78	73	78	82	71

Some improvement was seen although not to the levels seen in 2018/19. A reduction of 4 cases of hospital acquired bacteraemia was seen. Of the 23 cases, 6 were avoidable.

Seven cases were seen in Red (COVID) ITUs during the second wave of COVID in November 20 – March 21 and this is reflected in the high number of respiratory infections associated with MSSA bacteraemia shown in Figure 3

Figure 3: MSSA bacteraemia provenance 2019/20 – 2020/21



1.4.2 MSSA screening

MSSA has been known to be a major cause of orthopaedic surgical site infection and prosthesis infection for many years. One third of the normal population have nasal colonisation with *Staphylococcus aureus*. A screening programme for pre-operative total hip and knee replacement was introduced in November 2014. Patients found to be positive on pre-operative screening are treated with nasal antibiotic cream to reduce their risk of post-operative infection.

1.4.3 MRSA

There was no national HCAI objective for MRSA blood stream infections for 2020/21. However there was an expectation that no avoidable infections would be seen.

Cases are initially defined as non-trust apportioned if blood cultures are collected on the day of admission or the next day. All other cases are apportioned to the Trust. The national requirement for MRSA Post Infection Review (PIR) was withdrawn this year; however the Trust and WKCCG continued to use the process to apportion cases.

In line with the PIR process the Trust investigates every MRSA blood stream infection in collaboration with other care providers associated with the case. This process identifies lessons to be learned across the patient's pathway and determines the final assignment of the case to the CCG, Trust or Third Party.

The Trust has reported one non-Trust apportioned case and three Trust apportioned cases. Two Trust apportioned cases were for the same patient. The Trust cases were declared as Serious Incidents and further investigated through the SI process.

The root causes were found to be as follows:

Case 1: Recurrence of deep-seated infection related to metal work in the right ankle from previous injury

Case 2&3: First bacteraemia: Hospital acquired MRSA from an unknown source
Second bacteraemia: Line infection despite repeated systemic treatment for MRSA which failed to decolonise patient

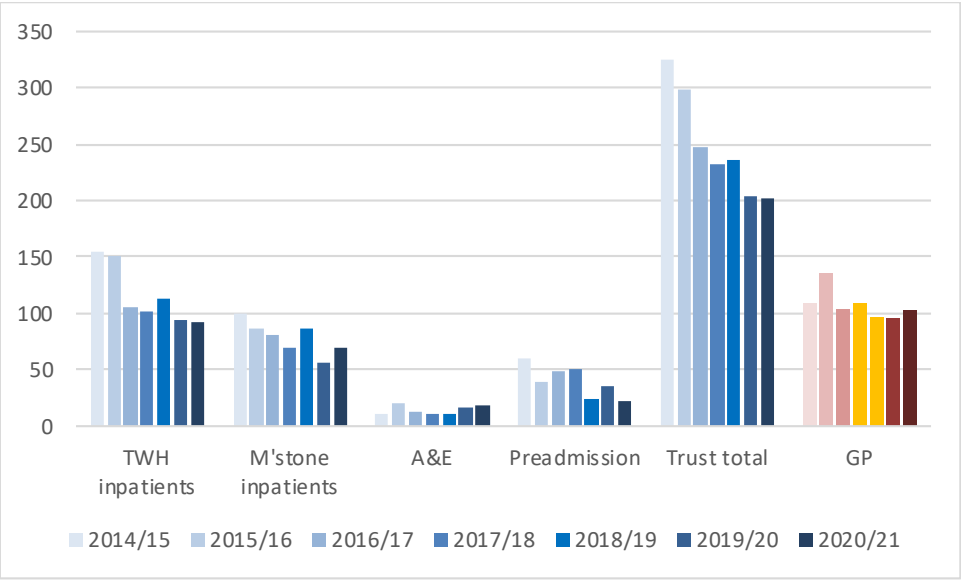
1.4.4 MRSA screening

The Trust continues to use a robust approach to screening the majority of patients, either pre-operatively or on admission. Since 2009, it has been Trust policy to screen all elective admissions (except for certain excluded groups) to comply with Department of Health policy. New guidance was published by the Department of Health in June 2014 (*Implementation of modified admission MRSA screening guidance for NHS* (2014). The guidance outlines a more focussed, cost-effective approach to MRSA screening. Following the publication of the guidance the screening at MTW was reviewed and revised. The revised policy was implemented in November 2014. Rates of MRSA infection and colonisation have remained relatively low and further revision has not been required although new guidance is anticipated in late 2021.

New patients who are colonised are usually identified within 24 hours of admission. Advances in laboratory testing enable a positive result to be available 18 hours after the specimen arrives in the laboratory. Colonised patients are also identified as a result of clinical samples. In turn, this allows effective decolonisation of the patient to be started in a timely manner, reducing the risk of infection and spread to other patients. Patients who remain in hospital for more than a week are rescreened on a weekly basis.

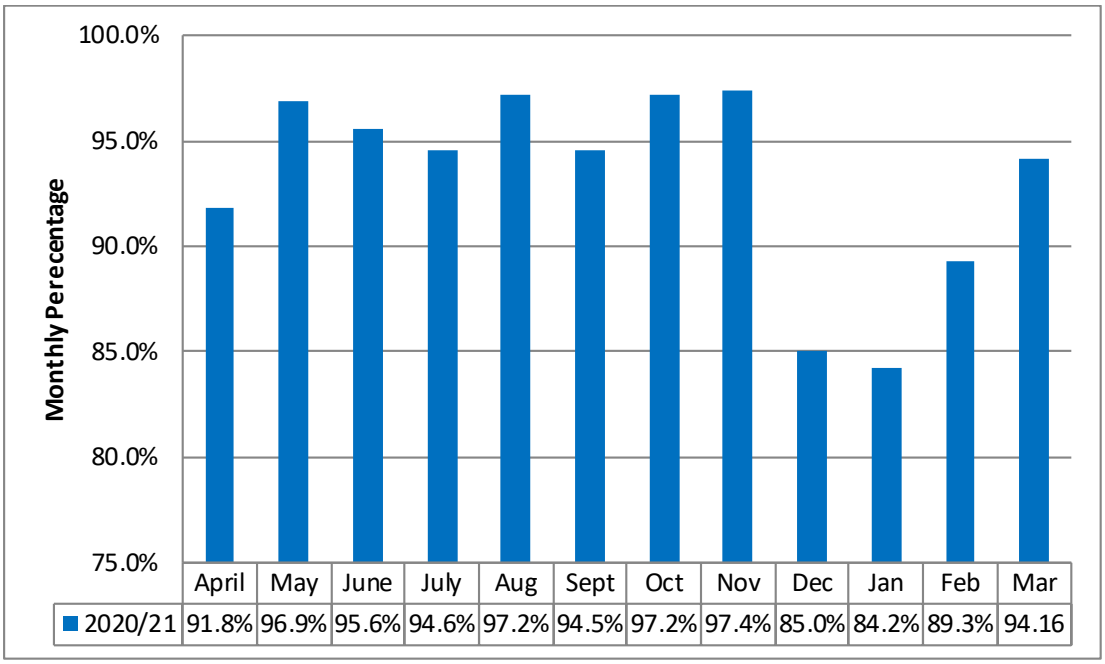
Patients who are known to be colonised are commenced on the decolonisation protocol on admission

Figure 4: New MRSA colonisations 2015-21



Non-elective screening compliance is monitored on a monthly basis. Due to the clinical pressures caused by the pandemic, compliance with MRSA screening was lower than the target of 95% during the pandemic peak months

Fig 5: MRSA screening 2020/21



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2020/21	91.8%	96.9%	95.6%	94.6%	97.2%	94.5%	97.2%	97.4%	85.0%	84.2%	89.3%	94.16

The number of patients who may have acquired MRSA colonisation in hospital is also monitored and investigated. For 2020/21, 3 such cases were identified at Maidstone Hospital and 12 cases at TWH. There were several investigations into possible cross infection but none were declared as outbreaks.

1.4.5 Periods of Increased Incidence

Where two or more new (post 48 hour) acquisitions (whether related or not) of MRSA colonisation are identified by screening on the same ward, a Period of Increased Incidence (PII) is declared for the ward where the acquisitions occurred. A single case of MRSA bacteraemia will also trigger a PII.

When the PII is declared the following actions are taken:

- Weekly audits of compliance with the *Control and Management of Meticillin Resistant Staphylococcus aureus (MRSA) including Screening and De-colonisation policy*
- Weekly audits of antibiotic prescribing
- The antibiograms of the MRSA isolates are examined for similarity. If the isolates are indistinguishable by antibiogram, they are sent to the reference laboratory for further typing and genetic finger printing.
- Where cross infection is proven:
    - An incident investigation is initiated.
    - Ward staff may be screened if further cases are identified

1.5 *Clostridioides difficile* infection (CDI)

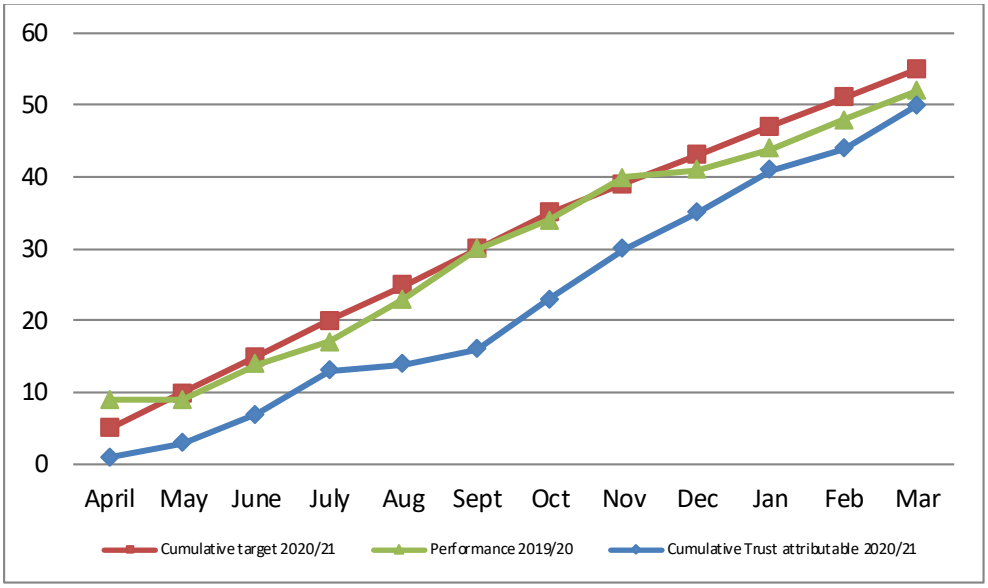
The CDI PHE objective for MTW for 2020/21 was unchanged at no more than 55 cases.

Cases are designated into one of four groups:
Hospital-onset healthcare-associated (HOHA) - Date of onset is ≥ 2 days after admission (where day of admission is day 1)
Community-onset healthcare-associated (COHA) - Date of onset is < 2 days after admission and the patient was admitted to the trust in the 4 weeks prior to the current episode
Community-onset indeterminate association (COIA) - Date of onset is < 2 days after admission and the patient was admitted in the previous 12 weeks, but not the previous 4 weeks prior to the current episode
Community-onset community-associated (COCA) - Date of onset is < 2 days after admission and the patient had not been admitted to the trust in the previous 12 weeks prior to the current episode.

Only healthcare in acute Trusts counts towards the definitions, inpatients in community settings such as cottage hospitals are counted as community cases.

In 2020/21 a total of 50 Trust attributable cases were seen, 35 HOHA cases and 15 COHA cases, a total rate of 18.1 cases per 100 000 bed days (compared with 21.4 for the previous year).

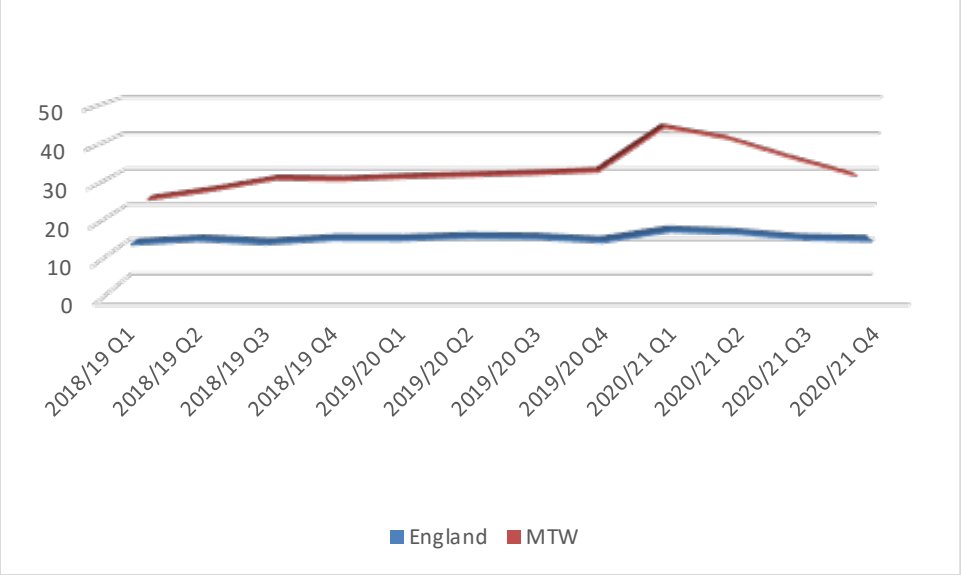
Figure 6: *C. difficile* performance against trajectory



1.5.1 Laboratory Diagnosis

C. difficile tests are processed on diarrhoea samples according to national guidelines. During 2020/21, the microbiology laboratory processed 6978 samples for *C. difficile* including those from GP patients, inpatients in acute or community settings, MTW A&E and outpatient attenders.

Figure 7: *C. difficile* toxin tests per 1000 bed days compared with England average 2018/19 to 2020/21



133 patients were newly identified as carriers of toxigenic *C. difficile* (109 in 2019/20). A treatment algorithm is in place to enable identified carriers at high risk to be treated to avoid progression to acute infection.

All toxin positive cases are sent to the reference laboratory for ribotyping to detect any possible links between cases. Further testing can be requested where a link between cases is possible.

Ribotyping enables us to be confident that we are not seeing patient to patient transmission of *C. difficile* infection

1.5.2 Case review

All healthcare-associated cases of *C. difficile* infection (CDI), both community onset and in-patient, are assessed by root cause analysis investigation. The IPCT works collaboratively with the CCG infection control teams to investigate COHA cases.

Root cause analysis multidisciplinary meetings are held for all HOHA and COHA cases. This enables any lessons associated with cases arising in the community to be learned and ensures that the impact of inpatient treatment on patients is understood. During peaks of COVID, data collection and analysis was done by the infection prevention and control team with review by the DIPC and deputy DIPC to confirm root cause in order to release clinical time. Outcomes and learning were fed back to the clinical teams

Where multidisciplinary meetings have been possible, the case goes to the *C. difficile* panel where the RCA is examined by the DIPC and Chief Nurse or their deputies. There is an expectation that the ward manager and consultant for the case will attend as a minimum.

All hospital-attributable cases were considered either by the panel or following IPT data collection. The outcomes of root cause analysis shown in the table below.

Table 1: Root causes of *C. difficile* infection

Cross infection	Inappropriate antibiotics	Appropriate antibiotics	Relapse
1	5	43	1

Six cases were found to be avoidable due to cross infection and inappropriate antibiotics being prescribed. A Serious Incident was declared for the case of cross infection.

The root cause analysis process identifies if there are any lapses in care that were likely or not to have contributed to the patient developing *Clostridium difficile* infection. The main areas for learning are:

- Delay in sending stool specimen and missed opportunities
- Diarrhoea rapid risk assessment not completed
- Incomplete documentation on stool charts

Actions plans were developed in response to all identified issues. The wards are monitored by infection prevention team audits and antibiotic prescribing audits throughout the periods of increased incidence (PII) and are subject to spot checks after the PII has been stepped down to ensure that sustainable change has been made.

1.5.3 Periods of Increased Incidence

The concept of Periods of Increased Incidence was introduced in the 2009 HPA/DH guidance '*Clostridium difficile* – How to deal with the problem'.

The guidance recommends that a PII should be declared when two cases occur in the same clinical area within a 28 day period. At MTW a PII is declared for the ward area whenever a new case of *C. difficile* is diagnosed. This increased response to a single case was implemented to identify and resolve any issues on the ward or associated with antibiotic prescribing in a timely way and has been successful in mitigating the risk of a second case occurring.

In response to the PII declaration, several actions have to be taken:

- Weekly audits of antibiotic prescribing by the antimicrobial pharmacist
- Weekly audit of the ward using the *C. difficile* High Impact Intervention audit tool until a score of >90% is achieved for three consecutive weeks and there have been no more cases during that time
- If poor audit scores are seen, an escalation meeting is held between the ward manager, matron and infection prevention to assess the need for additional support and training from the IPT
- Increased cleaning with throughout the ward with all single rooms decontaminated on discharge by either UV-C light or HPV fogging (depending on risk)
- Daily review by the infection control team

- When a PII is stepped down the ward is subject to random spot checks over the next month to ensure that improvement is sustained. If a ward fails a spot check, the PII is re-declared

If a second case occurs in the same ward area the PII is escalated to an incident and an investigation commences. If ribotyping leads to suspicion of cross infection or there is a third case, the incident is escalated to an outbreak and the Outbreak Policy is followed. A Serious Incident is also declared at this point. Additional IPC support is provided to wards where incidents occur

Changes were made to this process during peaks of COVID; a single ward audit was undertaken and where the audit score was >90%, no further audits were undertaken.

During 2020/21, thirty-two PIIs were declared for *C. difficile*, twelve at Maidstone and twenty at TWH. Five PIIs were re-declared due to standards not being maintained after initial closure. Six wards had two PIIs during the year, three wards had three and one ward had four. The PIIs lasted an average of five weeks with the longest period being eleven weeks. The majority of wards achieved the standard required in four weeks or less.

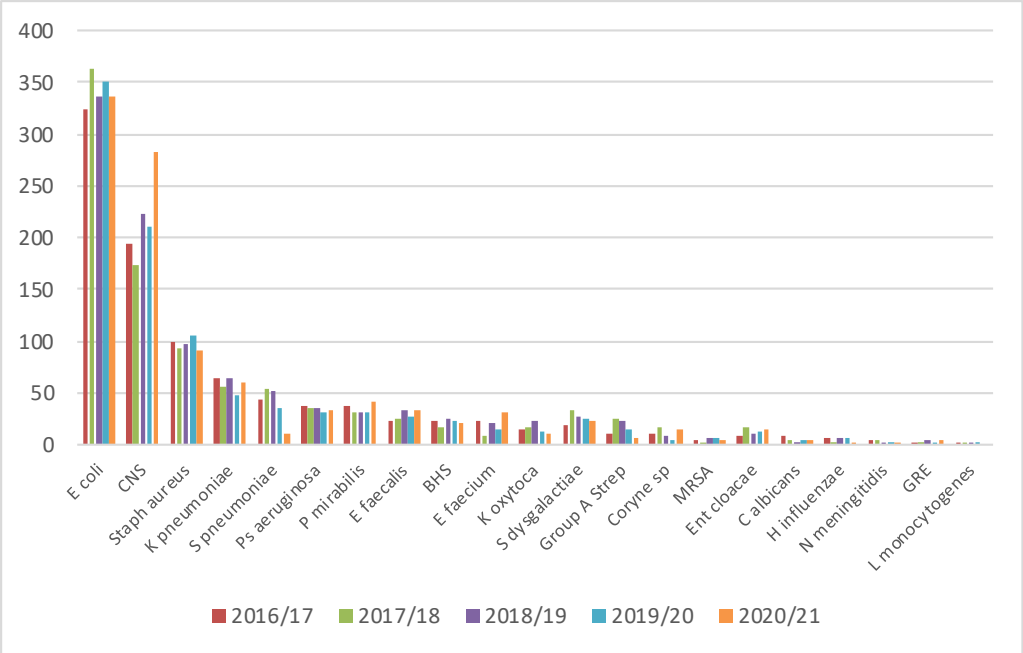
1.5.4 Non-Trust attributed CDI cases

There was an increase in the number of patients with non-Trust attributable CDI from 36 cases in 2019/20 to 56 cases in 2020/2021

1.6 Blood stream infections

A total of 1037 patients had positive blood cultures during 2020/21, a decrease (66 patients) on the previous year. *E. coli* is the commonest organism causing blood stream infection in the Trust accounting for around 33% of all positive cultures.

Figure 8: Commonest significant isolates from Blood cultures 2016-2021



Some isolates are seen in small numbers but are highly significant for their ability to cause severe infection. They include *Neisseria meningitidis* (a cause of meningitis), *Listeria monocytogenes* and glycopeptide resistant *enterococcus*

1.6.1 Gram negative blood stream infections

The NHS Long Term Plan supports a 50% reduction in Gram-negative bloodstream infections (GNBSIs) by 2024/25.These include:

- *E. coli*
- *Klebsiella species*
- *Pseudomonas aeruginosa*

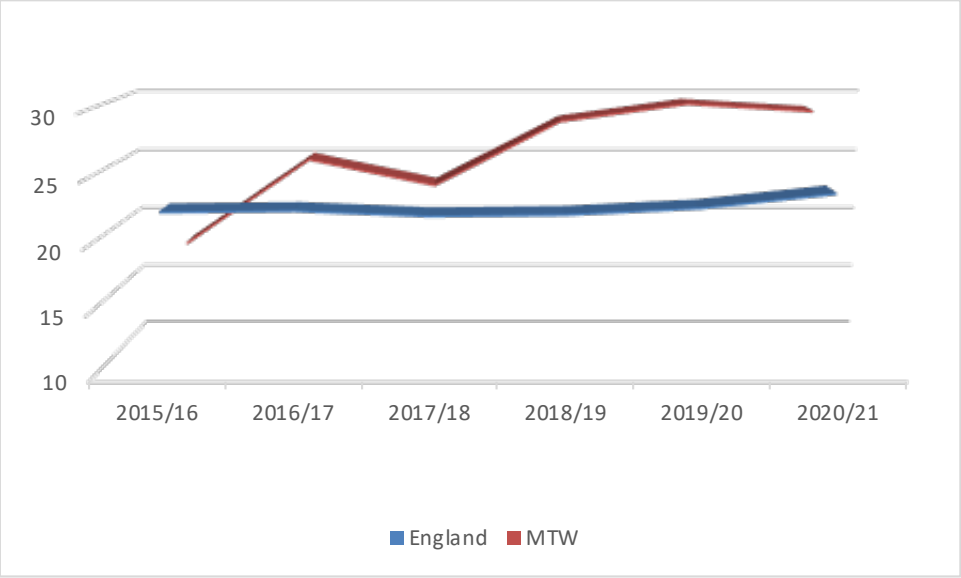
The Trust has been submitting *E. coli* surveillance data to PHE for many years and from April 2017 *Klebsiella species* and *Pseudomonas aeruginosa* data was also required

1.6.2 *Eschericia coli (E. coli)* bacteraemia

E. coli bacteria are frequently found in the intestines of humans and animals. There are many different types of *E. coli* and while some live harmlessly in the intestine, others may cause a variety of diseases. *E. coli* bacteraemia may be caused by primary infections such as urinary tract infections, biliary tract infections and others, spreading to the blood. The MTW rate of *E. coli* infections for 2020/21 was 28.9/100 000 bed days compared with an England rate of 23.7/100 000 bed days. This does not reflect the numerical reduction from 75 to 54 cases as bed occupancy was lower during the first wave of the pandemic.

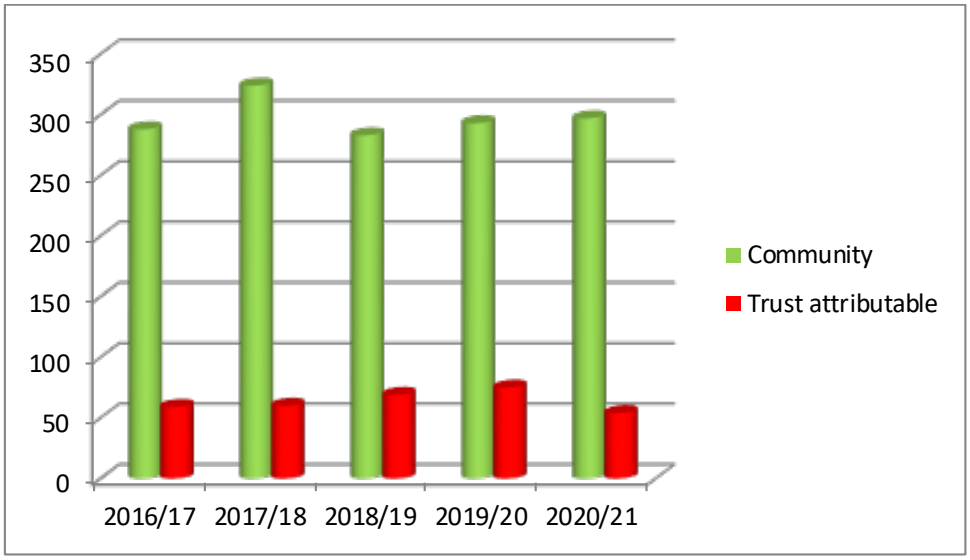
E. coli is the commonest cause of bacteraemia (all sources) seen in MTW

Figure 9: Hospital onset rates of *E.coli* bacteraemia



The rate of *E.coli* bacteraemia in hospital and in the community has not decreased despite interventions such as improvements in urinary catheter management.

Figure 10: Cases of *E. coli* bacteraemia 2016-2021



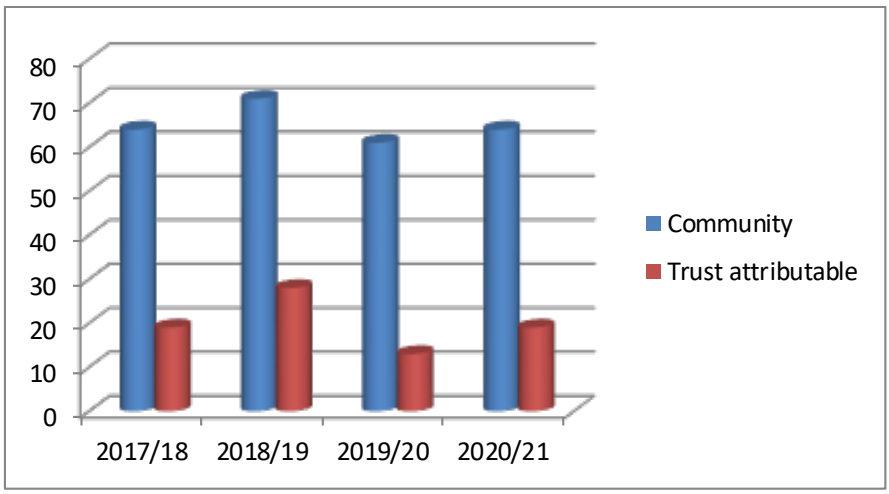
Previous actions taken to reduce the rate of *E. coli* bacteraemia have been continued in 2020/21. However, the associated quality improvement work has been curtailed by the

Further measures are outlined in the HCAI reduction plan for 2020/21.

1.6.3 *Klebsiella* species bacteraemia

Klebsiella species are gram negative rod-shaped bacteria which are ubiquitous in the environment and are found in the human gut. Three main species cause the majority of human infection; *K. pneumoniae, K. oxytoca* and *K. aerogenes.* Common presentations include ventilator-associated pneumonia (VAP), wound infections and urinary and biliary tract infections. Numbers of infections have continued to rise both in the community and the hospital setting and a national issue has arisen with VAP in ventilated COVID patients during this year

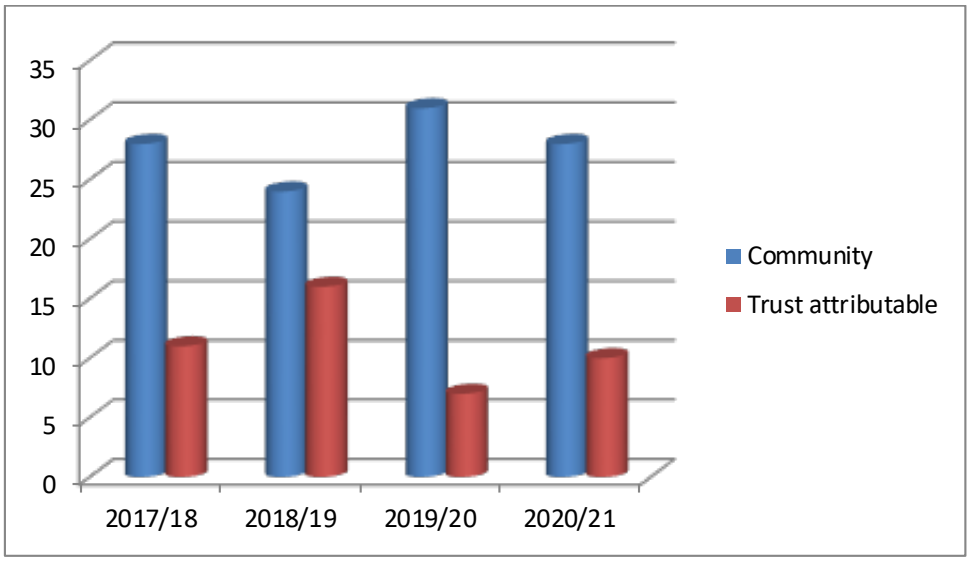
Figure 11: *Klebsiella* bacteraemia cases 2017-21



1.6.4 *Pseudomonas aeruginosa* bacteraemia

Pseudomonas aeruginosa is an opportunistic pathogen that infrequently causes infection in healthy individuals. It can cause a wide range of infections, similar to other gram negative organisms.

Figure 12: *Pseudomonas aeruginosa* bacteraemia cases 2017-21



In a healthcare setting pseudomonas can contaminate devices that remain moist such as respiratory equipment and catheters but also ice-making machines and equipment with a water reservoir. It also causes outbreaks in neonatal units.

1.7 Glycopeptide resistant Enterococci (GRE)

Glycopeptide-resistant enterococci are resistant to at least two important antibiotics widely used to treat infection in immunosuppressed patients. They are of particular concern in haematology patients who can be severely immunosuppressed as a result of both their underlying disease and chemotherapy.

A screening programme amongst haematology patients was put in place in March 2014 with all haematology patients screened on admission and discharge. The carriage rate amongst this cohort of patients has remained constant at around 20%. 21 carriers of GRE were newly identified from April 2020 – March 2021. Identification of carriers enables antibiotic regimens to be tailored to individual patients depending on their carrier status, improving patient safety.

Although the incidence of GRE infection has always been very low at MTW, with just three healthcare associated blood stream infections recorded in 2020/21, it is known that other Trusts in the region have endemic GRE and patients can acquire long-term carriage of this organism.

1.8 Extended Spectrum *Beta*-lactamase producing organisms (ESBLs)

ESBL organisms have the capability to produce enzymes which break down some of the more commonly used antibiotics. The numbers of patients developing infections with

these organisms has been rising steadily over the last few years. A number of these organisms also have other mechanisms of resistance which can in some cases severely restrict the choice of antibiotic and may lead to admission to hospital for intravenous antibiotics because there are no options for oral treatment.

Surveillance has been ongoing in the Trust since 2007. Earlier retrospective data shows that these organisms were seen at the Tunbridge Wells end of the Trust earlier than at Maidstone although the numbers seen at each hospital are equal now and the number of new acquisitions is staying steady.

There is no significant seasonal variation or trend in the number of cases seen. Most patients affected will carry the organism in their gut and as a result, urinary tract infections are the most commonly seen and account for around 90% of cases.

Figure 13: New ESBL cases 2009 - 2021

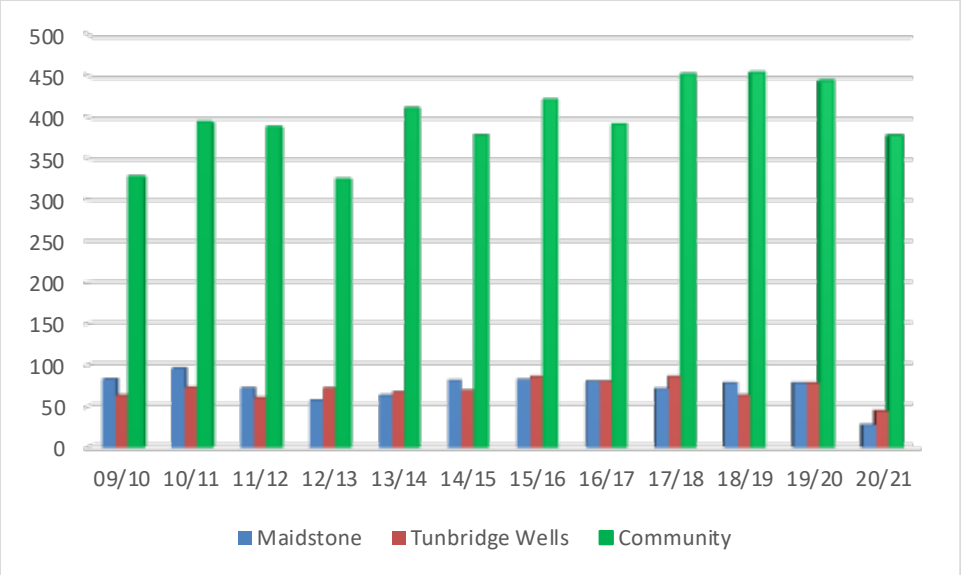
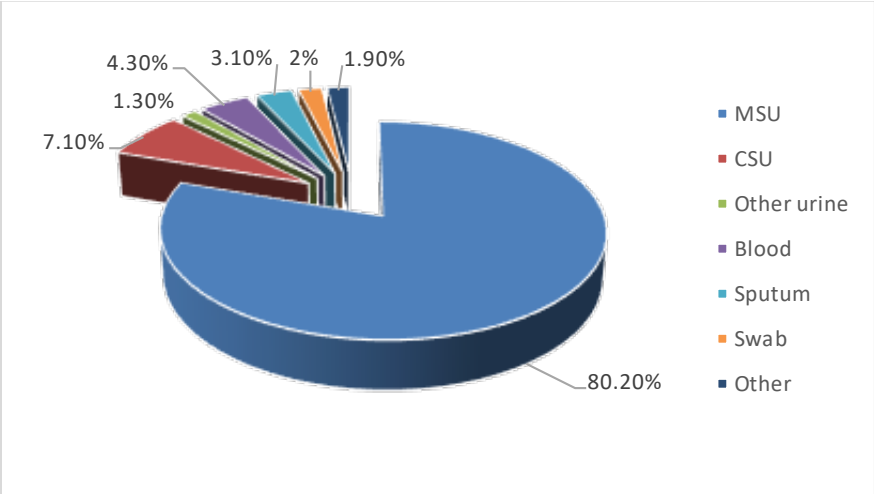


Figure 14: New ESBL isolates by specimen type 2020-21



1.9 Carbapenem resistant / Carbapenemase producing Enterobacteriaceae (CRE/CPE)

CPE and CRE are gram negative organisms found in the gut which are resistant to virtually every antibiotic including the Carbapenem group of antibiotics. They represent a major cross infection risk. Some of these organisms have the ability to transfer their resistance genes from one bacterium to another, even across species.

All Trusts have been required to have a screening programme for Carbapenem resistant organisms in place following a Patient Safety Alert in 2014. In 2020/21, 1458 CRE/CPE screening swabs were processed, around 1400 less than the previous year.

The reduction in screening is likely to be due to two factors, firstly the decreased bed occupancy during the first wave of the pandemic and secondly the risk assessment which identifies patients requiring screening focusses on screening patients transferred in from healthcare abroad and patients who are transferred from (or have recently been in patients in) other UK hospitals and tertiary referral centres, including haematology patients and neonates. Since travel has been curtailed to such a great degree during the pandemic, even within the UK, the number of qualifying patients has decreased.

Three adult patients and four children were identified as carriers on screening, five had recently been inpatients in other hospitals. All cases were identified on admission screening or were previously known carriers. All necessary precautions were implemented according to the policy and there were no episodes of cross infection.

1.10 Influenza

From October 2020 to March 2021, no patients with Influenza were admitted to the Trust. This is compared to 93 patients the previous year.

The only explanation for this is that the increased precautions, work from home order and mask wearing for the second wave of the pandemic, prevented transmission of influenza in the community.

The Trust is a Sentinel reporting site for influenza, reporting on all cases admitted to the Trust irrespective of level of care.

1.11 Norovirus

There were no cases of norovirus infection identified from April 2020 to March 2021.

1.12 SARS-CoV-2 (COVID-19)

COVID dominated the work of the infection prevention and control team for 2020-21.

The Infection Prevention and Control team had three main priorities; to ensure patient and staff safety, to advise and educate staff in new ways of working and to work with colleagues across the Trust to ensure that IPC was considered and included in all plans and changes, especially designing new patient pathways.

The Trust implemented national IPC guidance as it was published. The IPC team prioritised the clinical areas for support and increased the time spent on the wards to advise staff and ensure they were comfortable with the changes to practice. The team also worked closely with the Incident Control Centre (ICC), attending daily huddles and responding to queries through the COVID inbox.

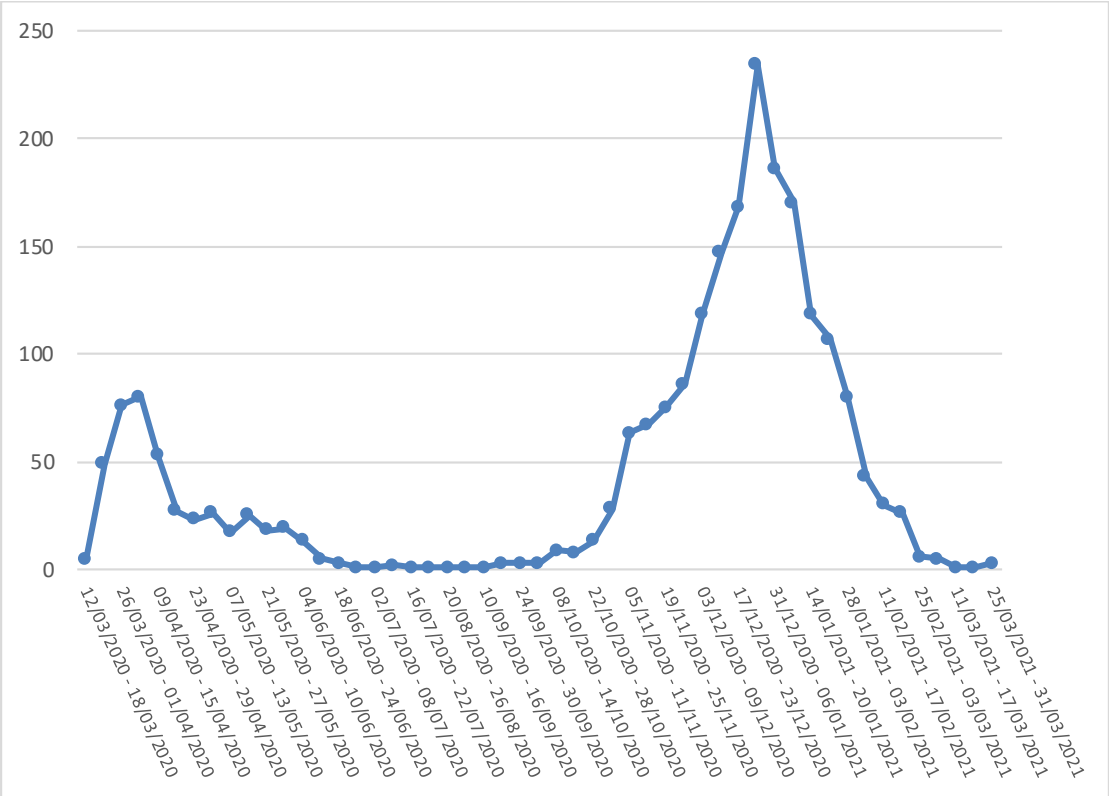
In order to support the Trust, the IPC team switched to an on-site 7-day presence and a 24/7 on call rota.

All clinical staff needed to be fit tested for FFP3 masks and supply issues led to the IPC team working closely with procurement to identify and purchase alternative respiratory protective equipment which complied with HSE standards. A fit testing team was rapidly deployed to ensure that all appropriate staff were tested against available masks. A working group was established to monitor mask availability, guide procurement and ensure that any issues were rapidly resolved

Staff found it difficult to adjust to the frequent changes in IPC guidance and the team worked with clinical staff to implement the changes and build confidence in the PPE advice.

All patients were PCR tested on admission, day 3 and day 5-7. Any patient developing typical COVID symptoms after this were also tested

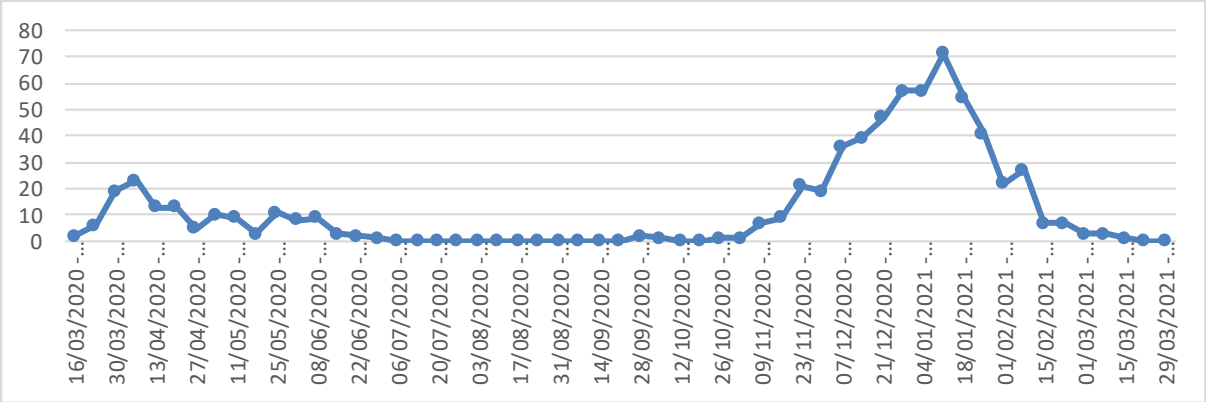
Figure 15: COVID positive admissions by week March 2020 – March 2021



The COVID positive patients in the above graph equate to 23027 bed days from 12 March 2020 to 31 March 2021.

The number of deaths was in keeping with the national picture with a peak in the second wave in mid-January 2021

Figure 16: Deaths due to COVID-19 March 2020 to March 2021



Wave 2 of the pandemic increased pressure on the organisation and brought further challenges for IPC. The predominance of the Kent variant was seen at MTW before it was recognised nationally as a new strain of the virus. Due to the increased infectivity of the variant, outbreaks were seen on many wards and processes were put in place to contain outbreaks rapidly and reduce patient to patient spread. By the end of 2020 the effect of the Kent variant on staff was so severe that the Trust implemented FFP3 masks for all staff caring for COVID patients to further protect them. This was against national guidance and was discussed with other local Trusts prior to implementation. Ultimately MTW was the only Trust in Kent and Medway to follow this policy.

Following wave 2 and moving into reset and recovery, the IPC team supported and advised on the reduction in IPC measures where appropriate, implementing the standard infection control precautions and cleaning regimes which enable the Trust to flexibly manage the challenge of COVID infection.

In wave 3 and beyond the team is working towards a new normal where COVID co-exists with the routine business of the Trust, looking at pathways and processes to ensure safety is maintained whilst enabling a level of normality to return.

Reflecting on the pandemic so far, it has been a hugely challenging time but has also allowed the team to develop new working relationships both inside the Trust and in the wider healthcare community, and to raise the profile of IPC across the organisation.

1.12.1 COVID positive staff

Throughout the pandemic the IPCT has given advice and guidance to staff on how to manage their personal risks, social distancing, contacts with positive individuals, manage family and household contacts and isolation following contact and infection.

Risk assessments have been developed to determine risk to other staff members when one is positive and reduce the incidence of staff outbreaks.

Staff have also been given advice on national travel guidance and self-isolation following travel as necessary.

Untoward Incidents and Outbreaks

1.13.1 SARS-CoV-2 (COVID-19)

Outbreaks of COVID are difficult to prevent. Infection prevention measures have been in place throughout the pandemic to minimise the risk of nosocomial (hospital acquired) COVID infection. These have included patient pathways to stream COVID and non-COVID patients separately to avoid contact, designated wards for COVID patients and additional isolation facilities for those on non-invasive ventilation, masks for both staff and patients, PPE, higher level of cleaning etc.

Where a patient tests negative on admission but positive on a routine day 3 or 5-7 swab, other patients will have been exposed to the individual. This is a particular risk where patients are cared for in four or six bedded bays. In this situation the other patients are 'quarantined' and are tested twice a week for 14 days to identify any secondary cases.

The definition of a COVID outbreak in hospital is two cases occurring in the same clinical area, one of which is diagnosed at day 8 of admission or later.

Twenty-three ward-based outbreaks of COVID have been identified from April 2020 to March 2021. An outbreak in May 2020 affected 14 patients and 24 staff; at this time the national infection prevention guidance was still changing. All the other outbreaks occurred during the second wave with the highly infections delta variant from November to January and affected a total of 240 patients and 220 staff. In addition, we had a number of outbreaks in non-clinical areas affecting 47 staff.

In general, the additional key measures taken to reduce outbreaks during 2020/21 were,

- Infection Prevention and Control Team provided support to the affected ward/department/team
- Observations of practice on ward areas undertaken by the Infection Prevention and Control Team with feedback to individual staff and nurse in charge on ward areas to support safe practice
- Weekly outbreak meetings held with areas affected and Infection Prevention and Control Team (more frequently where needed)
- Targeted actions developed and implemented through outbreak meetings for individual areas
- All outbreaks reported to the Incident Command Centre, Executive team and the Patient Safety team
- Flexible working and working from home rotations where possible for administrative areas to improve social distancing
- Improvements of signage throughout the hospital
- Daily communication through 'The Pulse' with key information and any learning identified from outbreak meetings (Trust wide publication)
- Regular reinforcement of social distancing and PPE requirements in trust wide communications

- Strict guidelines in place for staff reporting symptoms or testing positive. Same day PCR available on request for staff.
- Any staff member testing positive reported to the HSE as a RIDDOR
- Individual COVID risk assessments completed for staff as well as departmental/environmental risk assessments
- Lateral Flow Testing rolled out to outbreak areas as a priority
- Positive patients were cohorted in a designated area on the ward

Each outbreak investigated to identify trust wide learning and support for affected areas. Serious Incident declarations were made for all ward-based outbreaks. Duty of candour was completed with all affected patients receiving a letter and further information.

1.13.2 *C. difficile*

One episode of cross infection of *C. difficile* involving one hospital acquired infection was identified during November 2020 on a ward in Maidstone.

All outbreak management procedures were followed. A Serious Incident was declared and the root cause was found to be a breakdown in infection control measures.

Additional infection control support and training has been given to the ward staff in response to this outbreak.

Mandatory Surveillance of Surgical Site Infections in Orthopaedic Surgery

1.13 Surgical Site Infection

Orthopaedic surgical site infection (SSI) has been included in the mandatory healthcare associated infection surveillance system from April 2004. All NHS Trusts or facilities undertaking orthopaedic surgery must do surveillance in one or more of the orthopaedic categories - total hip replacement, hip hemi-arthroplasty, knee replacement and open reduction of long bone fracture. In any financial year, surveillance must be continued for a minimum of three consecutive months, commencing at the start of a calendar quarter.

The surveillance scheme is coordinated by the Healthcare-associated Infection and Antimicrobial Resistance (HCAI & AMR) Department of the Communicable Disease Surveillance Centre (CDSC) at the Public Health England (PHE) in Colindale.

The PHE web based data capture system also collates data from a number of other categories of surgery which Trusts can complete on a voluntary basis. Since December 2015 only the mandatory orthopaedic surveillance has been completed.

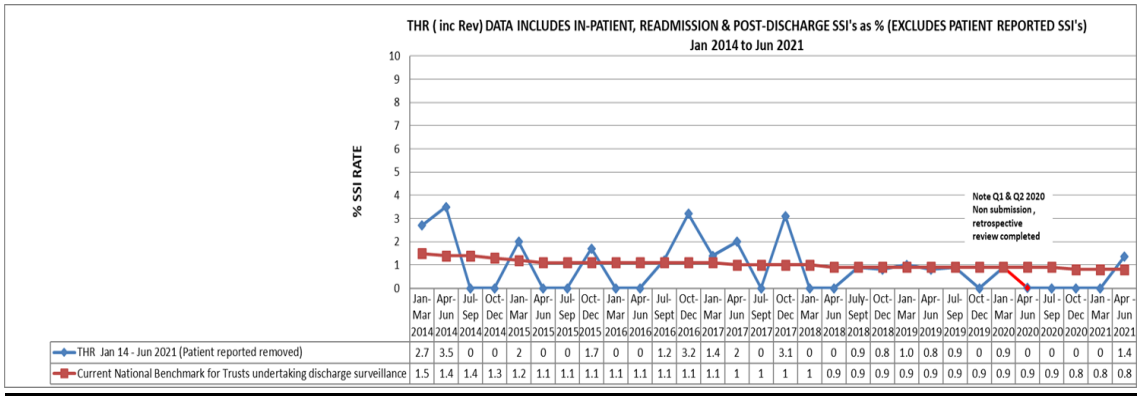
Patients are monitored for the first 60 days and infection rates monitored for up to one year post operatively. Monitoring is completed on inpatients and also by post-discharge surveillance through hospital readmission, outpatient review and patient discharge questionnaires. MTW completes the modules mandatory surveillance of elective total hip and total knee surgery, fractured neck of femur continuously throughout each year. Patient-reported SSIs are not included in the SSI performance data produced by PHE as

no infection has been proven. However, these infections are monitored and captured as part of the ongoing surveillance reports to PHE.

The overall numbers of orthopaedic operations undertaken throughout 2020 varied significantly due to the COVID-19 pandemic.

The retrospective analysis of Jan - June 2020 has been completed. Although the Trust was not permitted to retrospectively submit the data to PHE, undertaking this exercise has ensured continuous internal monitoring of our SSI rates, allowing comparison to the National average.

Fig 17: Results for elective hips

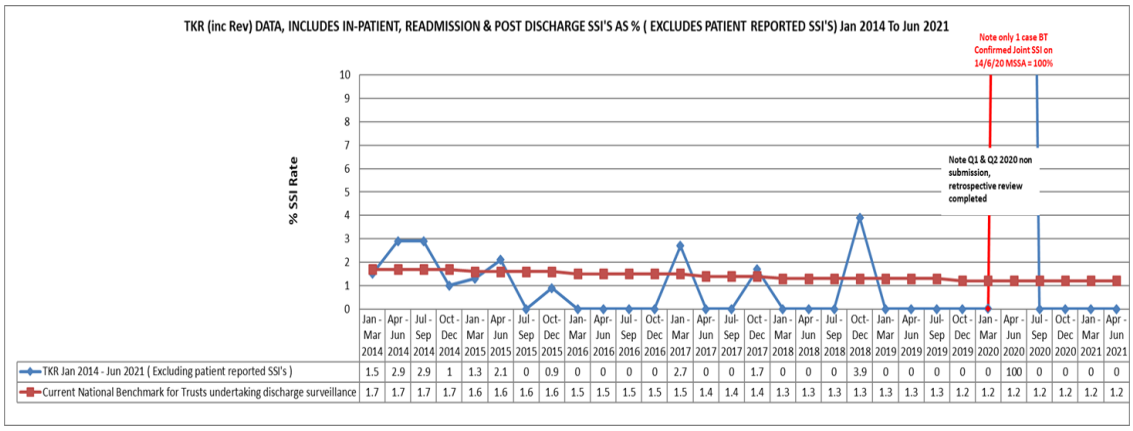


	Jan-Mar 2014	Apr-Jun 2014	Jul-Sep 2014	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sep 2015	Oct-Dec 2015	Jan-Mar 2016	Apr-Jun 2016	Jul-Sept 2016	Oct-Dec 2016	Jan-Mar 2017	Apr-Jun 2017	Jul-Sept 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018	July-Sept 2018	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	Oct-Dec 2020	Jan-Mar 2021	Apr-Jun 2021
THR Jan 14 - Jun 2021 (Patient reported removed)	2.7	3.5	0	0	2	0	0	1.7	0	0	1.2	3.2	1.4	2	0	3.1	0	0	0.9	0.8	1.0	0.8	0.9	0	0.9	0	0	0	0	1.4
Current National Benchmark for Trusts undertaking discharge surveillance	1.5	1.4	1.4	1.3	1.2	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1	1	1	1	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.8	0.8	0.8

In the 12-month period from Jan to Dec 2020, there was one confirmed SSI in this group, giving MTW an overall SSI rate of 0.3% across the same period for Total Hip Replacements including revisions.

From Q4 2020 the national average SSI rate in this group reduced from 0.9% to 0.8%.

Fig 18: Results for elective knees



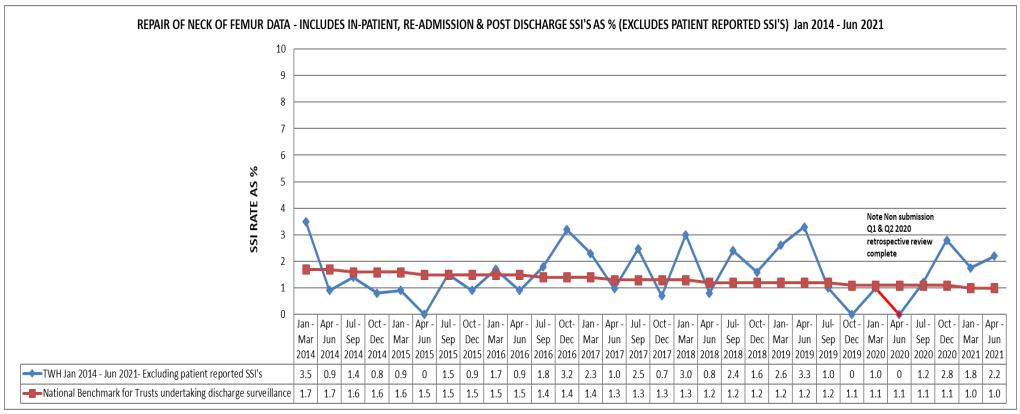
	Jan-Mar 2014	Apr-Jun 2014	Jul-Sep 2014	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sep 2015	Oct-Dec 2015	Jan-Mar 2016	Apr-Jun 2016	Jul-Sep 2016	Oct-Dec 2016	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018	Jul-Sep 2018	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	Oct-Dec 2020	Jan-Mar 2021	Apr-Jun 2021
TKR Jan 2014 - Jun 2021 (Excluding patient reported SSI's)	1.5	2.9	2.9	1	1.3	2.1	0	0.9	0	0	0	0	2.7	0	0	1.7	0	0	0	3.9	0	0	0	0	0	100	0	0	0	0
Current National Benchmark for Trusts undertaking discharge surveillance	1.7	1.7	1.7	1.7	1.6	1.6	1.6	1.6	1.5	1.5	1.5	1.5	1.5	1.4	1.4	1.4	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.2	1.2	1.2	1.2	1.2	1.2	1.2

There was only 1 operation throughout Q2 2020 in the Total Knee Replacement group. The patient went on to develop a Joint SSI therefore the SSI rate for Q2 = 100%.

In the 12-month period from Jan to Dec 2020, there was one confirmed SSI in this group, giving MTW an overall SSI rate of 0.5% across the same period, despite the 100% spike in Q2.

The national average SSI rate in this group remains at 1.2%

Figure 19: Results for repair of fractured neck of femur



During the first wave of COVID, low risk patients were diverted to the Horder Centre for their surgery. This meant the overall number of patients receiving their surgery at the TWH site April-June 2020 reduced significantly and there were no reported SSI's during this period.

From July onwards, as the number of operations being undertaken on the TWH site began to increase the number of confirmed SSI 's increased.

In the 12-month period from Jan to Dec 2020, there were a total of five confirmed SSI's in this group, giving MTW an overall SSI rate of 1.5% across the same period. Further analysis of these cases is being undertaken to understand the root cause of the high SSI rate. A trial of increased antibiotic prophylaxis (to bring fractured NOF patients in line with elective cases) commenced at the beginning of April 2021.

The National average SSI rate in this group remains at 1.1%

Compliance Criterion	What the registered provider will need to demonstrate
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Refurbishment and New Builds

2.1 Estates

The Estates and Facilities Department ensure that the IPC Team have been regularly involved, consulted and engaged in the planning stage of numerous work projects. This has enabled the team to actively influence improvements to infection prevention and control in the built environment providing input in two broad aspects of work:

- Planning – The IPCT are asked for input in reviewing plans to ensure that any refurbishments or new builds offer the best facilities to reduce the risk of infections in line with any relevant Health Building Notes and Health Technical Memorandum
- Operation – The IPCT are asked to review methods to reduce the risk of any infections presented by the actual refurbishment/build process.

Projects with which the IPCT have been involved include the plans for the new isolation rooms on Peale, changes to ED and changes to office spaces to enable social distancing on both sites

Estates report biannually to the IPCC on current and recently completed projects

Decontamination

2.2 Decontamination

The Decontamination Committee meets quarterly to consider all aspects of decontamination within the Trust. Sub-committees for each of the areas of responsibility have been formed to focus on departmental requirements and ensure ongoing HTM compliance and reporting back to the main committee

All decontamination and sterilisation of reusable surgical instruments is carried out off-site by an external provider. During the year the performance has been closely monitored and twice yearly reports are submitted to the IPCC. No major concerns have been raised and the service is compliant with HTM 01-01.

Decontamination and high level disinfection of flexible endoscopes is carried out in the endoscopy departments on both sites. The departments have JAG accreditation which was renewed in February 2019. Endoscopy is compliant with HTM 01-06.

The Trust laundry unit located off site at Parkwood continues to provide linen service to both of the Trust's hospital sites and Darent Valley Hospital, processing a total of over 7 million items per year. There are also a number of smaller community contracts. Annual audits are undertaken. The laundry is compliant with HTM 01-04

Cleaning arrangements

2.3.1 Monitoring

Domestic services report to the IPCC three times per year, providing details of audits of cleaning standards. The audit programme is regularly reviewed with infection control and audits are carried out weekly, monthly or bi- monthly, depending on the risk level, with unannounced visits to wards & areas by Facilities Management to maintain a consistent approach.

All audits have shown good compliance with standards of cleanliness and achieved the target scores of 95-98% for very high-risk areas and 85-95% for high risk areas. The high-risk scores were consistently above 95% for the year.

2.3.1.1 PLACE inspection

In September 2020 NHS England confirmed that the national PLACE collection 2020 would not go ahead due to the increased risk to patient assessors and staff in undertaking the full assessment programme while the COVID-19 pandemic continued.

On this basis, no internal assessments were completed throughout 2020 to reduce any risk as above to Trust staff who would normally be involved with PLACE Lite.

In March 2021, recommendation was received from NHS England & Improvement to undertake local PLACE-Lite assessments without the need to involve patient assessors.

A programme has been developed for 2021/22 for assessments across both sites including stakeholders from IPCT/Estates/Domestic Services with clinical colleagues when available.

2.3.2 Cleaning levels

Since the onset of the pandemic, enhanced cleaning has been in place in all areas including public areas. Diff X has been used as the disinfectant of choice and has been shown to have activity against COVID-19.

The facilities department provide a very high level of support to the Infection Prevention and Control Team and are able to respond quickly to infection prevention issues such as urgent deep cleans and hydrogen peroxide (HPV) fogging.

A range of cleaning levels have been in place in the Trust for many years and these are regularly reviewed to ensure that they are fit for purpose and enable the most efficient turnaround times. Additional indications have been required for level 3 UVC cleans including stepping clinical areas down from COVID to non-COVID and discharge of COVID patients from non-COVID wards.

Table 2: Annual cleans for Maidstone and Tunbridge Wells Hospitals 2020-21

Tunbridge Wells

	Level 2 Discharge Cleans	Level 3 - Steams	Level 3 – UV's	Level 4 - FOGs
2019/20	38,874	2928	841	762
2020/21	23144	894	4113	562

Maidstone

	Level 2 Discharge Cleans	Level 3 - Steams	Level 3 – UV's	Level 4 - FOGs
2019/20	7432	7892	360	345
2020/21	20317	2163	555	205

There is a significant difference in the numbers of cleans at the two sites and compared with the previous year. At Tunbridge Wells there is an increase in Level 3 UV cleans. This is due to our increased capacity to undertake UV cleans and the requirement for them for COVID discharge cleans in side rooms. At Maidstone there is a large increase in level 2 cleans which are routine for COVID discharge from a bay. Previously ward staff would undertake level 2 discharge cleans (numbers not recorded) and this task has now been fully transferred to the facilities teams.

2.3.3 Deep Cleaning

There is a rolling deep clean programme across the Trust which has been disrupted due to COVID but has proceeded wherever possible including when wards have been converted back from COVID to non-COVID. The Estates department are usually able to combine the deep cleans with maintenance works to reduce disruption.

2.3.4 Training

The IPC team delivered training sessions in correct handwashing/hygiene and PPE to all portering staff across both sites.

Additional training was provided to facilities staff to enable them to work safely during the pandemic, particularly noting increased PPE and working in COVID clinical areas.

Water Safety

2.4 Water Safety

The quarterly Water Hygiene Steering Group (WHSG) meets to discuss the relevant water hygiene policies and procedures, plus improvement works being carried out within the MTW Trust.

Legionella water sampling is undertaken twice yearly at Maidstone Hospital. Legionella sampling at TWH is carried out on a quarterly basis by Interserve. Samples for both legionella and pseudomonas are taken from various outlets and supplies such as water tanks and calorifiers. The sampling points at Maidstone Hospital have been reviewed and reconfigured so that every water system within the hospital is tested over a period of a year. Positive counts are recorded on the resampling action tracker, and recommendations undertaken in a timely manner. Prompt action to rectify issues identified enables all areas to return to operational use. Until these works are completed, suitable control measures are in place to ensure safe water system. Works have included the removal of little used outlets, showers, and long dead legs. All works are agreed with Infection Control.

At TWH, investigation has been undertaken into the finding of legionella colonies in the water system including balancing of the hydronic systems. Pipe work remediation is required to resolve the issue and further risk assessments are being undertaken

Compliance Criterion	What the registered provider will need to demonstrate
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

Antimicrobial Stewardship

3. Antimicrobial Stewardship Group (ASG)

The Trust multidisciplinary Antimicrobial Stewardship Group (ASG) is responsible for promoting and monitoring the prudent use of antimicrobials as outlined in the DoH guidance "Antimicrobial Stewardship - Start Smart then Focus" and recommendations from NICE guidelines (NG15). The ASG meets monthly to ensure the Trust antimicrobial stewardship programmes are implemented and review issues relating to antimicrobial use. The group members include consultant microbiologists, antimicrobial pharmacists, deputy chief pharmacist and WK CCG antimicrobial pharmacist. The group reports to the Drugs, Therapeutics and Medicines Management committee (DTMMC) and provides reports to the IPCC of which the antimicrobial pharmacist is a member.

Clinicians are invited to attend the meetings to discuss specialist guidelines and the ASG has made a significant contribution to the setting up of the Outpatient antimicrobial treatment (OPAT) service with Hospital at Home in 2020.

The group regularly review the Trust antimicrobial guide (on the trust intranet page) to ensure it is accessible and up to data. Existing guidelines are updated and new guidance developed in consultation with the relevant lead clinicians.

Of note the ASG published local guidelines on the use of antibiotics in COVID positive patients.

The group works collaboratively with the WKCCG antimicrobial pharmacist and an MTW consultant microbiologist sits on the WKCCG antimicrobial stewardship group.

The group also reviews any issues arising from the daily meetings between consultant microbiologists and pharmacists and medicines incidents involving antibiotics.

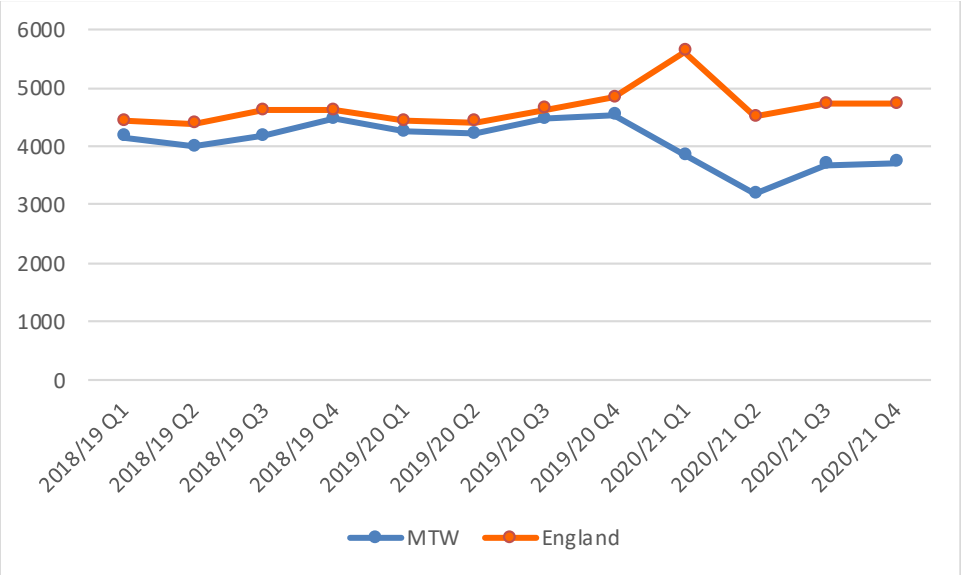
3.1 Antimicrobial Usage

The antimicrobial usage data in defined daily doses (DDD) per 1000 admissions is monitored by the group. Any unusual patterns of usage are followed up with clinicians.

Particular interest is taken in the prescribing of Piperacillin/Tazobactam (Tazocin) and Meropenem in the Trust. These are two broad spectrum antibiotics that are used in sepsis but are also associated with a higher risk of *C. difficile* infection. Meropenem is one of the Carbapenem antibiotics, resistance to which is becoming a significant problem nationally as discussed in section 1.9 of this report.

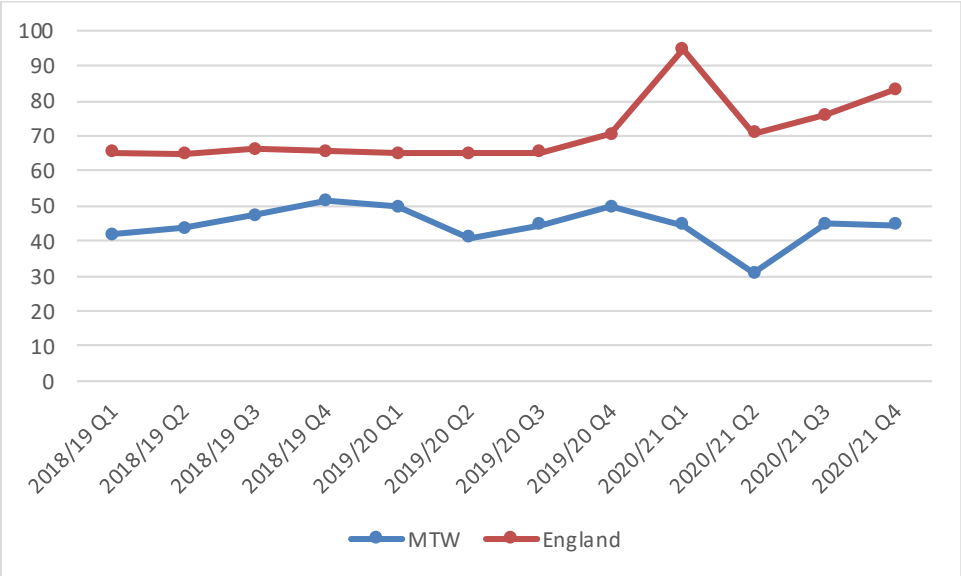
Usage has varied significantly, possibly as a result of increased use in COVID patients with secondary chest infections but also due to the increased acuity of patients, both COVID and non-COVID admitted in Q3 and Q4.

Fig 20: Total antibiotic prescribing DDDs per 1000 admissions by quarter



MTW remains below the national average for antimicrobial prescribing.

Fig 21: Carbapenem usage in DDDs/1000 admissions



MTW prescribing of meropenem is significantly below the England rate which saw a spike during the second wave of the pandemic.

3.2 Antimicrobial training and Education

A number of education sessions were delivered by the antimicrobial pharmacists and consultant microbiologists to medical staff and pharmacists. Education sessions include induction sessions for all new doctors, FY1 and FY2 teaching sessions and more

advanced sessions for core medical trainees. COVID has significantly reduced the amount of training possible this year.

Antimicrobial information leaflets are issued to new locum doctors and FY1 as part of their induction welcome packs.

3.3 Antimicrobial Audit

The pharmacists complete bi-monthly audits against the Antimicrobial prescribing policy. The audit results are reported to individual consultants, directorates and to the IPCC through the directorate triangulation reports. In line with best practice antimicrobial stewardship evidence of 72 hours review is now included in this audit.

In addition, weekly audits against the policy are carried out on wards where there is a PII in place.

Compliance Criterion	What the registered provider will need to demonstrate
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.

The Trust provides all service users with information as required. This includes infection prevention information in the form of information leaflets, posters and resource folders for staff, and information leaflets and posters for patients and visitors.

In outbreak situations or infection prevention incidents, duty of candour is completed for all patients affected either directly or indirectly.

Staff are also provided with policies, clinical guidelines and care pathways for specific conditions.

There are Infection Prevention resources on the Trust intranet and Internet sites.

Information is provided to external partners as appropriate including:

- Notifications of *C. difficile* cases and gram negative blood stream infections to the relevant CCG HCAI lead
- Electronic discharge notifications include MRSA status
- Inter-hospital transfer forms include information relevant to IPC
- Patients identified as *C. difficile* carriers or with *C. difficile* infection are issued with a 'green card' which advises other healthcare providers of their diagnosis and the importance of prudent antimicrobial prescribing
- IPC information is shared with GPs for information on a case by case basis

The infection prevention team attend the site meeting at least daily to share information regarding IPC risks and concerns. A daily side room report is shared widely to ensure the safe isolation of infectious patients.

From the beginning of the COVID pandemic, the IPCT attended the Incident Control Centre meetings daily and participated in daily executive and divisional calls to share information and update teams on the latest IPC guidelines and advice.

These meetings are now the daily executive strategic command calls which is attended by the DIPC and deputy DIPC or Lead IPC nurse.

Compliance Criterion	What the registered provider will need to demonstrate
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmitting the infection to other people.

The Infection Prevention and Control Team provides a 7-day service and an on-call microbiology service (laboratory and consultant) is available out of hours. The laboratory also provides 7 day working. The IPC team regularly visit the wards and review patients with infectious diseases.

All urgent microbiology results are telephoned to clinicians to ensure prompt treatment and review.

Side rooms are actively managed by the Infection Prevention team and the Isolation Policy, including risk assessments for side room requirement and leaving doors open, is available on the Trust intranet.

The IPT performs risk assessments for any potential infectious disease incident in the Trust. Contact tracing for both staff and patients is facilitated by the IPT working with Occupational Health where necessary.

Policies are also available for the management of patients with diarrhoea and a wide range of infectious diseases.

Patients are screened for MRSA, MSSA, GRE, CRE/CPE as appropriate (see Criterion 1).

An outbreak policy is in place and colleagues in Public Health England are available to assist with outbreak control if required.

At the start of the pandemic response the IPCT provided on site cover 7 days per week and a 24/7 on call service. See sections 1.12 and 1.13.1 for further information on COVID-19.

COVID lateral flow testing kits were rolled out to staff commencing in November 2020. Staff test themselves twice weekly and report the results on the staff testing portal. The portal also enables staff to book PCR tests. Guidelines are in place and a staff sickness line was set up to advise staff on what to do following development of symptoms or a positive test.

Compliance Criterion	What the registered provider will need to demonstrate
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

Staff Development and Training

Under normal circumstances the infection control team undertakes both formal and informal teaching as part of its training and education role. The formal face to face sessions were suspended during COVID and most formal training was transferred to e-learning with national packages used which cater for two different levels for staff working in clinical areas and those based in non-clinical areas. These national packages also include reference to COVID and PPE.

The frequency of training depends on individual's role; annual update for frontline clinical staff including domestics and porters, two yearly update for clinical but non-patient facing staff and three yearly update for non-clinical staff.

Compliance with training is above target for all groups: 88% for annual, 91% for two yearly and 92% for three yearly training.

The team also participates in the induction training for junior doctors with the DIPC leading the infection control training. The consultant microbiologists provide training in antibiotic prescribing during induction training. In addition, training on infectious diseases and the use of antibiotics is provided as part of the post graduate educational programme.

Other bespoke practical training sessions have been developed to provide targeted training to facilitate learning in staff who may not have English as a first language.

A resource pack has been developed for the wards containing a wide range of handbooks for various staff groups (temporary and substantive) and exemplars of how to complete IC documentation.

Virtual link nurse meetings are held monthly. Each meeting has an educational element followed by a round table session leading to discussion about issues raised. In addition, a link nurse study day is held annually with invited speakers and this is also open to MTW staff who are not link nurses and healthcare staff from other organisations. In 2020 the meeting was held virtually.

The DIPC teaches on the DIPC development programme and aspiring DIPC training course, both run by the Hospital Infection Society.

Within the IPCT members of the team are actively encouraged to pursue educational opportunities.

What the Board needs to know in order to fulfil its responsibilities in respect of Infection Prevention and Control

6.1 History

Infection prevention and control has been an area of focus within MTW since 2006 when the Trust suffered one of the largest *C. difficile* outbreaks in the UK which was subsequently investigated by the Healthcare Commission and described in their report: *Investigation into outbreaks of Clostridium difficile at Maidstone and Tunbridge Wells NHS Trust*, October 2007. The report estimated that 90 deaths were directly due to C. difficile and a further 241deaths had occurred where *C. difficile* had been a contributory factor.

Crucially the report identified that management systems had failed to provide patient safety and introduced the concept of board-to-ward accountability and responsibility.

The Trust's response to the report was positive and a year later the Healthcare Commission reported that there were encouraging signs of improvement. This improvement has continued and thirteen years on from the publication of the report, MTW is seen as a high performing Trust for Infection Prevention and Control.

The Trust Board has recognised and agreed collective responsibility for minimising the risk of infection and has delegated responsibility for the strategic and operational leadership to the Director of Infection Prevention and Control.

6.2 Key points

- All employees of the Trust have infection control responsibility detailed within their job description
- Infection prevention and patient safety remain key priorities for the Trust
- There is wide engagement with the infection prevention agenda throughout the Trust
- A challenge culture has been encouraged within the Trust to ensure that all staff comply with infection prevention policies and processes.
- A wide range of infection prevention policies and procedures have been developed and are regularly reviewed and updated
- Emphasis has been placed on the clinical environment and cleanliness. The infection prevention team works closely with the facilities management team. The Trust has been innovative in the introduction of cleaning methods such as Hydrogen Peroxide vapour (HPV) in 2007 and UV-C light in 2016. Cleaning standards are audited regularly and reported through the Trust including to the IPCC.
- *C. difficile* has been reduced to consistently low levels across the organisation

6.3 Hygiene Code compliance

The Health Act 2008, now superseded by the Health and Social Care Act 2013, contains a Code of Practice usually referred to as the Hygiene Code. The Code was most recently updated in 2015. The 2008 Act requires acute Trusts to comply with the Code and outlines penalties for non-compliance.

The Trust declared compliance with the Hygiene Code in March 2009 and continues to remain compliant, maintaining evidence files and undertaking self-assessment of compliance on an annual basis, reporting the outcome to the IPCC.

For 2019/20 the IPCT was involved in the preparations for CQC and undertook a KLOE self-assessment. A hygiene code gap analysis was undertaken for 2020/21

There is a compliance statement on the Trust Website

The compliance criteria and some examples (not comprehensive) of how we comply in addition to this report are shown in the table below;

Table 3: Hygiene code compliance criteria (2015)

Compliance criteria		Examples of how we comply
1	Systems to manage and monitor the prevention and control of infection.	• Governance and reporting structure • DIPC in post - reports to CEO • Infection prevention team • PPE and fit testing team • IPCC ToR • Annual work programme and action plan • Mandatory training • Link nurse network • Annual IPC audit programme • IPC policies and procedures in place • Side room management • Board level risk register • Outbreak policy • Surveillance systems • This report • COVID measures in place • IPC BAF for COVID
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	• Director of Estates and Facilities bi-annual report to IPCC • Policies for decontamination, cleaning and laundry in place including record keeping processes • Cleaning processes agreed with Infection Prevention • Cleaning audits reported to IPCC • Deep clean programme in place

		• Hand hygiene facilities, signage and audit • JAG accreditation • Commode audits • Uniform policy • Changes in cleaning frequency to support COVID management
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	• Antimicrobial stewardship group meets monthly • Antimicrobial prescribing policy • Antimicrobial prescribing guidelines • Antimicrobial pharmacists in post • ASG reports to IPCC • 'Start smart then focus' in place • Antimicrobial training for doctors
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.	• Range of information leaflets for patients and relatives • Regular communication with CCG HCAI lead • EDN includes MRSA status • Switchboard messages on norovirus • IC messages on internet site for visitors and patients including numbers of infections • Information for patients on antimicrobials • IC information shared with GPs on case by case basis • ICT attendance at daily site meetings • Participation in COVID ICC meetings and strategic command calls
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	• Urgent microbiology results telephoned to clinicians • Isolation policy • Active side room management by ICT • Risk assessments carried out • Screening in place for MRSA, MSSA, GRE, CRE/CPE as appropriate • Diarrhoea policy • Reporting mechanism for notifiable disease to PHE in place • Temperature and symptom checks at front doors. • Triage for COVID-19 at the front door of emergency departments • Separation of flow into green, amber and red pathways to ensure COVID and non-COVID streams do not mix

		• Cohorting of patients pending COVID test results to reduce nosocomial spread of infection
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	• Mandatory training for all staff and volunteers • Information provided to contractors • Temporary staff handbooks and competency • Bespoke training for certain groups of staff, eg porters, domestics • Handbooks for various staff groups • Exemplars of documentation provided to wards • IC resource folders on all wards – currently being converted to electronic format • Infection control responsibility included in all job descriptions • Facing to face ward based training for new nurses
7	Provide or secure adequate isolation facilities.	• Isolation policy • Negative pressure rooms available – A&E at TWH and John Day at Maidstone • TWH has >90% side rooms • Isolation rooms with positive pressure lobby on Lord North • Active management of side room provision • Clear isolation signage • COVID signage to identify red, amber and green wards • Negative pressure rooms created on Chronic Pain Unit and additional side rooms on Peale for COVID isolation
8	Secure adequate access to laboratory support as appropriate	• Microbiology laboratory on Maidstone site • KPIs monitored • ISO 15189 accredited • All referral labs accredited • Telepath system interfaced with ICNET • COVID PCR and antibody testing available on site. • Testing PODS on both sites
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	• Standard infection control policy • Policies for a range individual infections • Outbreak policy • Other policies in place to meet the requirements of the Code

		• Audit programme in place to monitor compliance with policies • All policies available on Trust intranet site • COVID measures in place. • PHE guidance followed
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	• Immunisation of staff policy in place • All staff can access on site occupational health services • Influenza vaccination offered to all staff and volunteers with achievement of annual targets for frontline staff • Risk based screening for communicable diseases and assessment of immunity • OH arrangements in place in respect of blood borne viruses • COVID testing available for all staff • COVID antibody testing available as needed • COVID vaccination provided for staff

6.4 Governance and Assurance

The Board receives assurance through the governance reporting structure described at 1.2, and directly from the DIPC who attends Board meetings to provide updates on infection control and new guidance relevant to the Trust.

C. difficile and MRSA and gram-negative bacteraemia numbers and rates are on the Board level dashboard together with MRSA screening rates.

Staff twice weekly lateral flow tests were rolled out from November 2020. A weekly report of compliance is provided. In addition, the uptake of COVID vaccine from December 2020 was reported weekly to Execs.

6.5 National Priorities

There are two key national priorities related to Infection Prevention and Control

Antimicrobial resistance – The next phase UK 5 year antimicrobial resistance strategy was published in 2019. The plan has been designed to ensure progress towards the 20-year vision on AMR, in which resistance is effectively contained and controlled. It focusses on three key ways of tackling AMR:

- Reducing the need for, and unintentional exposure to, antimicrobials
- Optimising use of antimicrobials
- Investing in innovation, supply and access

To support these aims there are actions across 15 'content areas', ranging from reducing infection and strengthening stewardship to improving surveillance and boosting research. The plan also sets out four measures of success to ensure progress towards the 20-year vision. These include, among others, targets to:

- Halve healthcare associated gram-negative blood stream infections
- Reduce the number of specific drug-resistant infections in people by 10% by 2025
- Reduce UK antimicrobial use in humans by 15% by 2024
- Reduce UK antibiotic use in food-producing animals by 25% between 2016 and 2020 and define new objectives by 2021 for 2025
- Be able to report on the percentage of prescriptions supported by a diagnostic test or decision support tool by 2024

COVID-19

The national COVID-19 pandemic is having a major impact on the way healthcare is provided in the UK. See 1.12 and 1.13 for further detail

The infection prevention team is committed to continuing to support the Trust to ensure that the safety of our staff and patients is maintained throughout whilst delivering national requirements and adhering to national guidelines.

Compliance Criterion	What the registered provider will need to demonstrate
7	**Provide or secure adequate isolation facilities**

Isolation Facilities

The Isolation policy is published on the Trust Intranet, together with the standard infection control policy which includes the use of personal protective equipment.

The Trust has a high proportion of single rooms although there is a disparity between the two sites with Tunbridge Wells Hospital having over 95% of beds in side rooms and Maidstone Hospital with 57 side room beds. Overall 54% of the beds in the trust are in single rooms with 50.4% en-suite, compared with 29.9% single rooms in England, 17.9% en-suite.

The target time for isolating patients with unexplained and potentially infectious diarrhoea (Pathway 1) is two hours. A rapid risk assessment is in place for all patients with diarrhoea

Active management of side room provision continues. The Infection Prevention team monitors isolation rooms on a daily basis to support the bed managers and ensure the best use of the side rooms available at Maidstone Hospital and to alert staff of infection control issues at Tunbridge Wells Hospital. The team advises on which patients may be de-isolated if necessary and prioritises lower risk patients who would benefit from isolation and the level of cleaning required when the patient is moved out of isolation. The team also alerts site practitioners to community issues such as outbreaks of COVID and norovirus in local nursing homes and community hospitals and any wider outbreaks which may result in patients attending A&E.

All *C. difficile* patients are isolated on diagnosis, if not already in a side room, and remain in isolation throughout their admission. In addition, those identified as carriers are isolated whilst they are symptomatic and for at least 48 hours after they become asymptomatic.

Pathways have been developed and are in use to separate COVID and non-COVID patients and ensure that there is no contact between the streams. COVID patients are cared for in cohort wards and side rooms. Strict conditions are in place to determine when the patients can be stepped down safely to general ward areas. Additional side rooms have been developed to aid the COVID response at Maidstone. Three rooms in the Chronic Pain Unit were converted to negative pressure and additional side rooms were constructed on Peale ward which is used for COVID positive and quarantine patients.

There are planned facilities in both Emergency Departments for isolating highly infectious individuals such as those suspected of having Ebola virus. The pathway for these patients is practised regularly to ensure that staff are aware of the enhanced precautions and how to don and doff the protective suits. These plans were also used in the early weeks of COVID-19, prior to the first cases emerging in the UK and more extensive plans being developed to separate the COVID and non-COVID patients.

Compliance Criterion	What the registered provider will need to demonstrate
8	Secure adequate access to laboratory support as appropriate

Laboratory Services

In house microbiology laboratory services are based at Maidstone Hospital The laboratory has ISO 15189 accreditation.

The laboratory is open 7 days a week and provides a 24-hour service with on call facilities from 6pm to 8am. During COVID the on-call service has been reduced to CDF samples for meningitis only.

Reference laboratory support is available at all times from both the Public Health England reference laboratories and other commercial laboratories which provide additional rapid diagnostics.

The microbiology changed in response to the COVID pandemic. In January 2020 there was an establishment of 12.1 WTE made up of specialist biomedical scientists (BMS), support medical lab assistants, admin support staff and trainee biomedical scientists working a rota that covered Monday to Friday 8.30-18:00 and overtime weekend cover 08.00-13.30. There was no provision for COVID-19 testing and limited experience and equipment with respiratory PCR testing. New skills and equipment were required well as the need for increased supplies specifically around viral transport medium. By March 2020 one additional low volume PCR instrument had been obtained allowing verification of COVID-19 testing on site with two staff completing training, increasing capacity to 24 tests in 6 hrs. A large number of swabs had to be sent to PHE reference lab for testing due to the capacity restraints. As more equipment was obtained and 10 BMS staff trained, testing capacity increased to 48 tests in 6 hrs across four pieces of equipment. With the support of 4 staff seconded from Blood Sciences and 2 from cellular pathology alongside some clerical support from GUMD, COVID testing was expanded to 15hrs a day 7 days a week. Microbiology staffing levels remained the same with every member of staff undertaking extra hours to cover the requirements of the service. COVID-19 testing capacity increased to 500 per day with additional transport runs supported by the Transport department.

The routine bacteriology/serology workload was also being covered by the same staff, although routine work was significantly decreased during the first wave. Contingency plans were not implemented due to the efforts of the staff and the lab continued to offer a full service, including TB work for EKHUFT.

As the effects of the first wave began to reduce the team reduced its staff levels in line with demand. required. As the reset and recovery work began the COVID testing workload significantly increased due to pre-assessment requirements.

New instrumentation provided by NHSE/I was slow to arrive so the Trust purchased one new piece of equipment which allowed testing capacity to increase to 700 tests per day by September 2020, and testing was also provided to IS providers who were undertaking surgical services for MTW patients.

NHSE/I amended the requirements for 'care home' testing and the lab was required to test outbreak specimens for a large number of care homes in the area.

Results were integrated to the staff portal already use by the Trust.

The lab also undertook other tests as part of the Trust COVID-19 response including antibody testing for staff and the samples from the Siren study.

As the Trust began to experience the effects of the second wave of the pandemic a recruitment drive helped to fill some of the essential roles with a rapidly adapted training programme to utilise the new staff to the fullest extent with Specialist staff working on each shift to supervise the trainees. Capacity increased to 1,000 swabs per day to

accommodate wave 2, outbreak screening and staff screening achieving the NHSE recommendation of 15-hour turnaround time 90% of specimens and averaging 6 hours.

Compliance Criterion	What the registered provider will need to demonstrate
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections

The Trust has policies, guidelines and standard operating procedures in line with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance. The documents are reviewed on a rolling programme and published on the Trust Intranet site.

The documents are monitored using a variety of audit tools to measure staff compliance with guidance.

Audit Programme

The infection control team have worked closely with the audit department to develop a comprehensive audit programme which monitors all aspects of infection control including compliance with infection control policies within the Trust. Audits are reported to the IPCC. Formal audits included:

- Re-Audit of catheter associated urinary tract infections and compliance with the HOUDINI criteria.
- Re-audit of compliance with screening for Carbapenemase-producing enterobacteriaceae (CPE).
- Audit of compliance with the Policy and Procedure for the Assessment of Patients Presenting with Diarrhoea
- Mattress Audit
- Audit of non-elective MRSA screening

In addition to these audits the IPT undertakes bi-monthly triangulation audits which are compared with the monthly ward audits and reported as a performance report to the IPCC by the directorate matrons.

The triangulation audits are conducted on:

- Bare below the elbows
- Hand hygiene including patient hand hygiene prior to meals
- Commode cleanliness
- MRSA decolonisation
- MRSA care pathway compliance

- MRSA non-elective screening
- Waste management

As part of the PII process additional audits are completed on

- Ward laundry management
- Decontamination of reusable devices

Compliance Criterion	What the registered provider will need to demonstrate
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

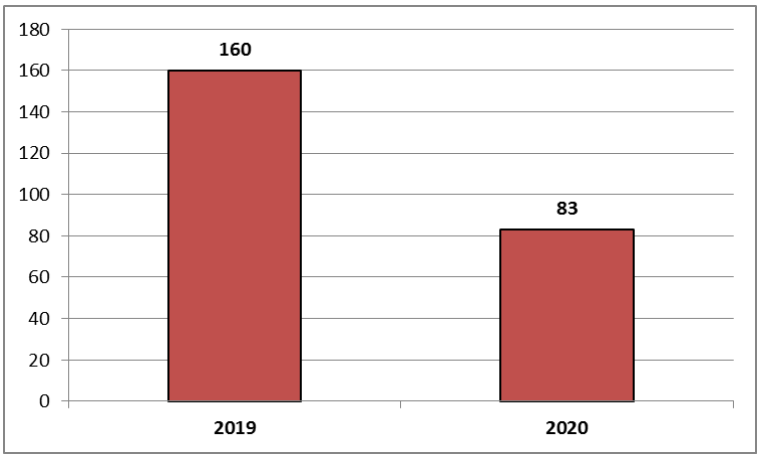
Occupational Health

The Occupational Health service provides pre-employment health assessments and assessment of immunity and provides vaccinations for new staff.

10.1 Sharps/Splash Injuries

There has been a significant drop in sharps and splash injuries in 2020. This is likely ot be due to the changes in services due to the pandemic. Around The occupational health department continues to review sharps injuries and examine ways to reduce the incidence with the Health and Safety team and the Sharps Working group.

Fig 22: Sharps and Splash injuries 2019-2020

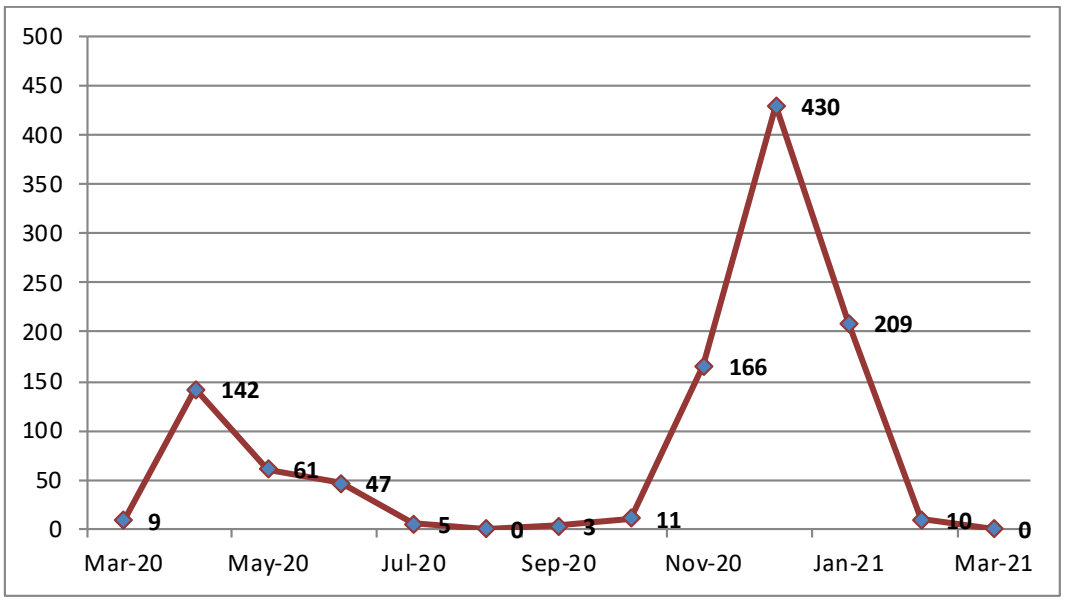


The split between types of injury has remained constant at around 75% sharps to 25% splash injuries

10.2 COVID-19

From March 2020 – March 2021, 1093 staff tested positive to COVID-19 with 264 cases seen in the first wave and 829 in the second wave

Fig 23: Staff COVID Infections 2020-21



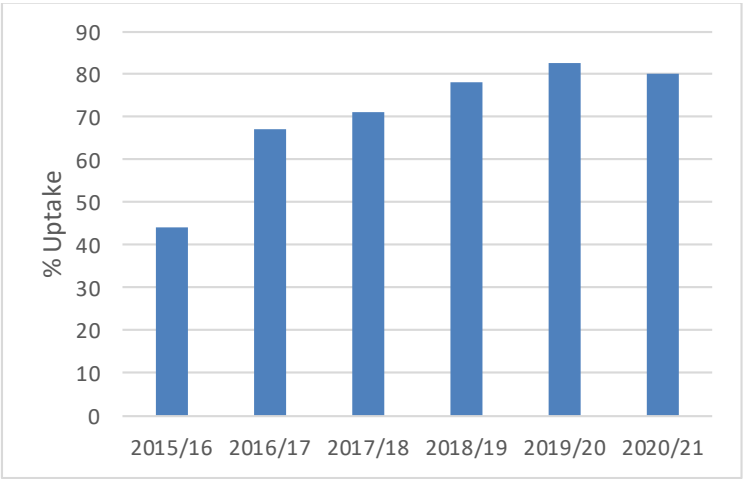
Several staff are experiencing ongoing symptoms of fatigue and reduced resilience and OH are offering them ongoing support and referral to a dedicated Trust physiotherapist.

The COVID vaccination centre was set up in December 2020 and delivered over 25000 vaccines to MTW staff and those of our partner organisations over a four-month period.

10.3 Influenza vaccination

The Occupational Health department leads the seasonal flu vaccination campaign. For 2020/21 the Trust achieved a vaccination level of 80%. The campaign was launched in September and used a peer vaccination programme to outreach into clinical areas.

Fig: 24 Influenza vaccine uptake by staff



Recommendations

The Trust Board is asked to note the progress in reducing healthcare associated infections, the COVID response and the Infection Prevention and Control Annual Work plan for 2020/21 (appendix 1)

INFECTION PREVENTION AND CONTROL WORK PLAN 21/22

RAG RATING DEFINITION	
R	ACTIONS APPEARS UNACHIEVABLE NEEDS RE-BASELING / REASSESSING
A	SUCESSFUL DELIVERY OF PROJECT TIME AND THERE ARE NO THREATS TO DELIVERY
G	COMPLETED AND CLOSED NO FURTHER ACTIONS REQUIRED

Action No	Date Identified	Source	Output (What are we trying to achieve)	Action (How are we going to do it)	By when	Work plan Quarter	Owner	Current Progress (How are we doing)	RAG Rating
CULTURE AND ENGAGEMENT									
CE-001	Apr-21	APW	Improved attendance and engagement to the IPC Link workers programme and meetings	1) Monthly Link worker Meetings to be held on alternate sites allowing for social distancing - via WebEx or Microsoft teams - Where meeting are difficult to arrange a IPC Link worker newsletter is to be provided 2) utilise funding from NHSE/I to allow for back fill time for links, consider training in environmental audit 3) Link worker attendance to be monitored, fed back to divisions and monitored through IPCC 4) Summary report to be presented to IPCC 5) Consider socially distance face to face sessions	Mar-22	Q4	Claire Taylor (Infection Prevention	It is planned to pick up virtual link meetings in April 2021 Kent & Medway Link worker virtual conference April 22nd	

CE-002	Apr-21	APW	Compliance with IPC practice and procedures	1) IPC team working with wards where non-compliances are identified, providing additional training and support - PPE compliance is monitored by the PPE officers and presented at IPCC (See SA -006) 2) findings from PII investigations are fed back, followed up and monitored 3) Audit programme developed and available on the Q drive. Also see Audit and Surveillance section of this work plan	Mar-22	Q4	Joanne Green (Nurse Consultant IPC)		
CE-003	Apr-21	APW	All medical devices and equipment to meet IPC requirements for use	1) IPC team to work with procurement to provide IPC advice on new products being considered 2) Attend the Medical devices meeting 3) IPC approval of products via pre-purchase questionnaire (PPQ)	Mar-22	Q4	Danny Moore (Infection Prevention Nurse)	The IPC team continue to provide advice and support on the procurement of equipment for the Trust and attend the medical devices meetings on a regular basis, and sign off PPQ's	
CE-004	Apr-21	APW	Continue to raise the profile of Infection Prevention and control	1)IPC attendance at ward managers and Matrons meetings 2) IPC team to visit wards & department daily 3) Participate in national and local initiatives to promote IPC. (Global Hand hygiene day, glove awareness week, International Infection Prevention week) 4) Use of social Media to promote IPC team and deliver key messages	Mar-22	Q4	Joanne Green (Nurse Consultant IPC)	The IPC team visit the wards and departments daily and work closely with all members of staff in the Trust. They have supported ward staff during the Pandemic and have received positive feedback in response. The IPC twitter page needs to be further utilised to promote key messages Attendance to Matrons and ward manager meeting will continue as we get back to business as usual	
CE-005	Apr-21	KLOE	Develop process of gaining patient feedback / experience of IPC (C1-2)	1) Audit and process has been agreed 2) Discuss proposed process with patient representatives and seek agreement 3) Work with the corporate team around seeking patient feedback around their experiences	Dec-21	Q3	Danny Moore (Infection Prevention Nurse)	A draft process has been developed for implementation Delayed until after the pandemic to avoid skewed results.	

SAFE, CLEAN ENVIRONMENT									
SCE-001	Apr-21	APW	Safe water systems	1) IPC representation at the Water Safety Meeting 2) All water sampling results and mitigating action taken to be sent to the IPC team for follow up 3) *Pseudomonas* risk assessment reviewed and updated yearly 4) Water safety workstream to be supported by consultant microbiologist	Mar-22	Q4	Joanne Green (Nurse Consultant IPC)	IPC team representation and involvement at the water safety meetings. IPT completion of pseudomonas risk assessments completed and returned to E&F	
SCE-002	Apr-21	APW	Environment is designed and refurbishments are completed with infection prevention and control in mind	1) IPC representation at capital planning meetings 2) Process is developed to ensure IPC is considered at the planning stage of building or refurbishment projects	Mar-22	Q4	Joanne Green (Nurse Consultant IPC)	Process to be agreed with Estates and facilities dept	
SCE-003	Apr-21	KLOEs (S1)	Improved compliance with the completion of the isolation risk assessment	Full review of isolation risk assessment to be undertaken. Process to be revised and re-implemented	Dec-21	Q3	Jacqui Griffin (Lead Nurse IPC)	As we get back to business as usual the completion of this will be promoted and monitored, review March 2021	
SCE-004	Apr-21	KLOE (S1)	Systems in place to ensure that patient equipment is clean between use and assurance that standards are maintained	1) Where deficiencies are identified through PII and audit, the process for the cleaning of patient equipment within the wards and department will be reviewed 2) Devise a process to identify if cleaning of patient equipment is robust across the Trust	Mar-21	Q4	Danny Moore (Infection Prevention Control)	To be progressed in 2021	
SCE - 005	Apr-21	KLOE & BAF (S1)	Greater involvement in cleaning and environmental audits to provide assurance of standards being reported	1) Ward / Department staff to attend the cleaning audits that are undertaken by the domestic supervisor 2) IPC team to attend a number of cleaning audits for assurance purposes 3) IPC to participate in PLACE assessments 4) IPC to participate in mock CQC walkabouts	Mar-22	Q4	Joanne Green (Nurse Consultant IPC)	To be progressed in 2021	

SURVEILLANCE & AUDIT									
SA-001	Apr-21	APW	Programme of audit to be developed and completed for 21/22	1) Audit programme to be developed and agreed at IPCC 2) Re audit of MRSA care bundle 3) Compliance of best practice guidance to reduce the risk of Pseudomonas and legionella in augmented care (August 2021) 4) Re-audit of CPE (Oct 21) 5) Outbreak preparedness (Fit testing) (Sept 21) 6)Ward/Dept environmental audits 7) PII audits of MRSA and CDI	Mar-22	Q4	IPCT	PII audits recommenced March 21 Audit programme agreed for 2021-22	
SA-002	Apr-21	KLOE (S2)	Improved compliance with the documentation of MRSA decolonisation	1) MRSA decolonisation paperwork to be reviewed 2) Alternative process to be evaluated and implemented	Mar-22	Q4	Jacqui Griffin (Lead Nurse IPC)	To be progressed in 2021	
SA-003	Apr-21	APW	Mandatory reporting of surgical site surveillance	1) SSIS to be reported 6-monthly to IPCC 2) Quarterly reports to PHE 3) Feedback of findings to orthopaedic directorate 4) Business case to be submitted to reflect the increase in service requirement	Mar-22	Q4	Linda Baker (surgical site surveillance Nurse) & Joanne Green (Consultant Nurse IPC)	Mandatory Orthopaedic SSIS continues, trial of altered antimicrobial prophylaxis for #NOF to be commenced Business case in progress for resources to expand SSIS into other areas	

SA-004	Apr-21	APW	No avoidable > 48-hour MSSA / MRSA bacteraemia	1) All pre and post 48 hours MSSA / MRSA bacteraemia to be reported on the DCS 2) RCAs to be completed on all > 48-hour MSSA/MRSA bacteraemia within 5 days and presented to the monthly panel for sign off 3) Trends and lessons learnt to be shared within the Trust wide 4) Panel outcomes to be shared with IPCC	Mar-22	Q4	Joanne Green (Consultant Nurse IPC)	The Trust breached its zero trajectory for MRSA bacteraemia in 2020-21, 2 of the cases was the same patient who acquired MRSA whilst an inpatient, the bacteraemia was deemed to be unavoidable due to complexities around wound management. The other case was associated with a previous MRSA osteomyelitis and deemed unavoidable.	

SA-005	Apr-21	APW & KLOE	50% reduction in gram negative blood stream infections by 2024/25 Gram neg 18/19 E coli 69 Kleb 28 Pseudo 16 **Total** 113 Gram neg 19/20 Ecoli 75 Kleb 13 Pseudo 7 **Total** 95 Gram neg 20/21 (08/03/2021) Ecoli 49 Kleb 17 Psuedo 6 **Total** 72	1) Attend Kent and Medway HCAI Improvement group meetings with CCG 2) Patient indwelling catheter cards to be provided to patients going home with indwelling catheters (E1.5) 3) Preventing CAUTI cards which promote Houdini (E1.5) 4) Laminated 'tea cup posters to be provided to ward to promote the hydration of patients (E1.5) 5) Continue to promote catheter passport 6) Report all > 48hr & <48 hr E.coli, Klebsiella and Pseudomonas aeruginosa bacteraemia on the National Data Capture System 7) RCAs to be completed on all gram negative bacteraemia which are considered avoidable and / or identify areas for learning 8) Volunteers to support additional drinks rounds to assist in promoting hydration. 9) Monitor trends against the national PHE fingertip data 10) Gram negative reduction meetings to be held 11) utilisation of GNBSI reduction plan tools and plan available at: https://improvement.nhs.uk/resources/gram-negative-bloodstream-infection-reduction-plan-and-tools/	Mar-22	Q4	Jacqui Griffin (Lead Nurse IPC)	Kent and Medway HCAI improvement group has not met during the Pandemic due to work priorities. MTW have seen a year on year reduction of E.Coli bacteraemia, workstreams to be re-prioritised in 2021 to ensure that downward trend.	

SA-006	Apr-21	APW	*Clostridium difficile* Trust attributable infections to be within the Trust Limit of 55 (19/20, we had 52 cases against a limit of 55 20/21, we had 50 cases against a limit of 55)	1) Monitor trends from the RCA & PIIs and act on findings 2) All RCAs are to be completed in 5 working days and presented to the monthly panel for agreement and sign off. 3) All samples to be sent for Ribotyping 4) Monitor for any evidence of transmission of infection	Mar-22	Q4	Joanne Green (Consultant Nurse IPC)	2020-21 achieved 47 from a limit of 55 cases	
SA-007	Jun-21	BAF	Board assurance framework is reviewed on a regular basis and presented to Trust Board	1) Updates to the BAF have been made during the Covid-19 pandemic to ensure staff safety including PPE use, and COVID management 2) PPE observational audits undertaken by the PPE safety officers 3) Audit findings to be shared with Divisions and presented at IPCC	Mar-22	Q4	Sara Mumford (DIPC) Joanne Green (Consultant Nurse IPC) Hayley Geere (PPE Lead)	BAF updated with additional COVID 19 PPE requirements presented to board PPE officers have been undertaking PPE audits on both sites - data presented at Feb IPCC and will be presented regularly to include more detailed information on compliance by ward/dept.	

SA-008	Aug-21	APW	Introduction of the updated ICNet system	1) ICNet advanced training to be delivered to IPC team 2) IPC team to implement the new ICNet system into their day to day work	Mar-22	Q4	Joanne Green (Consultant Nurse IPC)	The ICNet business case was approved for introduction in May/ June 2020 - due to the COVID Pandemic this was put on hold and will be progressed in 2021	
SA-009	Apr-21	APW	Support the introduction of the electronic audit programme	1) IPC team to attend and participate in the IVQIA meeting 2) Submit audit templates for conversion to electronic versions 3) Trial of electronic versions using iPads	Mar-22	Q4	Jacqui Griffin (Lead Nurse IPC)	Lead Nurse attending the IVQIA meetings. Templates provided. Awaiting iPads. Trial of electronic versions completed.	
SA-010	Apr-21	KLOE (S1)	Bed and Trolley mattresses to be clean and systems in place to ensure that checked, condemned and replaced if needed	1) Participation with annual bed and trolley mattress & pillow audits out and reports presented to IPCC 2) Review of trolley mattress to ensure they are cost effective and met the correct specification 3) Work with PMO to develop QIPs to address areas that require improvement 4) IPC team to attend the tele-tracking meeting that will support the tracking and cleaning of beds 5) Triangulation mattress audits completed by the IPT and fed back to divisions and wards	Aug-21	Q4	Joanne Green (Nurse Consultant IPC)	Regular attendance to the Bed and Mattress meeting	
TRAINING & EDUCATION									

TE-001	Jun-21	BAF	All training to be updated to include COVID 19 requirements	Update: 1) Online training package 2) Face to Face induction training 3) Hand hygiene practical sessions via link practitioners	Mar-22	Q3	IPC team	Training is being delivered on PPE requirements on induction Review of online package to be started	
NATIONAL & LOCAL STANDARDS									
NLS-001		APW	Delivery of the local Antimicrobial Resistance Strategy	1) ASG to report to the IPCC 6 monthly 2) AMR CQUIN for lower urinary tract infections in older people to be delivered	Mar-22	Q4	Helen Burns (Deputy Chief Pharmacist) & Grace Sluga (Consultant Microbiologist)	The antimicrobial resistance CQUIN 20/21 is yet to be published https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-20-21/antimicrobial-resistance-cquin-2020-21/	
NLS-002		APW / KLOE / EPOC	Demonstrate Shared learning from lesson learned from RCAs and incidents	1) Lessons learnt from RCAs to be identified and shared 2) Trends to be monitored and reported for wider shared learning 3) Closing the loops of RCAs - Actions from RCAs to be monitored through the IPCC to ensure that all actions have been completed (W4)	Mar-22	Q4	Joanne Green (Consultant Nurse IPC)	Due to Pandemic priorities the lessons learned from the RCAs was presented at the December 2020 IPCC, feedback from action arising is still required.	
NLS-003		APW	Support the Implementation of the Annual Flu plan	1) Peer vaccinators to recruited to support the 95% of frontline staff vaccination 2) Adequate stock of viral swabs, masks and anti-viral medicines 3) Fit testing of front-line staff 4) Flu Campaign 5) Surveillance of flu cases 6) Timely raising awareness emails to be sent regarding signs and symptoms of flu and differential diagnosis	Mar-22	Q4	IPC Team	Zero cases in 2020-21	

NLS-004		APW	Develop a Policy review programme to spread across the next 3 years to avoid Policies expiring at the same time Ensure Policies are reviewed in accordance with new national recommendations	1) Candida auris (New) (In progress) SM 2) Notification of Infection (New) (In progress) SM 3) Animal visitor policy went to PRC in June, amendments to be made- JG 4) Scabies policy - completed - waiting for upload - CT 5) TSE policy- April 2021- DM 6) Norovirus - Reviewed and extended Oct 2024 7) Isolation - Reviewed and extended Dec 2023 8) Control of resistant organisms - Reviewed and extended Oct 2024 9) Blood borne viruses - Reviewed and extended Oct 2024 10) Environmental disinfection - Reviewed and extended to 2024 11) Laundry- Reviewed and extended to 2024 12) CPE - Approved at Feb PRC, to be published 13) Decontamination of Mattresses - Reviewed and extended 2024 14) Single use medical devices - Reviewed and extended to 2024 15) Infection Prevention and Control -Reviewed and extended to 2024 16) TB - Reviewed and extended to 2024 17) VZV - Reviewed an extended to 2024 18) Outbreak of communicable disease -Reviewed and extended to 2024 19) Ward closure - Reviewed and extended to 2024 20) Hand hygiene - Reviewed and extended 2024 21) COVID PPE policy to be developed	Mar-22	Q4	Joanne Green (Consultant Nurse IPC) IPT		
NLS-005		CCG	Deliver CCG KPIs	1) KPIs to be agreed 2) Agreed KPIs to be monitored through the IPCC meeting	Mar-22	Q4	Joanne Green (Consultant Nurse IPC)	No changes have been made to the KPI's for 20/21, IPT have delivered the existing KPIs	

NLS-006		APW	Determine compliance with the code of practice the prevention and control of HCAIs	Self-assessment tool for prevention and control of HCAIs to be completed and reviewed quarterly	Mar-22	Q4	Joanne Green (Consultant Nurse IPC)	Hygiene code self-assessment summary was completed in 19/20 - further review needed for 21/22	
NLS-007		APW	Revise all IPC leaflets due for update during 20/21	All leaflets that require updating for 20/21 to be reviewed 1) Hand hygiene information for staff - August 20 2) CPE - information for patients (Standard and Large print) - April 20 3) *Clostridium difficile* - Easy read - Dec 20 4) MRSA - Easy read - Dec 20 5) Hand Hygiene - Easy read - Dec 20 6) MRSA - how to apply decol - Standard and large print) - April 21 7) Flu - April 21 8) Covid-19 leaflet to be developed (including easy read version)	Mar-22	Qu4	Joanne Green (Consultant Nurse IPC)	To be progressed in 2021	
NLS-008		APW	Seek opportunities to publicise and promote the work undertaken by the IPC team both locally and nationally	1) Utilise social media to promote the IPC service and team 2) Consider areas for innovation 3) Undertake QI projects and present findings	Mar-22	Qu 4	Joanne Green (Consultant Nurse IPC)	Planning to undertake QI project to support the mattress and bed cleaning compliance. Supported by PMO	

NLS-009		APW	Participate in developing a safe environment for staff and patients as COVID-19 progresses, developing new processes as we learn more about COVID	1) Peer vaccinators to recruited to support the 100% of frontline staff vaccination 2) Adequate stock of viral swabs, PPE 3) Ongoing fit testing programme for front-line staff 4) Covid-19 Campaigns for 2021-22 5) Surveillance of Covid-19 cases 6) Participate in the enhanced surveillance of Covid-19 and vaccination status 7) Participate with developing and implementing safe pathways for patient care as Covid-19 numbers rise and fall 8) Participate and advise on identification and isolation of patients with known or suspected Covid-19 9) Ensure national guidance is interpreted and implemented with Trust approval 10) Early identification and management of COVID related outbreaks	Mar-22	Qu 4	Joanne Green (Consultant Nurse IPC)	Working with the Trust to develop and advise on pathways for patients.	

Key	
APW	Annual Programme of Work
KLOE	Key Lines of Enquiry
BAF	Board assurance Framework
EPOC	Exceptional people outstanding care

NHS
Maidstone and Tunbridge Wells NHS Trust

Quarterly report from the Freedom to Speak Up Guardian	Freedom to Speak Up Guardian / Deputy Freedom to Speak Up Guardian

The latest quarterly report from the Freedom to Speak Up Guardian (FTSUG) is enclosed.

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

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

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

Board of Directors (Public)

Freedom To Speak Up Guardian Report Q3 (October – December 2021)

Action Requested / Recommendation

The Trust Board is asked to read the report and discuss the content and recommendations.

Summary

This is the 3rd quarter report to the board by the Freedom To Speak Up Guardian (FTSUG) which identifies trends, issues and progress report

Author; Ola Gbadebo-Saba, Deputy Freedom To Speak Up (FTSU) Guardian

Date; January 2022

Freedom To Speak Up Non-Executive Director	Maureen Choong
Freedom To Speak Up Executive Lead	Sue Steen
Freedom To Speak Up Guardian	Christian Lippiatt
Deputy Freedom To Speak Up Guardian	Ola Gbadebo-Saba

The FTSU Agenda is to;

- Protect patient safety and the quality of care
- Improve the experience of workers
- Promote learning and improvement
- Barriers to speaking up are addressed
- Encourage a positive culture of speaking up
- Ensure issues raised are used as opportunities for learning and improvement

By ensuring that;

- Workers are supported in speaking up

Themes / Issues

The last quarter was particularly challenging for staff in the Trust due to staff shortage and the new wave of Covid-19. A total of **twenty (20)** concerns were raised to the Freedom To Speak Up Guardians; **Seven (7)** concerns were on Health &Safety; **Five (5)** of which were raised in a particular clinical area at Tunbridge Wells Hospital. The concerns were on unsafe staffing with issues on skill mix, lack of support from manager, managers not listening or disregarding complaints raised to them, hence the need to raise their concern through FTSU. **Three (3)** other concerns raised in this same clinical area were on inappropriate behaviour by a male staff towards female staff which staff had escalated to their managers prior to contacting FTSU. Upon receipt of these allegations, the concern was immediately escalated to the HRBP, General Manager and Matron of the department for an investigation.

Two (2) concerns raised to Freedom To Speak Up Guardians were on Dignity and Respect. Staff who raised concerns on Dignity and Respect reported feeling undermined, treated like a child or being spoken to in ways that were demeaning by their line manager. There were also reports of feeling unvalued and low morale which was beginning to affect their productivity. One of the concerns was signposted to Freedom To Speak Up by a Safe Space Champion while the other was referred by one of the Senior Assistant Psychologists in the Trust. Both members of staff reported they were suffering a heightened level of stress & anxiety and one of them was considering leaving the Trust.

One (1) concern was on patient safety which was raised by a member of staff who has a disability and was admitted to the Trust because of a reaction to medication. Apart from the report on their experience / issues / concerns they had with the care received within the Trust, their disability was a significant aspect of care / dignity which was heightened by the unavailability of equipment that could have enhanced and improved their experience during their admission.

The other concerns raised were on issues ranging from lack of support from managers, increased stress levels in teams due to staff shortages, level of noise from construction work and the size / quality of the doctors' on-call room. The concern on the on-call room was raised on the anonymous portal and there was no detail on location.

FTSU strategy progress report

As a service we continue to work collaboratively with staff and regularly attend weekly commissioning meeting organised by the Deputy Chief People Officer – Organisational Development involving various teams such as Psychological Occupational Health, Staff Engagement, Learning &Development, Wellbeing partners. Issues affecting staff /wider teams are discussed at the meeting and some piece of work is commissioned for the purpose of gaining a better understanding of these issues & most importantly strategize to resolve & improve staff experience.

A few concerns raised at the meeting are not necessarily known to the FTSU team prior to the OD commissioning meeting but this suggests that more staff are feeling empowered to speak up, seek support, are assured that someone in the organisation is listening to them and most importantly, some steps are being taken to improve their work experience in the Trust.

Safe Space Champions

We currently have **twenty-seven (27)** fully trained Safe Space Champions (SSC) in different roles, departments and networks across the Trust. The role of the Safe Space Champions is to promote the FTSU agenda by listening to concerns, signpost & inform colleagues of support available in the Trust. FTSU Guardians and Equity, Diversity & Inclusion team have a six – eight weeks check in call with the SSCs as an opportunity to provide additional support and shared learning. SSCs are encouraged to share thematic contacts with FTSUG for the purpose of data collection.

In the previous quarter, SSCs have had 5 contacts, one of which was a case on Dignity & Respect. A few members of staff have expressed their interest to be SSCs in the Trust and a training session is being organised in February for the third cohort.

Feedback from staff who have contacted SSC have been encouraging as they have mentioned a heightened level of stress before speaking to the SSC and a sense of appreciation, relief and calmness after speaking with them.

National Guardian Office

There has been a change in leadership in the National Guardian Office with Dr Henrietta Hughes stepping down as National Guardian after five (5) years of being in post. Dr Jayne Chidgey-Clark, a clinical leader and registered nurse, with more than 30 years' experience in the NHS, higher education, voluntary and private sectors came into post as National Guardian on the 1st of December.

In addition to the NGO office establishing a Speak Up Partnership group with regulatory and professional bodies, Jayne will be attending network meetings to understand how the NGO and leaders of organisations can support the wellbeing and development of FTSUGs

Networking

The FTSU Guardian continues to attend regional and local network meetings as well as Trust staff network meeting, inductions and events.

At the last 2021 regional meeting which was held in November, there was a broad discussion around the psychological support and/or training Guardians might need to both help staff who approach them as well as any independent support that Guardians themselves might need. A short anonymous survey was created to gather some data on the needs of Guardians so it can be shown to the NGO for comment or support or to show other regions so they can adopt it to get a national picture. Findings of the survey will be shared at the Regional meeting on 22nd February 2022 and recommendations will be communicated to the Trust Board at the next Quarter report.

Data Collection; Concerns Raised

2021/22 details

Quarter	Month/Year	No. of Contacts	Open Cases		Quarter	Month/Year	MGH	TWH	Parkwood	Unknown
Q1	April-June 2021	17	3		Q1	April-June 2021	9	4	0	4
Q2	July - September 2021	53	23		Q2	July - September 2021	11	13	18	11
Q3	October – December 2021	20	4		Q3	October – December 2021	2	12	0	6
Total	**2021/2022**	**90**	**30**		**Total**	**2021/2022**	**22**	**29**	**18**	**21**

April -June 2021	

July – September 2021	

Staff Group	Number
Nursing & midwifery	2
Medical	0
Unknown	4
AHP's	1
Clinical Support	3
A&C	7
Total	**17**

Staff Group	Number
Nursing & midwifery	3
Medical	5
Unknown	9
AHP's	12
Clinical Support	4
A&C	20
Total	**53**

April – June 2021	
Theme	**Number**
Patient Safety	0
Bullying/ Harassment	8
Fraud	0
Health & Safety	0
Other	9
Total	**17**

July – September 2021	
Theme	**Number**
Patient Safety	4
Bullying/ Harassment	21
Fraud	0
Health & Safety	4
Other	24
Total	**53**

October – December 2021	
Staff Group	**Number**
Nursing & midwifery	1
Medical	1
Unknown	5
AHP's	8
Clinical Support	2
A&C	3
Total	**20**

October – December 2021	
Theme	**Number**
Patient Safety	1
Bullying/ Harassment	2
Fraud	0
Health & Safety	7
Staffing Pressure	3
Inappropriate behaviour	3
Lack of support	1
Trust Intranet	1
Space/ Quality of facility	1
Noise level	1
Total	**20**

Response to NHS England/Improvement's "Enhancing board oversight: a new approach to non-executive director champion roles" — **Trust Secretary**

NHS England/Improvement (NHSE/I) published new guidance, "Enhancing board oversight: a new approach to non-executive director champion roles" on 07/12/21. The guidance, which has been enclosed in full in Appendix 1, sets out a new approach to ensuring board oversight of important issues by discharging the activities and responsibilities previously held by some Non-Executive Director (NED) champion roles, through committee structures. It also describes which lead NED roles should be retained.

The Chair of the Trust Board and Trust Secretary reviewed the guidance on 09/12/21 and 17/01/22, and confirmed the allocation of the five retained lead NED roles, as follows:

1. "Maternity board safety champion": Maureen Choong (as the Chair of the Quality Committee).
2. "Wellbeing guardian": Wayne Wright.
3. "FTSU NED champion": Maureen Choong. This reflects the re-naming of the "Freedom to Speak 'sponsor'" role that Maureen has held since January 2019.
4. "Doctors disciplinary NED champion/independent member": David Highton (although David may designate others Non-Executive Directors to review specific cases, as required).
5. "Security management NED champion": David Morgan (as the Chair of the Audit and Governance Committee).

The new guidance did not include any role descriptions, but contains sufficient background information to enable the Trust to develop a brief description of the role's expectations. These descriptions will be added to the Trust's Standing Orders, which are scheduled to be approved at the Audit and Governance Committee in February 2022 (and then ratified by the Trust Board).

The Chair of the Trust Board also agreed that the NED roles that the Trust had already allocated should be incorporated as part of the remit of the Quality Committee. Although there will therefore no longer be a lead NED for the role, the Chair of the Quality Committee will ensure there is appropriate oversight. The relevant roles are as follows:

- "Non-Executive Lead for Safeguarding": Quality Committee (primarily via the Joint Safeguarding Committee).
- "Non-Executive Lead for Resus": Quality Committee (primarily via the Resuscitation Committee, which reports via the Surgery Division).
- "Non-Executive Director who formally holds the Emergency Preparedness, Resilience and Response (EPRR) portfolio": Quality Committee (primarily via the Health and Safety Committee).
- "Lay member on the Board with a responsibility/role for End of Life Care": Quality Committee (primarily via the End of Life Care Steering Committee, which reports via the Cancer Services Division).
- "NED with specific role/responsibilities for leading falls prevention": Quality Committee.
- "NED lead on mortality and learning from deaths": Quality Committee.
- "NED 'lead' for complaints": Quality Committee.

Finally, the Chair of the Trust Board agreed that the remaining roles listed in the "Roles to transition to new approach" in the new NHSE/I guidance i.e. that aren't covered in the list above, are incorporated as part of the remit of the following Trust Board sub-committees:

- "Hip fracture, falls and dementia": Quality Committee
- "Safety and risk": Quality Committee
- "Health and safety": Quality Committee (primarily via the Health and Safety Committee)
- "Children and young people": Quality Committee.
- "Cybersecurity": Finance and Performance Committee.
- "Counter fraud": Audit and Governance Committee.
- "Procurement": Finance and Performance Committee.

- "Security management- violence and aggression": Quality Committee (primarily via the Health and Safety Committee).

The Terms of Reference for the Quality Committee, Finance and Performance Committee and Audit and Governance Committee will therefore be reviewed to ensure that the areas listed above are appropriately reflected. The Trust Secretary will also then liaise with the Chairs of the three committees to ensure that the committees' forward programmes cover each area adequately, to enable the Trust Board to receive the assurance it requires.

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

Classification: Official

Publication approval reference: PAR994

Enhancing board oversight

A new approach to non-executive director champion roles

Version 1, December 2021

Contents

1. Summary

1.1 Introduction

This guidance sets out a new approach to ensuring board oversight of important issues by discharging the activities and responsibilities previously held by some non-executive director (NED) champion roles, through committee structures. It also describes which roles should be retained and provides further sources of information on each issue. For the purposes of this guidance the term NED champion includes ‘named NEDs’ and ‘NED leads’.

There are a range of issues which at various times have required additional board level focus to respond to and learn from high-profile failings in care or leadership. This has resulted in several reviews and reports establishing a requirement for trust boards to designate NED champions for specific issues to deliver change. This has led to an increasing number of roles spanning quality, finance and workforce.

The number of NED champion roles started to make it difficult for trusts to discharge them all effectively, particularly with a limited number of NEDs, and many do not have a role description, making it difficult to measure their impact on delivering change. Some roles have also been in place for over a decade without review.

Working with stakeholders, we have reviewed the issues the roles were originally established to address, to consider the most effective means of making progress now. There are a small number that are statutory requirements and some that still require an individual to drive change or fulfil a functional role. In these instances, the principle of the unitary trust board – with joint responsibility and decision making – remains. However, there are many issues where we now consider progress will be best made through existing trust committees rather than through individual NED champion roles.

This new approach will help enhance board oversight for these issues, by ensuring they are embedded in governance arrangements and assurance process, and through providing an audit trail of discussions and actions identified by committees. The risk of false assurance among chairs and directors who are not designated ‘champions’ will also be reduced, as oversight of transformational change to

improve care and responsibility to constructively challenge on all issues using Appreciative Inquiry approaches, will rest with the whole committee and not just an individual. By reducing the risk of individual NEDs becoming too involved in operational detail, this approach may also help maintain their independence – something that NEDs are uniquely positioned to bring to a board.

1.2 Status of guidance

This new approach is recommended but not mandatory. If trusts consider NED champion roles an effective tool to provide assurance to their board on specific issues, then they have the flexibility to retain or implement that approach.

1.3 Co-developing the approach

The new approach has been co-developed with a working group of trust chairs and we have also held a series of workshops with a range of providers. This enabled us to identify current roles and test alternative approaches to enhancing board oversight of important issues. We have engaged with national policy teams on the issues requiring oversight at board level that have associated NED champion roles. Further detail on each issue is provided in annexes 1 and 2.

We have engaged with the Care Quality Commission (CQC) throughout the development of this approach. While there is a shared understanding that strong leadership and board oversight is critical for the provision of high-quality care, the governance arrangements that individual trusts use to achieve this is expected to vary according to local circumstances and priorities. CQC inspectors will be looking for evidence of strong leadership and governance, with effective oversight of important issues. Trusts will be expected to demonstrate how they provide this, including with reference to this guidance where appropriate.

1.4 New recommended approach

For each issue, we identified the original review or report that recommended the establishment of a NED champion role and worked with the relevant national policy team to consider the current status of the role and the best way of responding to the issue at this point in time. In many cases, it was agreed that board oversight would be enhanced through a change from NED champion roles to committee discharge. It was also noted that the new approach should sit alongside other effective governance tools such as walkarounds, for example.

The table below sets out the NED champion roles that were in scope for this review and their status under the new approach.

Roles to be retained				
Maternity board safety champion	Wellbeing guardian	Freedom to speak up	Doctors disciplinary	Security management
Roles to transition to new approach				
Hip fracture, falls and dementia	Learning from deaths	Safety and risk	Palliative and end of life care	Health and safety
Children and young people	Resuscitation	Cybersecurity	Emergency preparedness	Safeguarding
Counter fraud	Procurement	Security management-violence and aggression		

It should be noted that the table above includes those issues for which a report or review has suggested a NED champion role should be established and does not include all important issues that trusts should have oversight of.

2. Implementation and support

To support the effective implementation of this new approach we recommend that trusts take the following steps:

2.1 Review current roles

Trusts should undertake a review to identify a list of their current NED champion roles. Annex 1 outlines roles that are statutory roles or that continue to require an individual to discharge those responsibilities. These roles should be retained. All other roles should be embedded in governance arrangements and aligned to committee structures where possible.

2.2 Align remaining roles to committee structures

Where we have recommended that issues are now discharged through a committee, we have grouped these issues by ‘theme’ to align with committee structures commonly used by trusts. However, this is not prescriptive, and trusts will want to align issues with the committee that they believe is the best fit and is aligned with their current governance arrangements.

Understandably some complex issues may fall under the remit of more than one committee structure – in these cases trust boards may wish to adopt a joint approach to ensure appropriate assurance.

2.3 Outline reporting structures

It will be up to trusts to decide how committees should report back on their assurance activities to the board, whether that is through existing reporting mechanisms or by establishing new periodic updates on issues that were previously the responsibility of a NED champion. Company secretaries may wish to ensure these issues are included on board/committee forward plans.

2.4 Update terms of reference

As trusts review their governance arrangements, they will want to ensure that committee terms of reference reflect any new responsibilities and respective reporting requirements because of these changes. Committee chairs and members

may wish to consider actions needed to discharge the roles effectively, such as regular engagement with an executive lead, background reading, visiting services and attending seminars or training as available and appropriate to the trust.

2.5 Ongoing support

While some trusts may already be working with similar arrangements, it is recognised that effective implementation may require cultural and behavioural shifts. To support implementation, it would be useful to receive trusts' feedback on where the proposed approach has worked well, to identify examples of best practice. We (NHS England and NHS Improvement) can then support in disseminating successful case studies and lessons learned with other trusts.

Existing platforms such as the NHS Providers Company Secretaries Network, existing care groups and regional forums will be used to share those learnings and collect feedback.

This guidance will be kept under review and updated as necessary.

Please send feedback and best practice examples to nhsi.providerpolicyengagement@nhs.net.

Annex 1: Retained NED champion roles

We have identified five NED champion roles which at this point should be retained. These are maternity board safety champion, wellbeing guardian, freedom to speak up guardian (FTSU), doctors disciplinary and security management. These should be retained because they are either a statutory requirement, the function requires a named individual to discharge or because we consider having an individual NED to be the most effective way of delivering the changes that are needed. This section provides further detail on these roles and additional sources of information are set out in the Resources section.

1. Maternity board safety champion

Applies to	All trusts providing maternity services
Type of role	Assurance
Legal basis	Recommended
Role description	Maternity NED role descriptor

In response to the Morecambe Bay Investigation (2015), this role was established through Safer Maternity Care 2016, which stated that “Senior trust managers will want to ensure unfettered communication from ‘floor-to-board’ by appointing a board level maternity champion”. The role is in line with recommendations from the Ockenden Review (2020) and while not a statutory requirement, for trusts providing maternity services having a named NED maternity board safety champion is recommended.

The champion should act as a conduit between staff, frontline safety champions (obstetric, midwifery and neonatal), service users, local maternity system (LMS) leads, the regional chief midwife and lead obstetrician and the trust board to understand, communicate and champion learning, challenges and successes.

The named champion could be the chair of the quality and safety committee and the requirements of the role could be discharged through the appropriate committee provided trusts ensure that the clinical director and director of midwifery are integral

to these committee meetings. NEDs should use appreciative inquiry approaches and the Maternity Self-Assessment Tool to provide assurance to the board that the best quality maternity care is being provided by their trust. Trusts may also wish to note that the NSR maternity incentive scheme safety actions refer to the maternity board safety champion role under Safety Action 9.

Along with other recommendations contained in the Ockenden Review, this role will be reviewed nationally in 2-3 years' time to gauge its effectiveness.

2. Wellbeing guardian

Applies to	All trusts
Type of role	Assurance
Legal basis	Recommended
Role description	Guardian community website and role description

This role originated as an overarching recommendation from the Health Education England 'Pearson Report' (NHS Staff and Learners' Mental Wellbeing Commission 2019) and was adopted in policy through the 'We are the NHS People Plan for 2020-21 – action for us all'. The NED should challenge their trust to adopt a compassionate approach that prioritises the health and wellbeing of its staff and considers this in every decision.

The role should help embed a more preventative approach, which tackles inequalities. As this becomes routine practice for the board, the requirement for the wellbeing guardian to fulfil this role is expected to reduce over time. The Guardian community website provides an overview of the role and a range of supporting materials.

3. FTSU NED champion

Applies to	All trusts
Type of role	Functional
Legal basis	Recommended
Role description	FTSU supplementary information

The Robert Francis Freedom to Speak Up Report (2015) sought to develop a more supportive and transparent environment where staff are encouraged to speak up about patient care and safety issues. In line with the review, it is recommended that all NHS trusts should have this functional FTSU guardian role so that staff have a clear pathway and an independent and impartial point of contact to raise their concerns in the organisation.

The role of the NED champion is separate from that of the guardian. The NED champion should support the guardian by acting as an independent voice and board level champion for those who raise concerns. The NED should work closely with the FTSU guardian and, like them, could act as a conduit through which information is shared between staff and the board (p.146, Francis FTSU report).

All NEDs should be expected to provide challenge alongside the FTSU guardian to the executive team on areas specific to raising concerns and the culture in the organisation. When an issue is raised that is not being addressed, they should ask why. A full description of NED responsibilities can be found in the FTSU supplementary information.

4. Doctors disciplinary NED champion/independent member

Applies to	All trusts (advisory for foundation trusts)
Type of role	Functional
Legal basis	Statutory
Role description	None

Under the 2003 Maintaining High Professional Standards in the modern NHS: A Framework for the Initial Handling of Concerns about Doctors and Dentists in the NHS and the associated Directions on Disciplinary Procedures 2005 there is a requirement for chairs to designate a NED member as “the designated member” to oversee each case to ensure momentum is maintained. There is no specific requirement that this is the same NED for each case. The framework was issued to NHS foundation trusts as advice only.

5. Security management NED champion

Applies to	All trusts, excluding NHS foundation trusts
Type of role	Assurance
Legal basis	Statutory
Role description	None

Under the Directions to NHS Bodies on Security Management Measures 2004 there is a statutory requirement for NHS bodies to designate a NED or non-officer member to promote security management work at board level. Security management covers a wide remit including counter fraud, violence and aggression and also security management of assets and estates. Strategic oversight of counter fraud now rests with the Counter Fraud Authority and violence/aggression is overseen by NHS England and NHS Improvement.

While promotion of security management in its broadest sense should be discharged through the designated NED, relevant committees may wish to oversee specific functions related to counter fraud and violence/aggression. We have included further guidance on these two functions in Annex 2. Boards should make their own local arrangements for the strategic oversight of security of assets and estates.

Annex 2: Issues that can be overseen through committee structures

This section covers those issues which reports or reviews previously suggested should be overseen by a NED champion, but which we now consider are best overseen through committee structures. Trusts should use their discretion to determine the relevance of each issue to their trust. It should be noted that there will be many other important issues not included in this guidance that trusts should also have oversight of.

For the purposes of this guidance the issues are grouped into ‘themes’ aligned to committee structures commonly used by trusts. However, each trust will need to determine whether each issue is relevant to their trust and how best they should be allocated to their committee structures, especially since some issues will cut across several committees. These issues and themes are summarised in table format under the resources section.

Quality and Safety Committee

1. Hip fractures, falls and dementia

All trusts and health boards should have a director with responsibility for falls and the ‘National Audit of Inpatient Falls Audit (NAIF) Report 2020’ recommends a patient safety group which is overseen by a member of the executive and non-executive team. This could be fulfilled by an executive rather than a NED, provided there is committee and board oversight of safety, prevention and risk management and use of data to gauge the effectiveness of practice.

Hip fractures and other serious harms resulting from inpatient falls can be linked to dementia. The board should consider the benefits of joint oversight and strategic planning across both agendas and implement where appropriate. Sufficient senior level support to enable systemic change is needed, including effecting change in partner external organisations and allocating resources as needed.

The Quality Committee may wish to ensure that the executive lead for dementia attends the Quality Committee and, in acute trusts, that they also attend the Dementia Steering Group, reporting issues into the Quality Committee. The NAIF audit has produced a useful information guide for healthcare champions which could be accessed to support this work.

2. Palliative and end of life care

The Ambitions for Palliative and End of Life Care National Framework 2021-26 set out six key ambitions for the improvement of Palliative and End of Life Care (PEoLC). Improving quality is one of the three strategic priorities of the national NHS England and NHS Improvement PEoLC programme, including high quality PEoLC, for all, irrespective of condition or diagnosis.

The impact of executive leadership on improving the quality of PEoLC is a theme that has been identified by the NHSE PEoLC team during visits to trusts. Having a NED as part of the PEoLC Executive committee, led to significant support at the Board and a focus on PEoLC. Board level oversight for PEoLC can be well supported through the Quality Committee, with reporting into the Board. The work of the Quality Committee might include:

- attendance of a NED from the Quality Committee at the PEoLC Executive Committee
- ensuring the board is aware of standards of care in PEoLC
- reviving PEoLC complaints to see where improvements could be made.

3. Resuscitation

Health Service Circular Series Number: HSC 2000/028 (Sept 2000) stipulates that chief executives of all NHS trusts should give a NED designated responsibility on behalf of the trust board for ensuring that a resuscitation policy is agreed, implemented, and regularly reviewed within the clinical governance framework.

This has been referred to more recently in the May 2020 Resuscitation Council Quality Standards in relation to acute, mental health and community trusts. The Quality Committee may wish to discharge this role, rather than an individual NED, and include this on the committee workplan, ensuring sign-off from the board.

4. Learning from deaths

Executive and non-executive directors have a key role in ensuring their provider is learning from issues such as incidents and complaints and identifying opportunities for improvement in healthcare identified through reviewing or investigating deaths. All NEDs play a crucial role in constructively challenging the executives to satisfy themselves that clinical quality controls and risk management systems are robust and defensible.

In particular, they should familiarise themselves with the care provided to individuals with learning disabilities and those with mental health needs and should encourage meaningful engagement with bereaved families/carers. The Quality Committee in particular should understand the Learning from Deaths review process, champion quality improvement that leads to actions that improve patient safety, and assure published information on the organisation's approach, achievements and challenges. Implementing the Learning from Deaths Framework: Key requirements for trust boards includes some useful questions that NEDs may wish to ask in relation to these responsibilities.

5. Health and safety

Strong leadership at board level and a strong safety culture, combined with NED scrutiny, are essential. Health and safety should be viewed in its broadest sense to include patient safety, employee safety, public safety and system leadership. As such the remit will cut across committees including Quality, Workforce/People and Planning (estates). All committees need to help ensure their organisation gets the right direction and leadership on health and safety matters through performing a scrutinising role – ensuring the integrity of processes to support boards facing significant health and safety risks.

Committee members should have a sound understanding of the risks, the systems in place for managing them, an appreciation of the causes of any failures and an understanding of the legal responsibilities of employers and individual directors for ensuring the health and safety of workers and others affected by work activities. They should be familiar with the trust's health and safety policy – which should be an integral part of the organisation's culture, values and standards – and assure themselves that this is being followed.

6. Safeguarding

Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff suggests that boards should consider the appointment of a NED to ensure the organisation discharges its safeguarding responsibilities appropriately and to act as a champion for children and young people.

This role could be discharged through a committee but in ensuring appropriate scrutiny of their trust's safeguarding performance, all board members should have Level 1 core competencies in safeguarding and must know the common presenting features of abuse and neglect and the context in which it presents to healthcare staff. In addition, board members should understand the statutory role of the board in safeguarding including partnership arrangements, policies, risks and performance indicators; staff roles and responsibilities in safeguarding; and the expectations of regulatory bodies in safeguarding.

The CQC Trust-Level Well Led Framework does not reference a safeguarding NED; rather it notes that the inspection team should speak to the/any senior member of the organisation with safeguarding responsibility.

7. Safety and risk

The Trust-Level Well-Led Inspection Framework refers to interviewing a sample of NEDs with the NED for safety and risk being a priority. This is not intended to imply that a specific NED champion role should be in place. Moreover, it refers generally to a NED that would have suitable oversight of these areas such as the chair of Quality and/or Audit committees as examples.

CQC have endorsed the new approach recommended in this guidance. However, should trusts wish to do so, then allocating the role to an individual NED as one tool for ensuring strong leadership and governance is acceptable practice.

8. Lead for children and young people

The Core Service Inspection Framework for Children and Young People (CYP) refers to an interview with the 'NED on the board with responsibility for CYP'. This is not intended to imply that a specific NED lead role should be in place. Moreover, it refers generally to a NED that would have suitable oversight of this area, such as the chair of quality for example. CQC have endorsed the new approach recommended in this guidance. However, should trusts wish to do so, then

allocating the role to an individual NED as one tool for ensuring strong leadership and governance is acceptable practice.

Audit and Risk Committee

9. Counter fraud

The role of fraud champion is one that is suited to a senior manager who is directly employed by the trust. This could also be an executive but is not intended to be a NED role. The 2004 Counter Fraud Directions included a requirement for NHS trusts to designate a NED to undertake specific responsibility for counter fraud. However, these were revoked by the 2017 Directions on Counter Fraud, so there is no longer a statutory requirement to designate a NED champion for counter fraud.

NHS funded services are required to provide the NHS Counter Fraud Authority (NHSCFA) details of their performance annually against the Government Functional Standard 013: Counter Fraud and NHSCFA ask that the audit committee chair (usually a NED) signs off the trust's submissions. The audit committee chair (and members) may also wish to review the local counter fraud specialist's (LCFS) final reports and consider any necessary improvements to controls, along with any recommendations contained within reports following NHSCFA's engagement through its quality assurance programme.

10. Emergency preparedness

The NHSE Emergency Preparedness, Resilience and Response (EPRR) Framework sets out the responsibilities of the accountable emergency officer (AEO), who is expected to be a board level director with executive authority and responsibility for ensuring that the organisation complies with legal and policy requirements.

The Framework suggests that a NED or other appropriate board member should support the AEO and endorse assurance to the board that the organisation is complying with legal and policy requirements. This will include assurance that the organisation has allocated sufficient experienced and qualified resource to EPRR.

The independence that NEDs bring is essential to being able to hold the AEO to account, but responsibility for EPRR sits with the whole board and all NEDs should assure themselves that requirements are being met. EPRR should be included on

appropriate committee forward plans and EPRR board reports, including EPRR annual assurance, should be taken to the board at least annually.

Given the synergies between the agenda for EPRR and other important issues such as security management and health and safety, triangulation between these areas through the Board and committees will be essential.

Finance, Performance and Planning Committee

11. Procurement

Procurement should be seen by the board as a value-adding function. The Finance, Performance and Planning Committee should help raise awareness of commercial matters at board and director levels and facilitate discussions that identify benefits to procurement activity and strategic development. The committee would need to understand the scope of procurement, the priorities (at national and at integrated care system level) and the challenges of delivering change. The Audit Committee should regularly review procurement.

Our Procurement Target Operating Model (PTOM) programme team is seeking ambassadors who can advocate and raise the profile of procurement at a local level. This role can also be carried out by an executive, provided there is committee and board oversight. NEDs should collectively provide assurance via these committees to the board that their trust is viewing procurement as a priority, engaging with the PTOM programme and aligning their procurement activity with national activity.

12. Cyber security

Board leadership is seen as essential to the success of this agenda so trusts may decide it is more appropriate for this function to be discharged by the board than a committee. NEDs should provide check and challenge, ensuring information governance has been considered in all decisions and that this can be evidenced.

Each trust should have a senior information risk owner (SIRO), who would usually be an executive, although trusts can appoint a NED to this role should they wish to do so. The SIRO should ensure on behalf of the board that the 10 minimum cyber-security standards are followed throughout their organisation.

The board/committee should regularly review cyber security risks, ensuring appropriate mitigation, and that regular maintenance of critical systems and equipment takes place, while minimising impact on clinical services during system downtime. This should include the following:

- Removal of unsupported systems from trust networks.
- Timely patching of systems and prompt action on high severity Alerts when they are issued.
- Ensuring robust and immutable backups are in place.

It is also recommended that boards undertake annual cyber awareness training, in addition to the mandatory and statutory information governance training that individual board members are required to complete.

Workforce/People Committee

13. Security management – violence and aggression

As set out in 'We are the NHS People Plan for 2020-21 – action for us all' and the NHS Violence Prevention and Reduction Standard 2020, the board may wish to ensure the following:

- The trust has committed to develop a violence prevention and reduction strategy and this commitment has been endorsed by the board, which is underpinned by relevant legislation (set out in the Violence Prevention and Reduction Standard 2020), ensuring the strategy is monitored and reviewed regularly – 'regularly' to be decided by the board.

- Inequality and disparity in the experience of any staff groups, including those with protected characteristics, has been addressed and clearly referenced in an equality impact assessment, which has been made available to all stakeholders.

- A senior management review is undertaken twice a year and as required or requested, to evaluate and assess the Violence Prevention and Reduction Programme, the findings of which are shared with the board.

The Workforce/People Committee may wish to align this with wider wellbeing work being undertaken by the committee, particularly in relation to wellbeing support after violence.

Resources

Summary of roles by suggested committee and further sources of information

The following is a list of further reading that NEDs and other board members may find useful in developing their knowledge and understanding of the issues highlighted in this document.

Role	Links to further reading
General	
Maternity board safety	• Morecambe Bay Investigation (2015) • Ockenden Review (2020) • NSR Maternity Incentive Scheme Safety Actions • Maternity and Neonatal Safety Champions Toolkit • Transforming Perinatal Safety Resource Pack • NHS England and NHS Improvement Maternity Safety Resources • Safer Maternity Care 2016
Wellbeing guardian	• Guardian Community website and role description • Health Education England 'Pearson Report' (NHS Staff and Learners' Mental Wellbeing Commission 2019)
Freedom to speak up	• Report template – NHS England and NHS Improvement website (england.nhs.uk) • Robert Francis Freedom to Speak Up report • FTSU supplementary information • FTSU Guidance and self-review tool
Doctors disciplinary	• Directions on Disciplinary Procedures 2005 • Maintaining High Professional Standards in the modern NHS
Security management	• Directions to NHS Bodies on Security Management Measures 2004

Role	Links to further reading
Quality and Safety Committee	
Hip fracture, falls and dementia	• Patient Information Resource National Audit of Inpatient Falls- Guide for Healthcare Champions • National Audit of Inpatient Falls (NAIF) 2020 Annual Report | RCP London • NICE Guidance - Falls in Older People: Assessing Risk and Prevention • Dementia Care Pathway- Full implementation guidance • Dementia wellbeing in the COVID pandemic • NHS England Dementia: Good Personalised Care and Support Planning Information for primary care providers and commissioners - Guidance
Palliative and end of life care	• Ambitions for Palliative and End of Life Care: a national framework for local action 2021-2026 • "What NHS England is doing to improve end of life care", NHS England and NHS Improvement webpage • "Resources on End of Life Care", NHS England and NHS Improvement webpage
Resuscitation	• Quality Standards: Acute Care, Resuscitation Council UK
Learning from deaths	• https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf
Safety and risk	• Inspection Framework – trust-wide well led, CQC
Lead for children and young people	• Inspection framework – NHS Hospitals services for children and young people, CQC
Safeguarding	• Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff
Health and safety	• "Leading Health and Safety at Work", HSE webpage • FAQs: Leading health and safety at work, HSE webpage • Leading health and safety at work: Actions for directors, board members, business owners and organisations of all sizes- Guidance, HSE

Role	Links to further reading
Audit and Risk Committee	
Counter fraud	• Refer to service condition 24 of the NHS standard contract: 2021/22 NHS Standard Contract, NHS England and NHS Improvement • "Information for Fraud Champions", Fraud Prevention, NHS Counter Fraud Authority webpage
Emergency preparedness	• NHS England and NHS Improvement Emergency Preparedness, Resilience and Response Framework – Guidance
Finance, Performance and Planning Committee	
Procurement	• NHS Procurement: Raising Our Game – Best Practice Guidance
Cyber security	• 2017/18 Data Security and Protection Requirements- Guidance • Data Security and Protection Toolkit, NHS Digital • The Minimum Cyber Security Standard- Guidance, Cabinet Office • Lessons learned review of the WannaCry Ransomware Cyber Attack – Independent report
Workforce/People Committee	
Security management - violence and aggression	• Violence prevention and reduction standard

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