

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

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

Virtually, via Webconference

Agenda

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

10-1

To receive apologies for absence

David Highton

10-2

To declare interests relevant to agenda items

David Highton

10-3

To approve the minutes of the 'Part 1' Trust Board meeting of 29th September 2022

David Highton

 Board minutes, 29.09.22 (Part 1).pdf (10 pages)

10-4

To note progress with previous actions

David Highton

 Board actions log (Part 1).pdf (3 pages)

10-5

Report from the Chair of the Trust Board

David Highton

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

10-6

Report from the Chief Executive

Miles Scott

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

Reports from Trust Board sub-committees

10-7

Quality Committee, 12/10/22 (incl. approval of the revised Terms of Reference)

Maureen Choong

 Summary of Quality C'ttee, 12.10.22 (incl. revised Terms of Reference).pdf (6 pages)

10-8

Finance and Performance Committee, 25/10/22

Neil Griffiths

 Summary of Finance and Performance C'ttee 25.10.22.pdf (1 pages)

10-9

People and Organisational Development Committee, 21/10/22 (incl. the Guardian for Safe Working Hours Annual Report 2021/22)

Emma Pettitt-Mitchell

 Summary of People and Organisational Development Cttee, 21.10.22 (incl. Guardian of Safe Working Hours Annual Report).pdf (6 pages)

Integrated Performance Report

10-10

Integrated Performance Report (IPR) for September 2022

Miles Scott and colleagues

 Integrated Performance Report (IPR) for September 2022.pdf (37 pages)

Planning and strategy 1

10-11

Review of the draft winter plan for 2022/23

Sean Briggs

 Review of the draft winter plan for 202223.pdf (191 pages)

Quality Items

10-12

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

Sara Mumford

 Annual Report from the Director of Infection Prevention and Control.pdf (58 pages)

10-13

Findings of the national inpatient survey 2021

Joanna Haworth

 Findings of the national inpatient survey 2021.pdf (94 pages)

10-14

Quarterly Maternity Services report

Sarah Flint

N.B. The item has been scheduled for 11:55am.

 Quarterly Maternity Services report.pdf (9 pages)

Systems and Place

10-15

Update on the West Kent and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)

Rachel Jones

 Update on the West Kent and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB).pdf (6 pages)

Planning and strategy 2

10-16

The outcome of the further work on the Divisional Improvement Projects

Rachel Jones

 The outcome of the further work on the Divisional Improvement Projects.pdf (14 pages)

Assurance and policy

10-17

Quarterly report from the Freedom to Speak Up Guardian

Natalie Hayward

N.B. The item has been scheduled for 12:20pm.

 Quarterly report from the Freedom to Speak Up Guardian.pdf (5 pages)

10-18

To consider any other business

David Highton

10-19

To respond to any questions from members of the public

David Highton

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

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

10-20

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

David Highton

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

**MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON
THURSDAY 29TH SEPTEMBER 2022, 9:45 AM, VIRTUALLY VIA
WEBCONFERENCE**

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board (Chair)	(DH)
	Sean Briggs	Chief Operating Officer (apart from part of item 09-11 - refer to the relevant minute for the specific details)	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	Neil Griffiths	Non-Executive Director	(NG)
	Peter Maskell	Medical Director	(PM)
	David Morgan	Non-Executive Director	(DM)
	Emma Pettitt-Mitchell	Non-Executive Director	(EPM)
	Steve Orpin	Deputy Chief Executive/Chief Finance Officer	(SO)
	Miles Scott	Chief Executive (for items 09-1 to part of item 09-11 – refer to the relevant minute for the specific details)	(MS)
	In attendance:	Karen Cox	Associate Non-Executive Director
Richard Finn		Associate Non-Executive Director	(RF)
Rachel Jones		Director of Strategy, Planning and Partnerships	(RJ)
Sara Mumford		Director of Infection Prevention and Control	(SM)
Sue Steen		Chief People Officer	(SS)
Jo Webber		Associate Non-Executive Director	(JW)
Richard Gatune		Deputy Chief Nurse for Quality and Experience	(RG)
Kevin Rowan		Trust Secretary	(KR)
Rob Parsons		Risk and Compliance Manager (for items 09-19 & 09-20)	(RP)
Observing:	The meeting was livestreamed on the Trust's YouTube channel.		

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

DH firstly noted that the Integrated Performance Report (IPR) item would be considered earlier than scheduled, as SB had to leave the meeting at approximately 10.30am to attend another important meeting.

09-1 To receive apologies for absence

Apologies were received from Jo Haworth (JH), Chief Nurse; and Wayne Wright (WW), Non-Executive Director.

09-2 To declare interests relevant to agenda items

No interests were declared.

09-3 To approve the minutes of the meeting of 28th July 2022

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

09-4 To note progress with previous actions

The content of the submitted report was noted and the following actions were discussed:

- **06-26 (“Arrange for the outcome of the further work on the Divisional Improvement Projects to be submitted to the Trust Board, when such work was completed”).** The content of the “Progress” column was noted.
- **07-6 (“Liaise with the Director of Emergency Response and Planning to ensure that the lessons learned review of the Trust’s response to the July 2022 ‘heatwave’ incorporated any patient feedback which had been received”).** The content of the “Progress” column was noted.
- **07-9 (“Draft a letter of commendation, on behalf of the Chair of the Trust Board, for the services provided by the Director of Medical Education during their tenure at the Trust”).**

The content of the “Progress” column was noted and DH added that the letter had now been sent, so the action could be closed.

- **07-12a (“Liaise with representatives from the Medicine and Emergency Care Division to investigate what, if any, actions could be implemented to expedite the recruitment process for Clinical Fellows”).** SS reported that conversations had started to be held to understand the recruitment processes and ensure that process progressed as swiftly as possible. DH therefore confirmed that the action could be closed.
- **07-19 (“Liaise with the Trust’s Chaplaincy Service to investigate what, if any, anonymised data sharing could be implemented in relation to staff concerns raised to the Chaplaincy Service”).** The content of the “Progress” column was noted and DH confirmed that action could be closed.

09-5 Report from the Chair of the Trust Board

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

- There had been six consultant appointments since the last Trust Board meeting, which was very positive.
- DH was pleased to announce that NG, the Vice Chair of the Trust Board, had been reappointed as a Non-Executive Director for a further four years, until February 2027.

09-6 Report from the Chief Executive

In MS’s absence, DH referred to the submitted report and congratulated Rantimi Ayodele for her appointment at another Trust. PM echoed DH’s congratulations, while SO acknowledged the significant work that Rantimi, and others, had done for the Trust’s Cultural and Ethnic Minorities Network (CEMN). SO also noted that Rantimi’s departure had heralded a significant change to the CEMN, which had been agreed at their recent Annual General Meeting.

Reports from Trust Board sub-committees

09-7 Quality Committee, 17/08/22 and 14/09/22

MC referred to the two submitted reports and highlighted the following points:

- Some very helpful reports had been given by RJ’s team regarding health inequalities, and MC would recommend that all Trust Board members read such reports.
- The review of the risks associated with the management of mental health presentations within the Trust’s Emergency Department (ED) had acknowledged that the location was not ideal for such patients.
- A significant proportion of the meeting had been spent on discussing Sepsis.
- Assurance had been given on the progress with harm reviews.
- The need for further work on the clinical coding challenges that affected the mortality position was acknowledged.

09-8 Finance and Performance Committee, 27/09/22 (incl. approval of revised Terms of Reference)

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

- A very good ‘deep dive’ session had been held with the Facilities leadership team, which had given confidence and assurance that the appropriate action was being taken.
- There had been a significant discussion on the options to improve patient flow, and the need to liaise with partners within the Kent and Medway system had been acknowledged.
- The Cost Improvement Programme (CIP) performance was discussed, and SO’s concerns were recognised.
- Revised Terms of Reference were agreed, which needed to be approved by the Trust Board.
- A Business Case for a Sunrise infrastructure upgrade was reviewed and recommended for approval by the Trust Board.

The revised Terms of Reference for the Finance and Performance Committee were approved as submitted.

09-9 People and Organisational Development Committee, 23/09/22 (incl. an update on the 'Messenger review; and approval of revised Terms of Reference)

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

- The meeting had been a 'deep dive', but recruitment and retention was discussed as was the case for each People and Organisational Development Committee meeting.
- The 'Messenger Review' and NHS "The Future of NHS Human Resources and Organisational Development" had been discussed, and information had been included in the submitted report.
- Revised Terms of Reference had been agreed, and these needed to be approved by the Trust Board.

The revised Terms of Reference for the People and Organisational Development Committee were approved as submitted.

09-10 Patient Experience Committee, 01/09/22

DH firstly noted that MC had chaired her last Patient Experience Committee meeting. MC then referred to the submitted report and highlighted the following points:

- The Committee had heard about the relaunch of the patient partner programme and the reinstatement of the Patient-Led Assessments of the Care Environment (PLACE).
- The Committee had also heard from the outpatient team on the work being done to improve patient experience.
- The Committee had discussed increasing the diversity of the membership, and that work would be taken forward by the new Committee Chair.

DH referred to the latter point and added that JW had agreed to be the new Chair of the Committee.

Integrated Performance Report

09-11 Integrated Performance Report (IPR) for August 2022

SB firstly referred to the "Patient Access" Strategic Theme and reported the following points:

- The metrics had been affected by significant increases in demand in some specialities, including urology, which had seen a 47% increase in referrals.
- The main cancer access standard had been met in July, and would likely be also met for August, but it was possible that the target would not be met for September 2022.

DH asked whether the increase in referrals was likely to be due to patients not presenting because of the COVID-19 pandemic, and therefore presenting with later stage illness than ordinarily would be the case. SB acknowledged that may have played a part in the current situation, but it was felt that a lack of access to primary care was a more significant factor, as was the Trust's agreement to accept referrals from some other local organisations that had been challenged. MS added that SB and his team were reviewing referral patterns, and working closely with the Chiefs of Service, as the nature of the increase would determine the nature of the Trust's response.

SB then continued and highlighted the following points:

- Diagnostic access standard performance had been affected by staffing issues and some equipment faults, but the operational team were confident the issues had now been addressed.
- The Trust continued to perform very well, in comparative terms, on the ED 4-hour waiting time target, but the pressure continued to increase.
- The Trust had recently been visited by the Emergency Care Improvement Support Team (ECIST), who had last visited the Trust circa four years ago. The ECIST had given some very positive feedback on the Trust's processes, but had also given some advice which the Trust could use to further improve, including in relation to therapies. That advice would inform the winter plan that would be submitted to the Trust Board in October 2022.

DH noted that the Non-Executive Directors in particular would be pleased to see the winter plan in October but asked for assurance that the therapies team would respond positively to the advice from ECIST. SB gave such assurance.

SB then continued and highlighted the following points:

- The aforementioned increase in referrals had also posed challenges in relation to the financial position, so it was important to try and ensure there was a balance.
- The Referral to Treatment (RTT) performance had continued to improve in many specialties, and the number of patients waited over 40 weeks for treatment had been reduced. It was acknowledged that further action was required in gynaecology, but the team and Chief of Service for the Women's Children's and Sexual Health Division was closely engaged in the work, and they were confident that the position would recover before the end of 2022/23.

SS then referred to the "People" Strategic Theme and reported the following points in relation to vacancies, and the "Turnover Rate" metric:

- The Trust's ability to recruit and retain staff was become increasingly challenging, as was the case with other NHS providers, but some positive trends were emerging, so all those working hard to improve the position, including SS' team, should be thanked.
- There nursing and midwifery vacancy rate was currently at 16%.
- The Trust had started to see the peak of the staff exodus that had occurred as the COVID-19 pandemic started to end.
- There were 757 people within the current recruitment pipeline, and 359 going through the pre-employment process.
- A successful international recruitment campaign had resulted in 117 recruits, and further open recruitment events were scheduled.

JW noted that there was significant pressure on therapies staff, so asked for an update on that, and also asked whether changes to the mix of therapists was being considered. SS acknowledged the challenge in therapies and noted that offering job flexibility was a key aspect. SS offered to provide further information on therapies at the next Trust Board meeting & JW agreed that would be helpful.

Action: Submit further details, to the Trust Board meeting in October 2022, on the action being taken regarding the recruitment and retention of Therapies staff (Chief People Officer, October 2022)

DM asked whether any analysis was undertaken on the staff that had left, to determine whether, for example, they had left for other local Trusts or left the NHS entirely. SS noted that the 'moving on' surveys tried to capture such data and added further details.

[N.B. MS left the meeting at this point]

KC then referred to the international recruitment and highlighted the need to support the staff who had been recruited. KC also asked for the breakdown between internationally-recruited and home-recruited midwives in the recruitment pipeline. SS gave assurance on the pastoral and other support that was available to international recruits and elaborated on the specific details. SS also stated that she would provide further details on the breakdown between internationally-recruited and home-recruited midwives at the next Trust Board meeting.

Action: Submit further details, to the Trust Board meeting in October 2022, of the breakdown between internationally-recruited and home-recruited midwives that were in the Trust's current recruitment pipeline (Chief People Officer, October 2022)

[N.B. SB was not present for the remainder of item 09-11]

DH noted that he had noticed that the advertisements for clerical posts on the Trust's social media platforms had implied that previous NHS clerical experience was essential, but the associated Job Description/Person Specification only listed such experience as desirable, so there was a risk that the Trust was closing the market to local recruits who had not worked for the NHS before. SS thanked DH for the feedback and agreed to explore and address.

Action: Correct any occurrences where the social media advertisements for clerical posts at the Trust implied that previous NHS clerical experience was essential, despite such experience only being listed as desirable in the relevant Person Specification (Chief People Officer, September 2022 onwards)

SS then concluded by reporting the key points in relation to the "Sickness Rate" metric.

PM then reported the key points in relation to the “Reduction in the rate of patient falls to 6.36 per 1000 occupied bed days by March 2023” metric within the “Patient Safety & Clinical Effectiveness” strategic theme, which noted that work on falls prevention continued with the wards that experienced the most falls.

SM then referred to the "Infection Control" metric and reported the following points:

- There had been an increase in *Clostridioides difficile* cases, which was a regional and national issue, and the infection control team were actively engaging with staff, particularly in relation to antimicrobial stewardship.
- An increase in COVID-19 cases had started to be seen, and there had been an increase in hospital-acquired cases, particularly in the areas that had bays rather than single rooms. The current guidance was to only test symptomatic cases on admission as well as in hospital, but the Trust was doing more, and testing all admissions on arrival, although further testing was only undertaken if patients became symptomatic or there was an outbreak.

RG referred to the “Patient Experience” Strategic Theme and reported the following point for the “Total Number of Complaints” and “Complaints responded within target” metrics:

- There had been some improvement, and weekly performance meetings were held with the Chief Nurse and Director of Quality Governance. The additional support that had been engaged to improve performance would also continue for the time being.
- The data was still being analysed regarding the reasons for complaints, as part of the Strategy Deployment Review (SDR) process.

RG then reported the following points in relation to the “FFT Response Rates – all areas” metric:

- The Trust had introduced a full text messaging service in July 2022.
- The outpatient FFT response rate had expected to increase, but had in fact declined, so liaison was taking place with the Trust’s provider, Netcall, to ensure that all the returned surveys had been processed.

RF asked for clarification as to the reasons why all the FFT-related metrics were in “Escalation”. RG elaborated on the situation, and the issues being discussed with Netcall. RF stated that he would be interested to hear Netcall’s response, as the issue seemed to be a significant constraint to progress. RG agreed.

EPM asked whether FFT surveys were given to patients randomly or given to all patients. RG explained that it was not random and an FFT was expected to be completed by every patient that had had an outpatient appointment. EPM also asked how the Trust supported the patients who were not as au fait with the use of text messages. RG noted that it was still possible to submit paper-based surveys and that was being closely monitored.

DH noted the trade-off between the number of questions on a text-based survey and the response rate, as there was likely to be an increased response rate on surveys with fewer questions. RG acknowledged the point and confirmed such issues would be considered as part of the work relating to the patient experience strategy.

RJ then referred to the “Systems” Strategic Theme and reported the following points for the “Decrease the number of occupied bed days for patients identified as medically fit for discharge” (which was now referred to as “patients who did not meet the criteria to reside”) and “Discharges before Noon” metrics:

- The former metric had seen three positive data points, but it was too early to draw any firm conclusions.
- The Hilton pathway and Nurse-led criteria discharge had been identified as the top contributors for the latter metric, so these would be the area of focus.

DH asked whether there was variance in the acceptability of Nurse-led criteria discharge process. RJ stated that there were other factors that were more important, and JH was closely involved in the associated work.

JW referred to the “Pharmacy TAT for Dossett’s [sic] and TTOs...” top contributor on page 26 of 39 and asked for further details. RJ noted that a working group was exploring the relevant pharmacy-related issues, and elaborated on the options that had been considered to address the issues.

SO then referred to the “Sustainability” Strategic Theme and reported the following points in relation to the “Agency Spend” metric:

- There had been a slight increase on expenditure but the work to understand the “Top Contributors” was not yet complete. However, 44% of the expenditure was within the Medicine & Emergency Care Division, so consideration was being given as to what concentrated support could be provided to that Division, to reduce such expenditure.
- Temporary medical staffing tended to be the area where significant premiums were paid, to ensure the relevant service was able to continue. The Breast Radiology service was an example of such a situation.
- An additional Deputy Medical Director had been recruited and his remit included workforce, so SO and his team looked forward to working with the individual in due course.
- The financial plan for the year to date had been delivered, but the plan now expected an improved position for the remainder of the year, so SO was concerned that the financial outlook looked more challenging than had anticipated. SO would therefore submit some reports to the Executive Team Meeting (ETM) and Finance and Performance Committee in the next month to explain the additional actions SO would propose.

DH noted that the Non-Executive Directors were concerned at the financial position, so emphasised the need for SO’s reports to the ETM and Finance and Performance Committee to be robust. SO acknowledged the point.

DH then also noted that many of the Trust Board members had referred to “A3” process, so asked SO to explain that process for any members of the public that may be observing the meeting. SO explained that “A3 thinking” was the formal term, which was part of the SDR methodology the Trust had adopted, and related to the fact that the data, analysis and action to be taken should all be able to fit on a single A3 sheet.

Quality Items

09-12 Quarterly mortality data

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

- The Hospital Standardised Mortality Ratio (HSMR) 12 and Summary Hospital-level Mortality Indicator (SHMI) were both as expected, but the reasons for the upward trends were being explored, and several steps had been taken, including steps to improve the clinical coding.
- The Medical Examiner service was still suffering from being underfunded. The expansion of the service into the community had commenced with some community hospital and hospice deaths being scrutinised, but that expansion was likely to be challenging.
- The backlog with Structured Judgment Reviews (SJRs) continued and PM had recently written a blog to try and increase the number of Structured Judgment Reviewers.

EPM referred to the comment on the “HSMR: Relative Risk for NEL Weekend Admissions” chart on page 11 of 23 that “Despite our Crude Rate being lower than our peer group, our Relative Risk of death at the weekend is higher” and asked for further details. PM replied that the number of deaths at the Trust was lower than its peers, but the ratio of expected to observed deaths was higher, which indicated that the calculated expected rate was probably too low. EPM clarified that there were therefore no concerns regarding weekend mortality. PM clarified that he did not believe the situation was completely understood as yet, but liaison was continuing with the Trust’s data provider, Telstra Health UK.

09-13 Summary of the changes to the updated NHS Safeguarding accountability and assurance framework

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

- The new framework had not changed significantly from its predecessor, but did reflect some changes in legislation.

- The new framework had already been incorporated into the Trust's safeguarding arrangements and policies.
- The "Current requirements and status at MTW" section rated most of the areas as green, but the Duty of candour had been rated as amber, because the statutory time frame not always being achieved.

RG then elaborated on the "Impact on Maidstone and Tunbridge Wells NHS Trust" section.

JW asked how assurance was obtained that the providers the Trust used for follow-up care were following the expected standards. RG explained that all providers within the pathway followed the safeguarding framework.

DH noted that the Trust Board took safeguarding extremely seriously and thanked RG for the detailed report.

Systems and Place

09-14 Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)

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

- Progress had been made with recruitment to the leadership within the ICB.
- Oversight meetings had been held with the Trust, and the West Kent HCP, and the details were included in the submitted report.
- The Trust was considered very positively within the overall system, and this was reflected in the three major projects the Trust was leading i.e. the elective orthopaedic centre, the Kent and Medway Medical School (KMMS) accommodation and education centre; and the Community Diagnostic Centre (CDC).
- Kent County Council (KCC) had engaged with key stakeholders on plans to move to locality based adult social care teams, and Trust's main concern was the demand and capacity intelligence that supported the proposed savings. A letter has been sent to KCC's Corporate Director for Adult Social Care and Health inviting him to join the discussion on neighbourhood integrated teams at the West Kent HCP 'away day' in October 2022.

DH noted that he could not attend the Kent and Medway symposium that had been scheduled for 28/10/22, so he had written to the Chair of the ICB to ask whether one of the Trust's Non-Executive Directors could attend in DH's place. DH continued that he had not yet received a response, so asked RJ to pursue the matter, to enable an attendee to be identified from among the Non-Executive Directors. RJ agreed.

Action: Pursue a response to the Chair of the Trust Board's query as to whether one of the Trust's Non-Executive Directors could attend the "Together, we can" symposium that was being organised by NHS Kent and Medway on 28/10/22 in the Chair's place (Director of Strategy, Planning and Partnerships, September 2022 onwards)

Planning and strategy

09-15 To approve a Business Case for a Sunrise infrastructure upgrade

DH firstly pointed out that the Case had been reviewed by the Finance and Performance Committee and been recommended for approval by the Trust Board. SO then referred to the submitted report and highlighted the rationale for the Case. SO also noted that the capital expenditure had already been included in the Trust's capital plan, but the revenue costs for future years would need to be covered via the Trust's business planning process.

Questions were invited. None were received. The Business Case was approved as submitted.

09-16 The Kent and Medway Vascular Surgery Decision-Making Business Case

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

- The Case was the culmination of work that had been taking place across Kent and Medway over several years.

- All of the diagnostic outpatient and non-inpatient surgery would remain at Medway NHS Foundation Trust (MFT), and the Case would only affect the current 260 patients per year that required inpatient surgery, which would now be provided at the Kent and Canterbury Hospital.
- The Case would deploy a 'hub and spoke' model.
- RJ and PM had been assured that the proposals were safe.
- Some of the changes had already been made, given previous concerns regarding safety at MFT.

MC welcomed the fact that RJ and PM were liaising regarding the safety considerations, but appealed for such considerations to include South East Coast Ambulance Service NHS Foundation Trust (SECAmb). RJ gave assurance that SECAmb were involved and that the new arrangements would be safer.

Assurance and policy

09-17 Responsible Officer's Annual Report 2021/22

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

- The Statement of Compliance needed to be approved before it was signed by MS.
- The Trust had achieved a 95% appraisal rate, and a separate workstream was in place to support the Trust's specialty doctors and specialist grade doctors, who had a lower compliance rate.
- An external review of the appraisal process had been undertaken, and a new web-based appraisal system had been introduced.
- PM would like the Trust Board's support to continue to address the issues regarding appraisal.

MC welcomed the report, and the further work that PM intended to undertake, given the opportunities for improved compliance, but asked whether the issues should also be considered at the People and Organisational Development Committee. PM welcomed the opportunity to submit appraisal data to that Committee, and EPM and RC agreed.

Action: Arrange for the People and Organisational Development Committee to consider the data regarding medical appraisal and revalidation (Trust Secretary, September 2022 onwards)

RF noted that that personal development plans (PDPs) should include 'hard' and 'soft' skills, so asked how many of the appraisals included 'soft' skills and values-driven behaviour. PM confirmed he did not have the relevant data to hand, and acknowledged that there was likely to be insufficient inclusion of 'soft' skills, but PM would expect good appraisers to incorporate such discussions in the appraisal, in the event of incidents. PM added that he would be content to collect the data, for inclusion in the next report, although he was not clear as to what the 'correct' level should be. RF stated that it would be a shame if 'soft' skills were only included following incidents. SM agreed and gave assurance regarding the use of 360° appraisals and the inclusion of consultants in the Exceptional Leaders programme. SM however emphasised the importance of including Serious Incidents and complaints within the appraisal process. DH also gave assurance that emotional intelligence and 'soft' skills formed part of the appointment process for new consultants.

The Statement of Compliance was approved as submitted.

09-18 To receive assurance regarding the confidentiality of patient information, in light of the 'Approaching Standards' submission on the Data Security and Protection Toolkit for 2021/22

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

- Each year the Trust commissioned an independent audit of compliance against the National Data Guardian's 10 data security standards, and the latest audit had concluded "Moderate assurance", on the basis of a "Limited Assurance" conclusion for the "IT Protection" standard. However, the Trust had developed a robust action plan, which had been agreed with NHS Digital, to address the technical issues impacting assurance levels associated with that Standard.
- The Trust had an Information Governance Committee.
- In the last 12 months the Trust has had one data breach that met the criteria for reporting to the Information Commissioner's Office, but that incident had now been stood down.

DH emphasised the need for the Trust to be completely honest in any self-assessments it undertook against external standards, and was pleased to see the progress that had been made.

09-19 Health & Safety Annual Report, 2020/21 and agreement of the 2022/23 programme (including Trust Board annual refresher training on health & safety, fire safety, and moving & handling)

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

- After lower levels of incident reporting in 2020/21, overall reporting rates had increased by 17.6%. The main outlier was violence and aggression incidents, which represented a significant increase from pre-pandemic levels.
- There had been a general upward trend for staff, public and Trust incidents, which was encouraged, as reports are encouraged to be reported.
- The report included two Statistical Process Control (SPC) charts, which indicated that reporting during periods of increased pressure tended to focus on the more serious incidents, rather than the less serious.
- There had been 22 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) incidents.
- There were six main learning points, which related to violence, abuse and harassment; absconding patients; Legionella at Tunbridge Wells Hospital; high risk inanimate load moving and handling; sharps/splash reporting; and health and safety inspections and risk assessment audit compliance.
- The objectives for 2022/23 were included in the submitted report.

DH referred to the violence and aggression incidents and asked whether there was any link with the increase in patients with mental health issues or dementia, or whether it was a more widespread issue. RP stated that the data revealed a link with such patients, but the issue was likely to be affected by wider factors.

DM welcomed the use of normalisation/SPC charts but suggested the use of SPC be widened. RP agreed to consider for future reports.

RP then highlighted the content of the “2022/23 Training update – What does the Board need to know?” section, which included some legal cases and a Bow Tie analysis. The objectives for 2022/23 were then approved.

09-20 Ratification of the revised Health & Safety Policy and Procedure

RP referred to the submitted report and highlighted the changes that had been made since the previous version of the policy, which included the addition of the “Health and safety statement of intent”, which would demonstrate the top-level commitment to Health and Safety.

MC noted the importance of staff being aware of the policy so asked whether there was an easily accessible version. RP replied that the aforementioned “Health and safety statement of intent” was part of the efforts to raise the awareness among staff.

The revised Health & Safety Policy was ratified as submitted.

09-21 Approval of Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment

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

- The Trust was again fully compliant with the required standards, and the Trust was considered externally as an organisation that demonstrated best practice.
- The report described some areas for further work, and these would be pursued over the next year.

DH noted that the Trust Board was aware of the Trust’s strong performance as a result of the leadership of the Director of Emergency Planning & Response.

The Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment was approved as submitted.

09-22 Ratification of the revised policy and procedure for the production, approval and ratification of Trust-wide policies ('Policy for policies')

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

- The confirmation, by the ETM, of the permanent introduction of the use of a 'policy manual' approach, which was trialled for the Trust's People policies, required the 'policy for policies' to be revised, to allow the use of alternative formats to the policy template. The opportunity was therefore also taken to review the policy in full, and make some other changes.
- The changes were summarised on the cover page of the report which included additional text to make it clear that local policies should not conflict with any Trust-wide policies, and in the event of a conflict the Trust-wide policy should take precedence.

DH asked whether the Policies Manual was primarily made available in electronic, rather than in printed form. KR explained that staff were encouraged to access the electronic versions of Trust policies, as they would be assured that they would be accessing the latest version of each policy. DH also asked for assurance regarding the search functionality of the policies system. KR acknowledged that there had been some issues regarding such functionality but he was confident that any staff member should be able to access the policy they needed.

The revised policy and procedure for the production, approval and ratification of Trust-wide policies was ratified as submitted.

09-23 Annual review of the Trust Board's Terms of Reference

DH referred to the submitted report and highlighted that the revision should be considered as an interim step, given the future publication of the "updated Code of governance for NHS provider trusts".

The revised Trust Board Terms of Reference were approved as submitted.

09-24 To consider any other business

There was no other business.

09-25 To respond to questions from members of the public

KR confirmed that no questions had been received.

09-26 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'
06-26	Arrange for the outcome of the further work on the Divisional Improvement Projects to be submitted to the Trust Board, when such work was completed.	Director of Strategy, Planning and Partnerships	October 2022	A report has been submitted to the Trust Board meeting in October 2022.
07-6	Liaise with the Director of Emergency Response and Planning to ensure that the lessons learned review of the Trust's response to the July 2022 'heatwave' incorporated any patient feedback which had been received.	Chief Executive	October 2022	Staff were asked to increase patient rounds during the heatwave, increase hydration rounds and observations. Although the Trust only had one formal complaint relating to heat and lack of hydration, a number of informal comments were given. All but one related to the Maidstone Hospital site. The Tunbridge Wells Hospital site did not encounter as many issues and the comments regarding that site came from the new Paediatric Emergency Department (ED). There were anecdotal concerns from patients in the maternity service, but nothing formal was provided to the Emergency Planning & Response team (the maternity area is the only part of the PFI build that encounters higher temperatures due to its position). The issues raised all related to: <ul style="list-style-type: none"> ▪ Heat and lack of ventilation ▪ Lack of sleep due to heat ▪ Being uncomfortable due to the heat (sweating etc.) ▪ Concern for staff working hard during the heat.

1

Not started

On track

Issue / delay

Decision required

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
				A report has been prepared for consideration at the Executive Team Meeting (ETM) with some actions for discussion.
09-11a	Submit further details, to the Trust Board meeting in October 2022, on the action being taken regarding the recruitment and retention of Therapies staff.	Chief People Officer	October 2022	The resourcing team are working with the division to identify recruitment activity and a resourcing plan. There has been an initial deep dive into the retention and turnover in Therapies with input from both the HRBP and the OD team, this needs to be extended to the senior leadership in the team. The exit interview data has also been reviewed and there are themes that need to be further explored to understand the culture and leadership challenges that may be affecting the retention.
09-11b	Submit further details, to the Trust Board meeting in October 2022, of the breakdown between internationally-recruited and home-recruited midwives that were in the Trust's current recruitment pipeline.	Chief People Officer	October 2022	Month: September 2022 International: 12 UK: 24 Total: 36
09-11c	Correct any occurrences where the social media advertisements for clerical posts at the Trust implied that previous NHS clerical experience was essential, despite such experience only being listed as desirable in the relevant Person Specification.	Chief People Officer	October 2022	The issue has been addressed via the Recruitment team.
09-14	Pursue a response to the Chair of the Trust Board's query as to whether one of the Trust's Non-Executive Directors could attend the "Together, we can" symposium that was being organised by NHS Kent and Medway on 28/10/22	Director of Strategy, Planning and Partnerships	October 2022	Clarification regarding the attendance was obtained, and event will be attended by the Director of Strategy, Planning and Partnerships, Vice Chair of the Trust Board and Chair of the Trust's Quality Committee.

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	in the Chair's place.			
09-17	Arrange for the People and Organisational Development Committee to consider the data regarding medical appraisal and revalidation.	Trust Secretary	October 2022	The matter was formally referred to the Chair and Vice Chair of the People and Organisational Development Committee, and this has been added to the Committee's forward programme (as an annual report)

Actions not yet due (and still 'open')

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

Report from the Chair of the Trust Board

Chair of the Trust Board

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?
06/10/22	Consultant Clinical Oncologist, Special interest in CNS and UGI	Samantha Lisa	Forner	Oncology	TBC	New
06/10/22	Consultant Clinical Oncologist, Special interest in Gynae and LGI	Lorna Jeanne	Kviat	Oncologist	TBC	New

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:

- With COVID rates in the community increasing, we have seen a steep rise in admissions across our hospitals particularly over the last month. In the last few weeks, the number of admissions exceeded our first wave peak back in the spring of 2020. Thankfully, only a very small number of these patients have needed treatment in our intensive care units. However, the decision was made to return to some of our previous safety precautions in our hospitals to help reduce the risk of infection as much as possible. This included asking all staff, patients and visitors to wear face masks at Maidstone and Tunbridge Wells hospitals in clinical and public areas (from Wednesday 12 October) and our teams have been busy ensuring masks are available at all our entry points so that everyone is able to stay protected. Mask wearing in these areas will continue until March 2023 as a minimum, but unlike previous waves, we are currently not placing any restrictions on visiting or access to our hospitals.
- With COVID very much present within our hospitals and heading into the winter months, we have continued to roll out our autumn COVID booster and flu vaccination to our staff. This began last month and we have already issued over 2,500 vaccinations to colleagues and will be continuing to provide the vaccines to staff in the weeks to come.
- Earlier this month, Kent Police charged David Fuller with 16 further offences relating to the final 23 mortuary victims. This means that all 101 victims have now been reflected in the charges. No further charges are likely and Fuller is expected to appear in crown court next month. As you know Fuller was tried at Maidstone Crown Court in November last year. At that time, he pleaded guilty to the murders of Wendy Knell and Caroline Pierce in 1987. He also confessed to a number of offences with bodies in the mortuaries at the Kent and Sussex Hospital and Tunbridge Wells Hospital. In December 2021 he received two whole life sentences for the murders. He was also given a concurrent 12-year sentence for a number of other crimes, including the offences in the mortuaries. An independent inquiry led by Sir Jonathan Michael was established at the beginning of 2022 and will report to the Secretary of State for Health. Phase one of the inquiry is considering how Fuller was able to carry out unlawful actions in the mortuaries. This is expected to be published in the first half of 2023 and the Trust continues to offer the inquiry its full support. Phase two of the inquiry will look at the wider national focus and include hospital and non-hospital settings.
- Earlier this month, the National Blood Service (NHSBT) declared an amber alert due to low level of blood group O red cells. At MTW, we currently have sufficient blood stocks and are reviewing the situation on a daily basis. We are following all national guidance on the issuing and use of blood, and our aim is to continue with elective procedures while doing all we can to address any issues with blood supplies. All patients are urged to attend their procedures as planned unless told otherwise by our surgical or clinical teams.
- It has been great to see the fantastic work and innovation of our teams celebrated in both national and regional media recently with coverage in *The Times* and on BBC South East News and ITV Meridian News, which featured a number of colleagues in our Care Co-Ordination Centre and Maidstone Emergency Department. The reports focussed on our work to improve patient flow, with the use of our digital bed management system and real time data to help reduce both the time it takes to move a patient from ED into a bed and the time it takes to turn around an empty bed so it's ready for a new patient. More recently, MTW has been ranked as the fifth best-performing trust in the country in the latest NHS data tracker published by *The*

Telegraph on 13 October. The tracker covers 120 hospital trusts and is based on targets including cancer and Emergency Department waiting times.

- Last month, Therese Coffey, the Secretary of State for Health and Social Care, set out 'Our plan for patients'. We welcome the plan which focuses on improving patient access to NHS and social care this winter. The four priorities detailed are ambulances, backlogs, care and doctors and dentists. I am pleased to report that MTW's performance against priorities relating to hospital trusts is strong and includes:
 - A reduction in the number of long waiting patients (those waiting 52 weeks) from 1,000 to zero in less than a year. We are now working to reduce waiting times so no one is waiting for 40 weeks by the end of March. (The national expectation is 78 weeks by the end of the financial year.)
 - Emergency Department performance. Attendances at our EDs are nearly 20% up on the same period 3 years ago, but we are in the top ten trusts in the country for ED performance against the 4-hour standard.
 - We see more than 800 ambulances each week at our hospitals (a 16% increase on the numbers seen 3 years ago) and turnaround 99% of these in under an hour.
 - We have achieved the 62-day cancer standard for 37 consecutive months – one of only a handful of trusts in the country to do this. This has been delivered against a challenging pandemic backdrop and a 34% rise in referrals to our cancer services.
- We look forward to engaging with the plan to improve services further and enable us to deal with current pressures. And as we move into the winter months the plan's focus on high quality timely care and hospital discharges will be really important to us.
- I am delighted we have been able to open up a new area for staff, patients and visitors at Maidstone Hospital after officially opening our Organ and Tissue Donation Memorial Garden at the end of September during Organ Donation Week. The quiet green space celebrates the generosity of those who have donated their organs and tissues and is a place to remember those who have sadly died. We also invited donor families and a cornea transplant recipient to the event and it was wonderful to be able to share the opening with them.
- This month we've launched our Patient Pledge which describes what can be expected from us at MTW and what our staff ask from our patients. The pledge includes our commitments to treat all patients with dignity and respect and ensure we do everything possible to get our patients discharged and back with their families as quickly as possible. It is also a chance to reflect on the many ways in which we already work in partnership with our patients and their families to deliver outstanding care.
- Our work in both recruiting new staff and retaining the talented colleagues we have continues to ensure colleagues and patients are supported. Our target is to reduce our turnover rate to 12% by March next year and we're beginning to make some really great progress. Our recruitment team has already held a number of recruitment events in the UK and overseas and our events calendar is full for the rest of the year. The new recruitment website, launched earlier this year, has already had more than 60,000 hits and are launching a large-scale advertising campaign shortly which will include billboards in London stations. Thanks to this recruitment drive, which began in April we have offered nearly 700 positions and successful recruitment events in the Philippines, Jamaica and Trinidad, have resulted in an additional 200 job offers.
- Dr James (Jim) MacDonald took up a new role as Deputy Medical Director at the beginning of October. Jim brings his 10 years of experience of working in Emergency Medicine, and his time as Chief Clinical Information Officer at MTW, to this new role which will focus on:
 - Medical Workforce, including support with medical workforce strategy, recruitment and medical engagement
 - Mental Health and Mental Health Capacity Assessment strategy
 - Supporting digital transformation
 - Caldicott Guardian duties

- Earlier this month we also appointed Daniel (Danny) Lawes as our new Deputy Chief of Surgery. Danny has been our Clinical Director for General Surgery for the last six years and will start this new role on 28 November.
- Our Health Play Specialist Vicki Belton has been recognised as the runner up in the Mentor of the Year category at this year's Starlight Health Play Awards, which marked the start of National Play in Hospital Week (10 to 14 October). Run by health play charity, Starlight, the Awards recognise the dedication, ingenuity and resilience of play specialists and other health professionals who are changing the experience of hospital treatment for seriously ill children.
- Congratulations to the winner of the Trust's Employee of the Month scheme for September – Ervis Kulka who works within our Domestic Team in the Surgery Division. Ervis was recognised for always being on hand to assist patients, helping to make them more comfortable and receiving many kind comments for going above and beyond the call of duty.

Which Committees have reviewed the information prior to Board submission?

N/A

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

Information and assurance

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

Summary report from Quality Committee, 12/10/22 Committee Chair (Non-Exec. Director)
(incl. approval of revised Terms of Reference)

The Quality Committee met (virtually, via webconference) on 12th October 2022 (a Quality Committee 'deep dive' meeting).

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

- The **actions from previous meetings** were reviewed and the Chair of the Committee provided an update on the Trust's efforts to reinvigorate patient engagement.
- The Senior Nursing Information Officer (SNIO), Chief Clinical Information Officer (CCIO) and Medical Director presented a further **review of the Quality and Clinical Governance issues associated with the implementation of the Electronic Patient Record** wherein the Committee were provided with a detailed overview of the improvements which had been enacted in response to feedback from Trust staff; the further resourcing requirements to support continued digital innovation at the Trust; and the importance of a data lead approach and it was agreed that the Assistant Trust Secretary should schedule a "Further review of the Quality and Clinical Governance issues associated with the implementation of the Electronic Patient Record" item at the April 2023 Quality Committee 'deep dive' meeting.
- The Director of Quality Governance and Patient Safety Manager presented a **repeat Patient Safety Incidents – Key Themes and Improvement plans** item which provided Committee members with details of the key themes for suboptimal care / treatment and the associated action plans which had been developed; however, the further work required was acknowledge. The Committee then emphasised the availability of charitable funding to support patient safety initiatives and outlined the importance of ensuring the accessibility of patient safety data and it was agreed that the Chief Nurse should liaise with the Chief Executive to consider, and confirm to the Trust Secretary's Office, whether the "Sepsis Incident Impact Film" should be scheduled at the 'Part 2' Trust Board meeting in October 2022. It was also agreed that the Assistant Trust Secretary should ensure that the Divisional Directors of Nursing and Quality (or equivalent) were invited to future Quality Committee 'deep dive' meetings, as formal attendees.
- The received an **update on the Trust's Patient Safety Incident Response Framework (PSIRF) progress and the improvement of the Trust's investigation processes**, wherein the Committee were informed of the launch of the Patient Safety Syllabus mandatory training and the associated compliance and the intention to mandate completion of the Safety Culture and Reporting survey.
- A discussion was held on the **items that should be scheduled for scrutiny at future Quality Committee 'deep dive' meetings**, wherein it was agreed that the Assistant Trust Secretary should schedule a brief "Update on the implementation of the Electronic Prescribing and Medicines Administration (EPMA) module" item at the December 2022 Quality Committee 'deep dive' meeting. It was also agreed that the Assistant Trust Secretary should schedule a "Review of the management of pressure ulcers" item at the February 2022 Quality Committee 'deep dive' meeting. Finally, it was agreed that the Chief Nurse and Chair of the Quality Committee should liaise to consider, and confirm to the Assistant Trust Secretary, the scheduling of a "Review of the Trust's medicine management and optimisation" item at a future Quality Committee 'deep dive' meeting.
- The Committee members conducted their first **evaluation of the meeting**, wherein the quality of the presentations was commended and the importance of enhanced representation from the Trust's five clinical Divisions was emphasised. It was agreed that the Assistant Trust Secretary should provide the Vice-Chair of the Sepsis Committee with the Quality Committee dates for 2023, to prevent the risk of further clashes. it was also agreed that the Assistant Trust Secretary should amend the Committee's Terms of Reference to include the Patient Safety Manager within the "Membership" section (and arrange for the amendment to be approved by the Trust Board) The revised Terms of Reference are enclosed, in Appendix 1 (with the proposed changes 'tracked'), for the Trust Board's approval.

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

1. Information and assurance
2. To approve the Committee's revised Terms of Reference (see Appendix 1)

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

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)
- Director of Quality Governance*
- Patient Safety Manager*
- 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 Director¹
- 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 Director¹
- 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~~ Core Clinical Services 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
12. The Sepsis Committee

A report from the Clinical Governance Committees (or equivalent forums) 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.

- 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
- Revised Terms of Reference agreed by the Quality Committee, 11th May 2022
- Revised Terms of Reference approved by the Trust Board, 26th May 2022
- Amendment agreed by the Quality Committee, 12th October 2022 (to add the Patient Safety Manager to the Committee's membership)
- Revised Terms of Reference approved by the Trust Board, 27th October 2022

Summary report from the Finance and Performance Committee, 25/10/22
Committee Chair (Non-Exec. Director)

The Committee met on 25th October 2022, via a webconference.

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

- The **actions from previous meetings** were reviewed.
- The divisional management team for the **Women's, Children's and Sexual Health Division**, attended for a **deep dive** into the divisional financial position, which focused on the issues driving the overspend and lack of CIP progress. The divisional financial recovery plan was noted, and the scale of the challenge acknowledged in the context of the current regulatory parameters for women's and children's
- **Patient Access strategic theme metrics for month 6** were reviewed, which noted challenges to maintaining cancer performance due to increased urology activity and a rise in late oncology referrals from primary care. It was noted that MTW had been ranked 5th nationally in a recent Daily Telegraph table of outcomes/performance for NHS hospitals. There was additional discussion of the need to validate and assure the position around outpatient utilisation.
- The Chief Finance Officer reported on the **financial performance for month 6**, confirming that the Trust was on plan at end of September; Cost Improvement Plans (CIPs) were however behind plan, with stepped increases required from October; this combined with significant overspend in some areas in the first half of the year.
- It was noted that the forecast break-even position in **financial forecast for 2022/23** required further actions to achieve that outcome. The proposed approaches to financial recovery were reviewed, along with potential measures to be taken. Further consideration of necessary actions, against the context of MTW operational and winter planning, was due at the Executive Team meeting on 08/11/22, and a subsequent proposal would be scheduled for the Finance and Performance Committee and Trust Board in November.
- The **quarterly analysis of consultancy use** was noted.
- The Deputy Chief Operating Officer then outlined **the winter plan** based on MTW and System modelling, which showed an expectation of an increase of 4.2% in ED activity on last winter; non-elective attendances of 3700 (Jan.'23); and deficit of 156 and 173 beds in January and February 2023 respectively. Twelve schemes had been set out in the plan to mitigate this shortfall down to 64, including those schemes already considered by the committee earlier in the year. It was agreed that the additional options for consideration should further mitigations be required, should be included in future iterations of the plan. The winter plan would be resubmitted for further consideration at the next Finance and Performance Committee meeting, following its review at the Executive Team meeting on 01/11/22. The Deputy Chief Operating Officer additionally undertook to liaise with the Chief People Officer re the challenges in recruiting staffing for the Virtual Ward.
- The **uses of the Trust Seal** since the last meeting were noted.

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: 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

1. Information and assurance

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

Summary report from the People and Organisational Development Committee, 21/10/22 (incl. the Guardian of Safe Working Hours Annual Report 2021/22)
**Committee Chair
(Non-Exec. Director)**

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

The key matters considered at the meeting were as follows:

- The **actions from previous 'main' meetings** were reviewed.
- The Committee heard a brief introduction from the Trust's new Deputy Medical Director wherein the Deputy Medical Director outlined their key areas of focus.
- The Deputy Chief People Officer, People and Systems provided a **review of the "Strategic Theme: People" section of the Integrated Performance Report (IPR)** which included an overview of the return on investment from the Altadicta marketing campaign; wherein the Committee noted the beneficial impact from Altadicta's communications and public relations expertise and acknowledged the importance of ensuring the lessons learned were reflected on the Trust's internal approach. The following actions were agreed:
 - The Deputy Chief Nurse, Workforce and Education should develop a communication plan to illustrate to Trust staff of the improvements in the onboarding time for new starters.
 - The Deputy Chief People Officer, People and Systems should provide Committee members with details of the Trust's vacancies by NHS Agenda for Change (AfC) pay band.
 - The Deputy Chief People Officer, People and Systems should inform Committee members of the return on investment, in terms of the Trust's turnover rate, from the implementation of "stay interviews".
 - The Deputy Chief People Officer, People and Systems should consider, and confirm to the Trust Secretary's Office, the scheduling of an "Update on the work to improve the lead times for bank and agency shifts" item at a future Committee meeting, with the Head of Temporary Staffing and E-rostering in attendance.
 - The Deputy Chief People Officer, People and Systems should provide Committee members with the cost differentials between the utilisation of bank, agency and substantive staff.
- The Deputy Chief People Officer, Organisational Development discussed how **the themes and learnings from the Trust's Listening Events could be understood** and gave an **update on employee engagement** which included the continued impact of COVID-19 on Trust Staff; and it was agreed that the Deputy Chief People Officer, Organisational Development should consider whether the Divisional Clinical Governance meetings could be utilised as an engagement platform for the Trust's Listening Events. It was also agreed that the Deputy Chief People Officer, People and Systems should investigate whether the Trust kept a record of those agency staff that cancelled an agreed shift at short notice, or did not turn up to the allocated shift; and, if required, consider the development of such a record.
- It was agreed that the **review of the findings from the survey to investigate the Trust's flexible working offerings and associated improvement recommendations** should be reschedule to the November 2022 People and Organisational Development Committee 'deep dive' meeting, as the first substantive item on the agenda, with the Deputy Medical Director in attendance.
- The Deputy Chief Nurse, Workforce provided a **review of the Trust's submission for the NHS England Nursing & Midwifery retention self-assessment tool** which provided details of the Trust's performance against each of the key elements and the actions which had been developed in response, and it was agreed that the Chief People Officer should investigate whether a self-assessment tool for other staffing groups, including Medical Staffing, was available, and if such a self-assessment tool was not available consider the feasibility of the development of such a self-assessment tool.
- The Director of Communications attended for the latest **quarterly review of internal communications** which included details of the delay to 'go live' of the Trust's new intranet; an

update on the GovDelivery programme, and the intended revisions to the Team Brief process wherein it was agreed that the Director of Communications should ensure that a future “Quarterly review of internal communications” report to the Committee includes an update on the improvements to the Trust’s Team Brief process. It was also agreed that the Deputy Medical Director should liaise with the Director of Communications to provide feedback regarding the additional mechanisms which could be implemented to increase clinical engagement with Trust-wide communications. Furthermore, it was agreed that the Director of Communications should investigate the provision of a single point of access to the Trust’s Employee Self Service portal on the Trust’s new intranet.

- The Deputy Chief People Officer, Organisational Development then updated the Committee **on the revised appraisal process** which covered the compliance rate with the appraisal process; and the outputs of the training needs analysis section. It was agreed that the Deputy Chief People Officer, Organisational Development should submit the findings of the review of the quality of the appraisals conducted at the Trust to a future Committee meeting. It was also agreed that they Deputy Chief People Officer, Organisational Development should consider what, if any, mechanisms could be implemented to make Trust staff aware of the alignment between the Trust’s appraisal process and the allocation of Continuous Professional Development (CPD) funding.
- The **Guardian of Safe Working Hours Annual Report** (covering October 2021 to September 2022) (enclosed in Appendix 1, for information and assurance) was reviewed and the Committee was informed of the challenges associated with the exception reporting process during 2021/22 and the solutions which had been implemented.
- The Committee conducted an **evaluation of the meeting** wherein it was agreed that the Assistant Trust Secretary should ensure that the “Monthly review of the “Strategic Theme: People” section of the Integrated Performance Report (IPR)” item at future Committee meetings was allocated additional time, to enable further consideration of the key issues.

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

The issues from the meeting that need to be drawn to the Board ‘s attention as follows: The Guardian of Safe Working Hours Annual report is enclosed in Appendix 1, for information and assurance.

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
– NOVEMBER 2021**



**THE GUARDIAN OF SAFE WORKING HOURS ANNUAL REPORT
(COVERING OCTOBER 2021 TO SEPTEMBER 2022)**

**GUARDIAN OF SAFE
WORKING HOURS**

It is outlined within “Schedule 06 – Guardian of Safe Working Hours” of the “Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016” that the Trust Board must receive a Guardian of Safe Working Hours report no less than once per quarter, which should include data on all rota gaps on all shifts. The required quarterly report is submitted via the People and Organisational Development Committee as part of the Committee’s summary report to the Trust Board.

An internal decision was made to combine these quarterly reports into an Annual Report which covers each cohort of junior doctors and therefore does not follow the reporting schedule for the financial year, however covers a full year period of October to September. The latest report is enclosed which will be submitted to the October 2022 ‘Part 1’ Trust Board meeting as an Appendix to the “Summary report from the People and Organisational Development Committee”.

Key points:

- There was a total of 321 exception reports during this period
- 12 exception reports were filed due to missed education opportunities
- The largest proportion of exception reports were filed by foundation grade doctors
- On the whole Clinical supervisor response rates have improved to exception reports raised
- Issues were raised with medical staffing’s support of the Guardian and Exception reporting system in March 2022
- New medical staffing personnel are working tirelessly to rectify issues raised

Reason for submission to the ‘Main’ People and Organisational Development Committee

Information and assurance

Report Commentary:

Annual report for the period October 2021 - September 2022

During this period there was a total of **321** Exception Reports received.

- October 2021-December 2022 **107**
- January 2022-March 2022 **80**
- April 2022-June 2022 **53**
- July 2022-September 2022 **81**

The number of exceptions reports relating to missed educational opportunities were **12** during this period.

Most ERs filed during this period were generated by foundation grade doctors, with the medical directorate producing the greatest share. These numbers are documented in the quarterly reports.

During this period reasons for ERs being raised included:

- Short staffing
- Complicated patients
- Missed lunch breaks
- Workload not finished on time
- An urgent procedure needed to be performed on a patient
- Excessive workload

Challenges for the Guardian during this report period:

During this period, I routinely have had to remind clinical supervisors to respond to ERs in a timely manner and remind individuals of the 7-day response outlined in the revised TCS 2016 to ERs being raised.

Response rates by clinical supervisors, I'm pleased to report has improved over the year. However, it's ~10 supervisors who have had to be reminded on multiple occasions to respond to their trainees and discuss the ERs filed. I've explained to the supervisors that if the ERs are not discussed, then opportunities are missed for their specialty to understand working condition issues for their juniors and to offer advice or develop a strategy to mitigate ERs being further filed.

I had to contact the Chief of Service for Medicine and Emergency Care regarding a clinical supervisor that was not fulfilling their role responsibilities, concerning the ER process.

The main issue I had over the last 9 months of this period, related to inadequate support from the medical staffing department. This resulted in the most challenging period of my Guardian tenure.

Issues first began to arise, after I found out that the Medical Staffing Manager, had gone on secondment and a replacement was enlisted in March 2022.

I was not made aware of the Medical Staffing Manager leaving and sent several emails to them regarding ER issues I wanted to discuss. After some detective work, as I had had no response from them, which was unusual, I discovered they had left and a replacement made.

After an initial meeting with the new medical staffing manager, it soon became apparent, that they had no understanding of the TCS 2016 relating to the Guardian of Safe Working's role and the exception report process. I went onto have a meeting with them, explaining my role, the ER process, the Allocate reporting system and the fact that there were multiple ERs still on the Allocate system needing addressing by them, concerning payment to junior doctors and the ERs needing removing from the system.

I went onto supply them with the TCS 2016 chapter on 'Guardian of safe working and Exception reports', so they could gain clarity in our roles and the trusts responsibility to its trainees.

It was suggested after several email conversations by the end of April 2022, that medical staffing's role in ER response was now in hand.

With the end of the working year rapidly approaching in June 2022 I asked that all ERs be paid before the beginning of August, as there didn't appear at this stage, to be any traction in ERs being taken off the Allocate system and Juniors paid for excessive hours worked.

As my concerns with support from Medical Staffing were escalating, I relayed to the Deputy Chief People Officer, People and Systems the issues I was having with support from medical staffing.

The new intake in August arrived and none of the ERs from the previous intake that were overdue by many months at this stage had been processed, as I was assured, they would be. I again contacted Medical Staffing at this stage and made the Deputy Chief People Officer, People and Systems aware also.

It then come to my attention at the later stage of August 2022 that none of the new trainees had been assigned new log ins for the Allocate system., as per previous years in which there have never been problems.

I went on to escalate this to the Deputy Chief People Officer, People and Systems again and on to the Chief People Officer, and explained to the BMA Rep, the issues I'd been experiencing as Guardian over the past year and how as a Trust we would rectify the situation.

I was particularly impressed with the assistance from the Strategic Medical Education Manager and their team, who within a week had organised Allocate logins for the new trainees.

This unfortunately resulted in several trainees submitting multiple reports in one sitting, for which if I had seen a pattern in their submissions, I could have intervened quicker.

In mid-September the Medical Staffing Manager resigned at short notice. Since then, a new colleague has come into post with previous MTW Medical Staffing experience and their re-joining the team, has been well received. The Medical Staffing Manager and colleagues have also made fast and positive progress in addressing the historical issues

Measures to improve working conditions for trainees over next annual report period:

- Contact all Education/clinical supervisors underlying their role with regard supporting their trainee doctors and understanding working condition issues they have and supporting them appropriately and responding to ERs in a timely manner and to offer advice on how to mitigate extra hours worked.
- Work closely with the new interim medical staffing manager and junior staff, to learn from the issues of the last 9 months and rectify outstanding issues. I'm pleased to report that all outstanding payments now have been made to doctors who finished their last jobs in August. I have also suggested that additional staff are required to deal with the workload the team experience. This has duly been noted by Deputy Chief People Officer, People and Systems.
- Measures need to be in place for our next intake of doctors, that there are adequate Allocate logins for distribution, so trainees can exception report if needed.
- Ensure that there is adequate training for colleagues in medical staffing relating to the TCS of trainee Doctors and the ER system.
- Reducing the number of exception reports for the future requires the trust to look at areas of need, where junior doctors work is excessive. After reviewing the past years exception reports, most reports are filed by foundation grade doctors (particularly FY1 grade). I am pleased to report an extensive piece of work is currently being undertaken by the Deputy Chief of Service for Medicine and Emergency Care and the Divisional Director of Operations for Medicine and

Emergency Care, looking into the areas of need across both hospital sites, where staffing numbers are being compared to the level of service level provision needed. With this work completed, I am confident the Deputy Chief of Service for Medicine and Emergency Care will find solutions to staffing issues across the trust and increase numbers of clinicians onto teams that require additional support.

Trust Board meeting – October 2022

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

The IPR for month 6, 2022/23, is enclosed, along with the monthly finance report and the latest 'planned vs actual' nurse staffing data.

Which Committees have reviewed the information prior to Board submission?

Executive Team Meeting, 25/10/22, Finance and Performance Committee, 25/10/22

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

Review and discussion

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

Integrated Performance Report

September 2022

Contents

• Key to Icons and scorecards explained	Page 3
• Executive Summary	Page 4
• Assurance Stacked Bar Charts by Strategic Theme	Page 5
• Matrix Summary	Page 6
• Strategic Theme: People	Page 7
• CMS: Reduce Turnover Rate	Page 8
• Escalation Page: Workforce	Page 9
• Strategic Theme: Patient Safety & Clinical Effectiveness	Page 10
• Escalation Page: Patient Safety and Clinical Effectiveness	Page 11
• Strategic Theme: Patient Access	Page 12
• CMS: We will achieve the submitted RTT Trajectory	Page 13
• CMS: Achievement of Planned Activity Levels: New Outpatients	Page 14
• Escalation Page: Hospital Flow	Page 15
• Escalation Page: Outpatients	Page 16
• Escalation Page: Diagnostics	Page 17
• Escalation Page: Activity Levels	Page 18
• Strategic Theme: Patient Experience	Page 19
• Escalation Page: Complaints	Page 20
• Escalation Page – FFT Response Rate	Page 21
• Strategic Theme: Systems	Page 22
• CMS: To increase the number of patients leaving our hospitals by noon on the day of discharge to 25%	Page 23
• Strategic Theme: Sustainability	Page 24
• CMS: Reduce the amount of money the Trusts spends on premium workforce	Page 25
Appendices	Page 26
• Business Rules for Assurance Icons	Page 27 - 29
• Consistently, Passing, Failing and Hit & Miss Examples	Page 30

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.

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

Name of Metric/KPI	Latest			Previous			Assurance		
	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Driver / Variation	Assurance	CM Action
A reduction in harm (target to be determined) by March 2022. - Incidents resulting in Harm	100	159	Oct-21	100	159	Sep-21	Driver		Verbal CMS

Callouts:
 - This section shows the 'actual' performance against plan for the latest month (points to Latest columns)
 - This section shows the 'actual' performance against plan for the previous month (points to Previous columns)
 - This icon indicates the variance for this metric (points to Driver/Variation cell)
 - This icon indicates the assurance for this metric (points to Assurance cell)
 - This icon shows the CMS Action that is needed (points to CM Action cell)

Further Reading / other resources

The NHS Improvement website has a range of resources to support Boards using the Making Data Count methodology. This includes a 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>

Executive Summary

Executive Summary

Vacancy Rate is now experiencing special cause variation of an improving nature and variable achievement of the target. The Trust Turnover Rate has failed the target for more than six months and is in special cause variation of a concerning nature.. Agency use and spend is consistently failing the target. Sickness is in variable achievement and Safe Staffing levels remain in escalation as has not achieved the target for more than six months which is impacting on key quality indicators. The Trust Appraisal rate is improving but remains in escalation as is not achieving the target.

The rate of inpatient falls continues to experience common cause variation and variable achievement of the target. Both the Hospital on-set of COVID and C.Difficile indicator have not achieved the target for more than six months and have therefore been escalated. These indicators also impact the Incidents resulting in harm indicator which is experiencing common cause variation and variable achievement of the target.

Diagnostic Waiting Times has remained similar in September and is now experiencing special cause variation of an improving nature at 90%, driven mainly by a drop in Echocardiography performance. RTT performance is experiencing special cause variation of a concerning nature and has not achieved the trajectory target for more than six months. We continue to be a Trust with no 52 week waiters (one of the first Acute Trusts to have cleared these long waiters). First outpatient activity levels are experiencing special cause variation of an improving nature but have failed the trajectory target for the last six months. Levels were above 1920 levels for Quarter 1, August and September 2022. Diagnostic Activity levels have not achieved the target for more than six months but remain consistently above 1920 levels. Elective activity achieved the plan for Quarter 1 overall as well as having achieved the plan for the months of June, July, August and September and is therefore above plan Year to date (YTD).

A&E 4hr performance is experiencing common cause variation at 84.7% and has not achieved the target for more than six months. However, the Trust's performance remains one of the highest both Regionally and Nationally. Ambulance handovers also remains in full escalation. The Trust continues to achieve the National Cancer 62 Day Standard (86.1%) and the national 2 Week Wait (2WW) Standard (94.5%) in August 2022. Achievement of these standards continues to remain increasingly challenging with the continued high number of 2WW referrals and the number of patients on the 62 day backlog.

Please note that some of Counter Measure Summaries (CMS)'s are still in development as the A3's are still in progress.

Escalations by Strategic Theme:

People:

- Turnover Rate (P.8)
- Sickness Rate (P.9)*
- Appraisal Completeness (P.9)

Patient Safety & Clinical Effectiveness:

- Safe Staffing (P.11)
- Infection Control (P.11)*

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

Patient Access:

- RTT Performance (P.13)
- Planned levels of new outpatients activity (P.14)
- A&E Performance (P.15)
- Outpatient Calls answered <1 minute (P.16)
- Outpatient Clinic Utilisation (P.16)
- Ambulance Handovers >30 minutes (P.15)
- Diagnostic Waiting Times (P.17)
- Planned levels of Diagnostics activity (P.18)

Patient Experience:

- Complaints responded within target (P.20)
- FFT Response Rates - all areas (P.21)

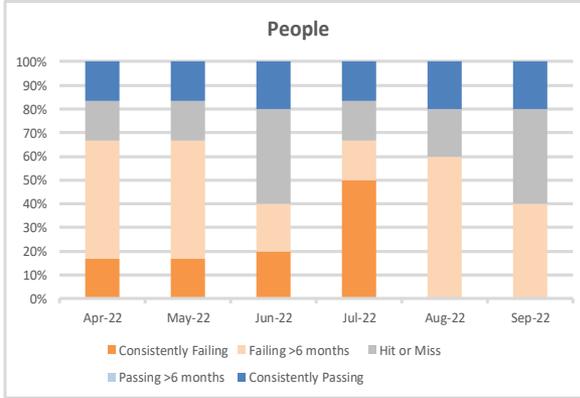
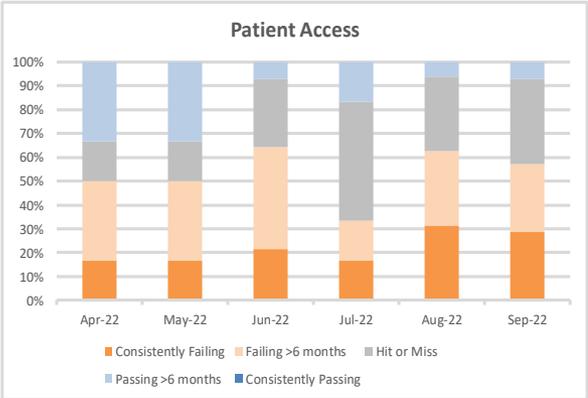
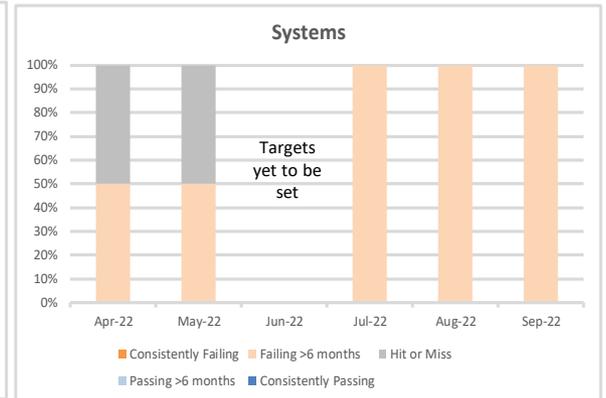
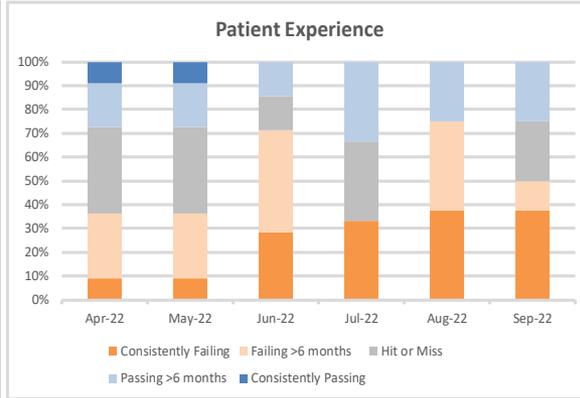
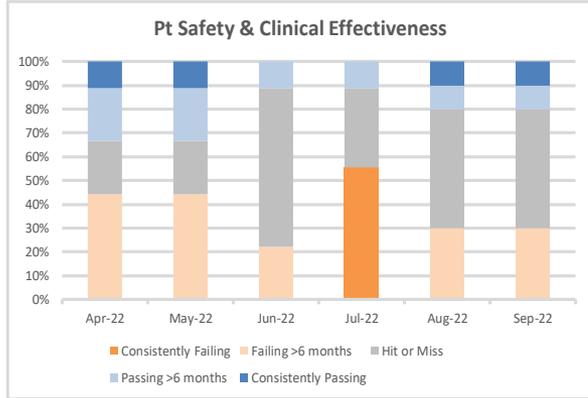
Systems:

- Discharges before Noon (P.23)

Sustainability

- Agency Spend (P.25)

Assurance Stacked Bar Charts by Strategic Theme



Matrix Summary

September 2022

Assurance

		 Pass★	 Pass	 Hit and Miss	 Fail	 Fail -
Variance	Special Cause - Improvement 		Never Events Flow: % of Emergency Admissions that are zero LOS (SDEC)	Reduce the Trust wide vacancy rate to 12% by the end of the financial year 2022-3 Vacancy Rate Friends and Family (FFT) % Response Rate: Inpatients	To achieve the planned levels of new outpatients activity (shown as a % 19/20)	Transformation: CAU Calls answered <1 minute Access to Diagnostics (<6weeks standard)
	Common Cause 	Cash Balance (Ek) Capital Expenditure (Ek)	Cancer - 62 Day Complaints Rate % VTE Risk Assessment (one month behind)	Reduction in incidents resulting in harm by 8.2% by March 2023 To reduce the overall number of complaints or concerns each month Reduction in the rate of patient falls to 6.36 per 1000 occupied bed days by March 2023 Achieve planned levels of activity - Total Elective Achieve planned levels of activity - Follow Up Outpatients Number of New Sis in month Cancer - 2 Week Wait Sickness Absence IC - Number of Hospital acquired MRSA Flow: % of Emergency Admissions into Assessment Areas	Achieve the Trust RTT Trajectory by March 2023 To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience. A&E 4 hr Performance Safe Staffing Levels Infection Control - Hospital Acquired Covid Appraisal Completeness % complaints responded to within target IC - Rate of Hospital C.Difficile per 100,000 occupied beddays Flow: Ambulance Handover Delays >30mins	Achieve planned levels of activity for diagnostics - MRI Achieve planned levels of activity for diagnostics - CT Achieve planned levels of activity for diagnostics - NOUS Diagnostic Activity (MRI,NOUS,CT Combined) To increase the number of patients leaving our hospitals by noon on the day of discharge Transformation: % OP Clinics Utilised (slots) Friends and Family (FFT) % Response Rate: A&E
	Special Cause - Concern 	Summary Hospital-level Mortality Indicator (SHMI) Statutory and Mandatory Training	Delivery of financial plan, including operational delivery of capital investment plan.	RTT Patients waiting longer than 40 weeks for treatment Standardised Mortality HSMR	Reduce Turnover Rate to 12% by March 2023 Reduce the amount of money the Trusts spends on premium workforce spend Flow: Super Stranded Patients	

Strategic Theme: People

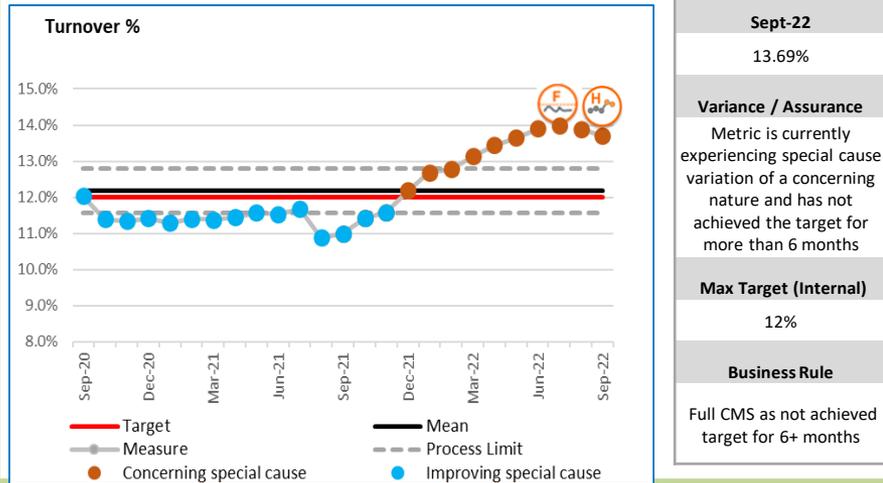
	CQC Domain	Metric	Latest			Previous			Actions & Assurance			
			Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Well Led	Reduce the Trust wide vacancy rate to 12% by the end of the financial year 2022-3	12%	11.4%	Sep-22	12%	12.3%	Aug-22	Driver			Note Performance
Breakthrough Objectives	Well Led	Reduce Turnover Rate to 12% by March 2023	12%	13.7%	Sep-22	12%	13.9%	Aug-22	Driver			Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Well Led	Sickness Absence	4.5%	4.1%	Aug-22	4.5%	5.0%	Jul-22	Driver			Not Escalated
	Well Led	Appraisal Completeness	95.0%	90.5%	Sep-22	95.0%	88.8%	Aug-22	Driver			Escalation
	Well Led	Statutory and Mandatory Training	85.0%	86.3%	Sep-22	85.0%	86.3%	Aug-22	Driver			Not Escalated

Breakthrough Objective: Counter Measure Summary

Metric Name – Reduce Turnover Rate to 12% by March 2023

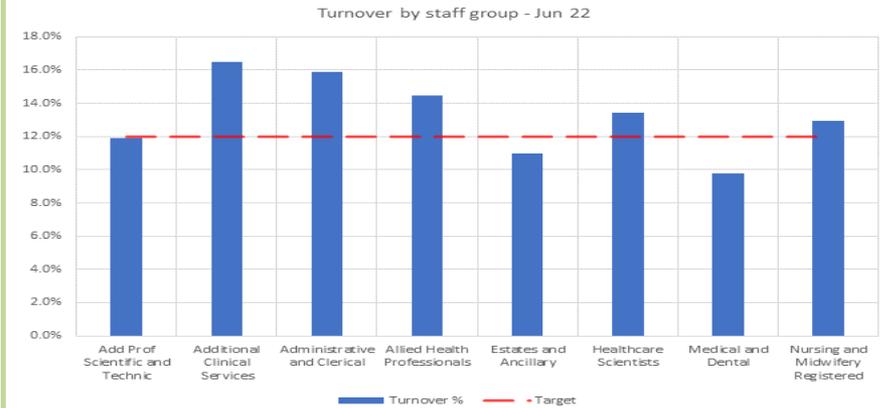
Owner: Sue Steen
Metric: Turnover Rate
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



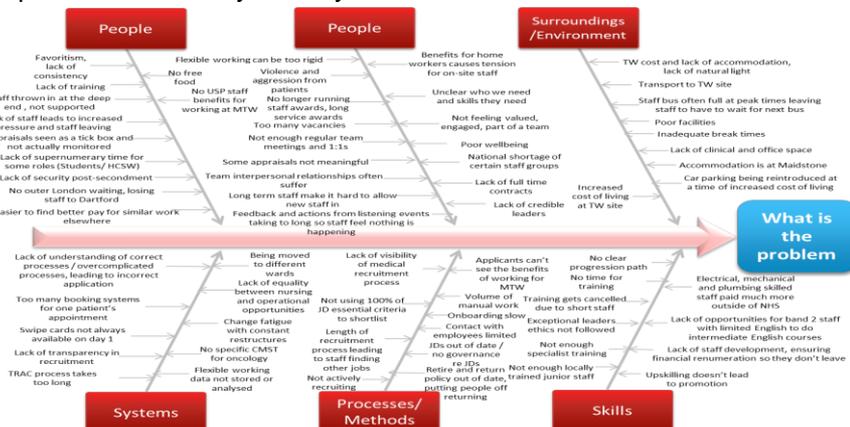
2. Stratified Data

** This is an early view and further analysis will be undertaken



3. Top Contributors

A3 Stakeholder engagement workshop took place on for 26th September to identify the key contributors:

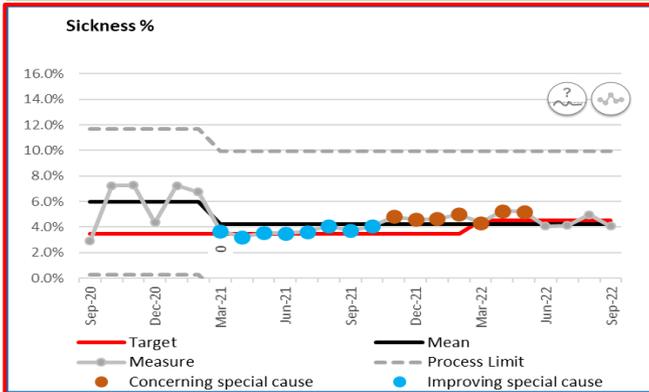


4. Action Plan

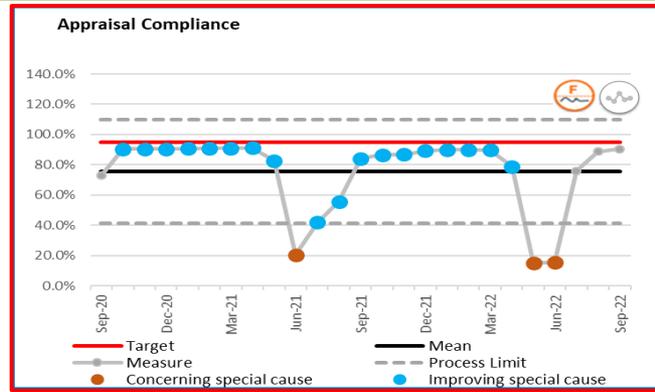
The A3 continues to be developed, with countermeasures identified and to be implemented.

- Action completed/planned
- Review of data undertaken
- A3 Stakeholder Workshop took place to identify top contributors and countermeasures
- Prioritisation of countermeasures through the use of a PICK chart completed
- KPIs finalised
- Working Groups being set up to take forward actions

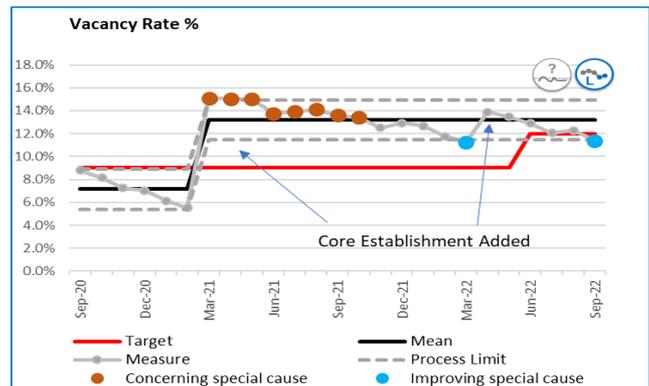
People – Workforce: CQC: Well-Led



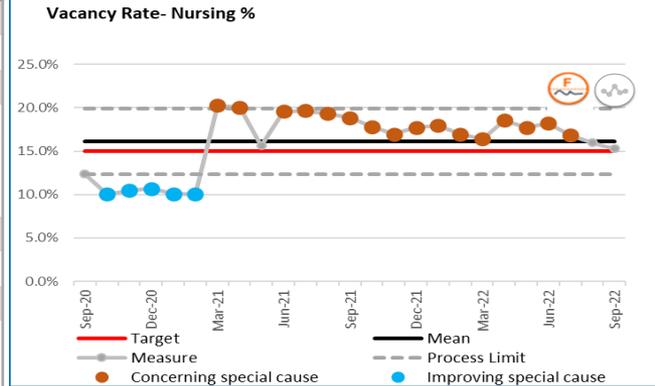
Aug-22
4.6%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Max Target (Internal)
4.5%
Business Rule
Escalated as in Hit & Miss for >6months



Sep-22
90.48%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and failing the target for 6+ months
Max Target (Internal)
95%
Business Rule
Has failed the Target for 6+ Months



Sep-22
11.4%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of a concerning nature and has failed the target for 6+ months
Max Limit (Internal)
12%
Business Rule
Not Escalated - Shown for Information



Sep-22
15.31%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of a concerning and consistently failing the target
Max Limit (Internal)
15%
Business Rule
For Information as linked to Vacancy Rate

Summary:

Sickness % - This metric is experiencing Common Cause Variation and variable achievement of the Target

Appraisal Completeness - This metric is experiencing Common Cause Variation and failing the target for 6+ months

Vacancy Rate: Shown for information as is now experiencing special cause variation of an improving nature (as has achieved the target in September) and variable achievement of the new target..

Vacancy Rate (Nursing): Shown for information as linked to Vacancy Rate . Is experiencing common cause variation and has failed the target for more than six months

Actions:

Sickness: Has reduced from the spike due to covid absence in July, with non-covid absence being below the 4.5% target

Appraisal Compliance: Appraisal compliance is being looked at across all areas and improvement work is ongoing.

Vacancy Rate: The vacancy rate has improved to 11.4% for this month, a reduction from August (12.29%). Every division showed either an increase or no change in their numbers this month. Overall, this is an increase of 67WTE for the month and with high levels of recruitment activity, bringing us to just over 800 vacancies across the trust.

Agency staff: increase in usage this month, despite a further increase in permanent WTE.

Turnover: not reported here, however a breakthrough objective with a target of 12% by 31 March 2023. September rate is 13.69%, a further decrease from the 13.98% peak in July.

Assurance & Timescales for Improvement:

Sickness: Absence data holds a 2 month lag, we therefore anticipate next month's report to begin to show an uptick in covid related absence, before the following month to show a greater level.

Vacancy Rate % - Recruitment pipeline shows high level of recruitment activity and due to the increase of recruitment activity with international recruitment, marketing campaign and events etc we expect this metric will continue to improve.

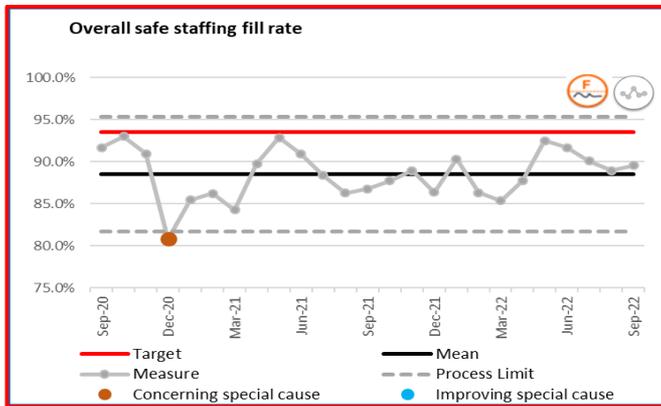
Agency Staff: HRBPs, with Finance Manager colleagues are beginning business planning sessions with managerial teams which will cover this area. In addition, the new Head of Temp Staffing reviewing the structure / practices within the team to improve engagement on this.

Turnover: Workforce Supply programme has been launched, with working groups now running to build on existing interventions regarding this target – we hope this will build on the reversal of the trend

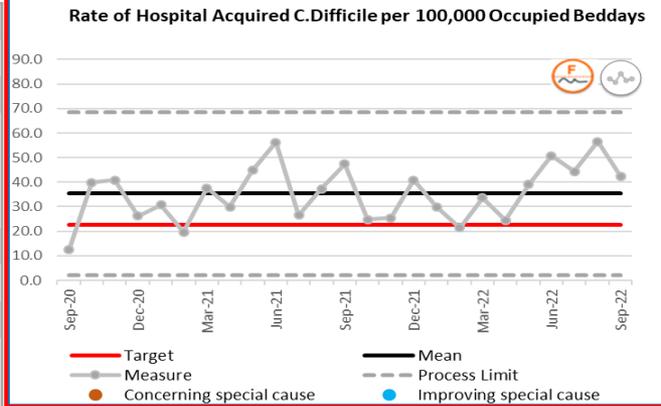
Strategic Theme: Patient Safety & Clinical Effectiveness

	CQC Domain	Metric	Latest			Previous			Actions & Assurance			
			Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Safe	Reduction in incidents resulting in harm by 8.2% by March 2023	129	179	Sep-22	130	195	Aug-22	Driver			Verbal CMS
Breakthrough Objectives	Safe	Reduction in the rate of patient falls to 6.36 per 1000 occupied bed days by March 2023	6.79	6.89	Sep-22	6.86	7.09	Aug-22	Driver			Verbal CMS
Constitutional Standards and Key Metrics (not in SDR)	Safe	Number of New SIs in month	11	8	Sep-22	11	9	Aug-22	Driver			Not Escalated
	Safe	Standardised Mortality HSMR	100.0	105.3	Jun-22	100.0	103.5	May-22	Driver			Not Escalated
	Safe	Summary Hospital-level Mortality Indicator (SHMI)	100.0	97.3	May-22	100.0	98.6	Apr-22	Driver			Not Escalated
	Safe	Never Events	0	1	Sep-22	0	0	Aug-22	Driver			Not Escalated
	Safe	Safe Staffing Levels	93.5%	89.0%	Sep-22	93.5%	90.1%	Aug-22	Driver			Escalation
	Safe	Infection Control - Hospital Acquired Covid	0	45	Sep-22	0	6	Aug-22	Driver			Escalation
	Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays	22.7	42.4	Sep-22	22.7	56.5	Aug-22	Driver			Escalation
	Safe	IC - Number of Hospital acquired MRSA	0	0	Sep-22	0	1	Aug-22	Driver			Not Escalated

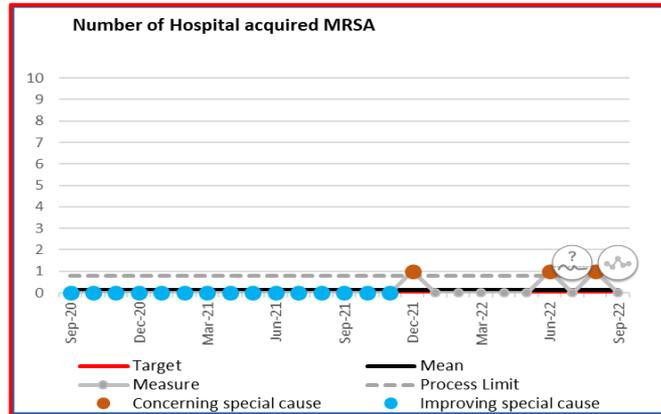
Patient Safety and Clinical Effectiveness: CQC: Safe



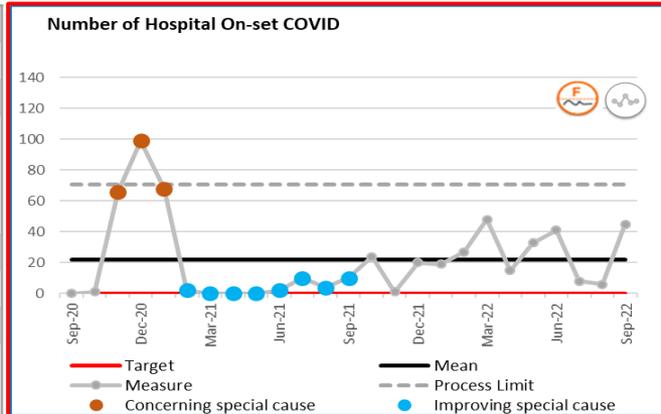
Sep-22
89.6%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has not achieved the target for >6months
Target (Internal)
93.3%
Business Rule
Full Escalation as has not achieved the target for > 6 months



Sep-22
42.4
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has failed the target for >6months
Max Target (Internal)
22.7
Business Rule
Full Escalation as Hit or Miss > 6 months



Sep-22
0
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



Sep-22
45
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has not achieved the target for >6 months
Max Target (Intern)
0
Business Rule
Full Escalation as has not achieved the target for > 6 months

Summary:

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

Rate of C.Difficile: continues to experience common cause variation but has now failed the target for more than six months

MRSA: The level of MRSA has returned to 0 and is back in common cause variation and variable achievement of the target

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

Actions:

Safe Staffing Fill Rate: Daily staffing huddles review nursing and midwifery rosters. The temporary staffing team continue to attend site meetings. The Matrons afternoon staffing huddles are supported by the Bank team to ensure the staffing allocations mitigate any safety risks. Rostering Confirm and Support meetings are now embedded, with a view to ensure effective rostering within clinical teams. Reporting for these meetings is currently being compiled. Nursing establishment reviews will commence next month to ensure the staffing template is correct to support patient care. Retention of Registered Nurses/Midwives and Clinical Support Workers (CSWs) is now a focus with a view to reduce turnover rates. Career roadshows have commenced on both sites to support staff with CPD opportunity and career planning.

Infection Control: Trust wide incident meeting held. Another planned for first week in November. Ward based training provided by the IPCT. Antimicrobial stewardship rounds by the microbiologists are continuing. There is a national increase in cases however the Trust is in the 3rd quartile for performance. The Trust has seen 51 cases to the end of September against a year end limit of 62. Management of diarrhoea and prevention of CDI is a key focus for the infection prevention team
The Trust continues to see a number of Covid outbreaks which are mainly associated with Covid positive patients being identified in a bay with subsequent transmission of infection. All Covid contacts are identified and quarantined. Weekly outbreak meeting are held to support the management of the outbreaks and identify areas for action.

Assurance & Timescales for Improvement:

Safe Staffing Fill Rate: Real time daily staffing data has been developed by the Senior Corporate Nursing and ICC team. New processes for the redeployment of staff are now live, ensuring governance and reporting is in place to document staff moves. The Trust continues to roll out SafeCare, with Phase two of the project now live. Recruitment activity continues to move at pace with recruited IEN's being mapped into clinical areas. Increased OSCE training capacity is in place to support the numbers of IEN's joining MTW. The OSCE training facility with relocate in October 2022 to support and develop OSCE training. Face to face recruitment events continue to have good attendance. The aim is to reduce the Nursing and Midwifery vacancy rate to 10% by December 2022.

Infection Control: The IPC team has provided additional IPC updates to all wards and department to promote the core IPC principles the return to standard Infection prevention and control precautions. All C diff samples are sent to the reference laboratory to assist in identify transmission of C diff infection and outbreaks. The Infection prevention team will continue to monitor and escalate where infection and nosocomial rates are rising, RCA scrutiny will continue for alert organisms including *C.difficile*.

Covid-19 outbreak management meetings continue to be a high priority in the Trust, and we continue with precautions to help minimise the spread of infection

Strategic Theme: Patient Access

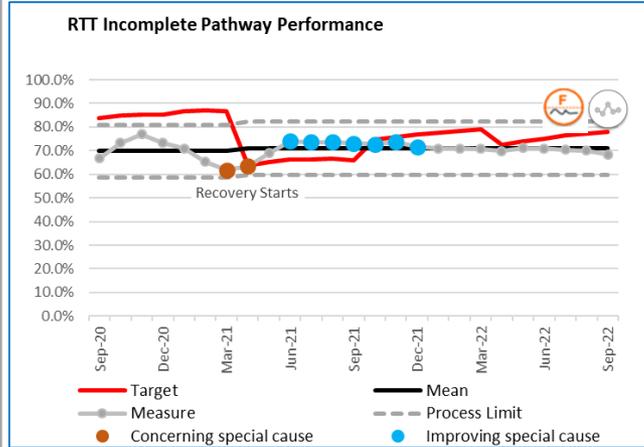
			Latest			Previous			Actions & Assurance			
CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	
Vision Goals / Targets	Responsive	Achieve the Trust RTT Trajectory by March 2023	78.0%	68.3%	Sep-22	77.3%	70.1%	Aug-22	Driver			Full CMS
Breakthrough Objectives	Responsive	To achieve the planned levels of new outpatients activity (shown as a % 19/20)	120.5%	110.6%	Sep-22	131.9%	114.3%	Aug-22	Driver			Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Responsive	RTT Patients waiting longer than 40 weeks for treatment	492	811	Sep-22	505	899	Aug-22	Driver			Not Escalated
	Responsive	Access to Diagnostics (<6weeks standard)	99.0%	90.0%	Sep-22	95.7%	89.7%	Aug-22	Driver			Escalation
	Responsive	A&E 4 hr Performance	95.7%	84.7%	Sep-22	95.7%	86.4%	Aug-22	Driver			Escalation
	Responsive	Cancer - 2 Week Wait	93.0%	94.5%	Aug-22	93.0%	95.0%	Jul-22	Driver			Not Escalated
	Responsive	Cancer - 62 Day	85.0%	86.1%	Aug-22	85.0%	85.1%	Aug-22	Driver			Not Escalated
	Effective	Transformation: % OP Clinics Utilised (slots)	85.0%	60.8%	Sep-22	85.0%	60.5%	Aug-22	Driver			Escalation
	Effective	Transformation: % of Patients Discharged to a PIFU Pathways	1.5%	1.8%	Sep-22	1.5%	1.0%	Aug-22	Driver			Not Escalated
	Effective	Transformation: CAU Calls answered <1 minute	90.0%	64.0%	Sep-22	90.0%	67.2%	Aug-22	Driver			Escalation
	Effective	Flow: Ambulance Handover Delays >30mins	5.0%	11.6%	Sep-22	5.0%	9.1%	Aug-22	Driver			Escalation
	Effective	Flow: % of Emergency Admissions into Assessment Areas	65.0%	63.0%	Sep-22	65.0%	65.8%	Aug-22	Driver			Not Escalated
	Responsive	To achieve the planned levels of elective (DC and IP cobined) activity (shown as a % 19/20)	104.5%	105.9%	Sep-22	111.0%	114.9%	Aug-22	Driver			Not Escalated
	Responsive	To achieve the planned levels of outpatients follow up activity (shown as a % 19/20)	104.3%	104.1%	Sep-22	105.9%	112.3%	Aug-22	Driver			Not Escalated
	Responsive	To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20)	200.5%	119.3%	Sep-22	196.3%	122.2%	Aug-22	Driver			Escalation

Vision: Counter Measure Summary

Project/Metric Name – Achieve the Trust RTT Trajectory by March 2023

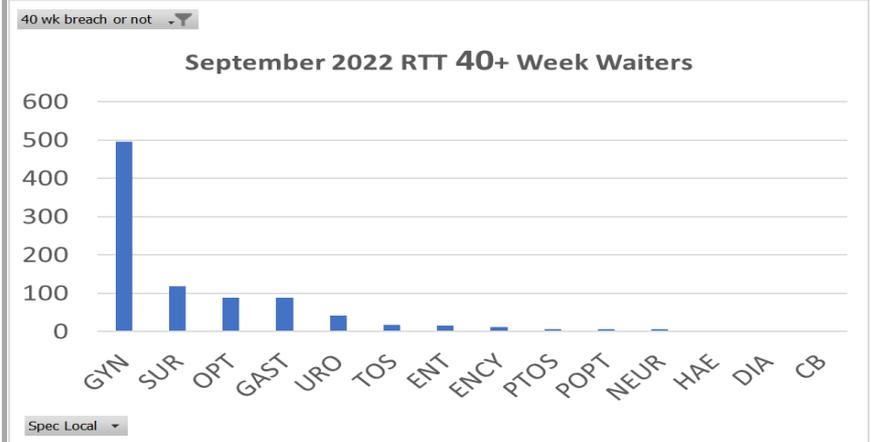
Owner: Sean Briggs
Metric: Referral to Treatment time Standard
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Sept-22
68.3%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
78.0%
Target Achievement
Metric has failed the target for >6 months

2. Stratified Data



3. Top Contributors

- Gynaecology identified as biggest contributor. Divisional project commenced, analysis in progress

4. Action Plan

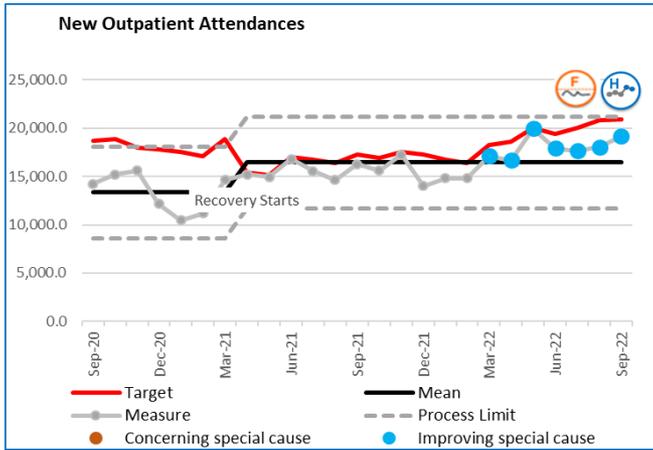
Countermeasures	Action	Who / By when	Complete (Y/N)
Super September	Validation of waiting list down to 35-40 weeks	CAU & PAT team	Complete
Daily PTL	Gynae team	Gynae & PAT team	Daily and in progress
Close monitoring of all patients over 40 weeks	Tuesday PTL and Trust Access Performance meeting	RTT Lead and PAT team	Weekly and in progress
40 week trajectory	Review speciality long waiters and forecast trajectory	RTT Lead, BI Team	In progress

Breakthrough Objective: Counter Measure Summary

Project/Metric Name – To achieve the planned levels of New Outpatient Activity

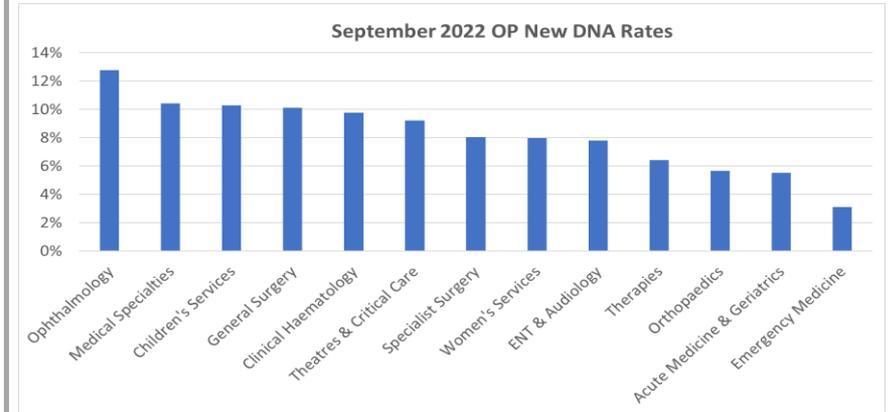
Owner: Sean Briggs
Metric: Elective Activity: New Outpatients
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



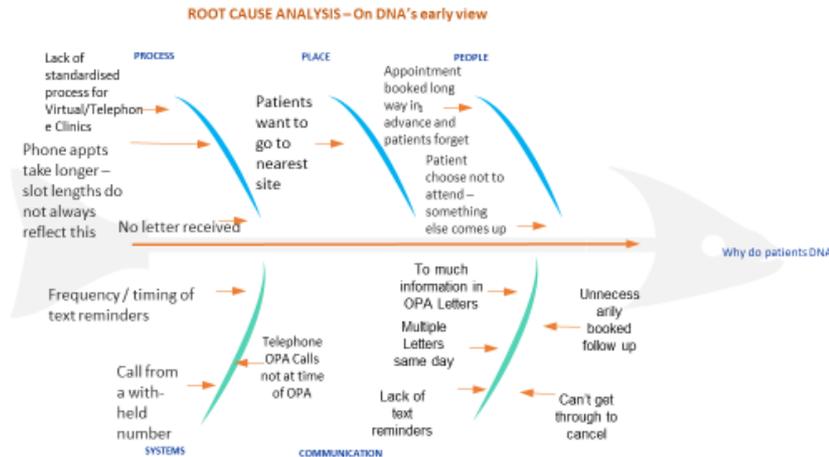
Sept-22
19,163
Variance Type
Metric is currently experiencing Special Cause Variation of an improving nature
Target
20,870
Target Achievement
Metric is consistently failing the target

2. Stratified Data



Although the Trust is near its 5% target the specialties that are not achieving activity levels have a DNA rate of 9% or above

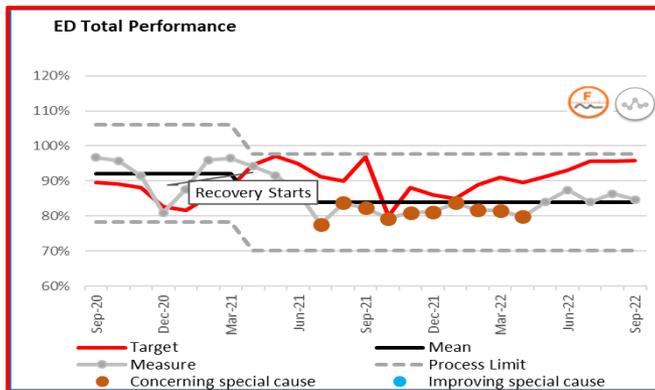
3. Top Contributors



4. Action Plan

Countermeasures	Action	Who / By when	Complete (Y/N)
Review of Text reminder service	Review of functionality with Netcall 25/10	Project Team	October
	IT Load balancers installed	IT	January 2023
Provide alternative to patients to cancel appointments when phones are busy	Review if cancellation can be added to text reminder	Project Team	Mid Oct
Telephone Clinics – review of letter re working for Private Number/time of call	Telephone letters reviewed wording updated and live on system	Steph Parrick/Tabby Jovanovich	Completed 14/10/2022

Patient Access – Hospital Flow: CQC: Responsive

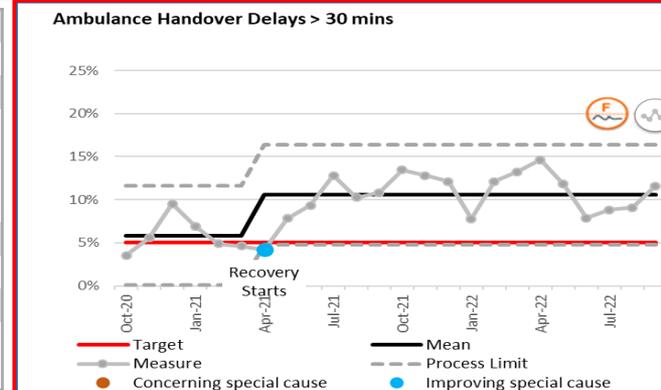


Sep-22
84.7%

Variance / Assurance
Metric is currently experiencing Common Cause variation and has failed the target for >6 months

Target (Internal)
95.7%

Business Rule
Full Escalation as has failed the target for > 6 months

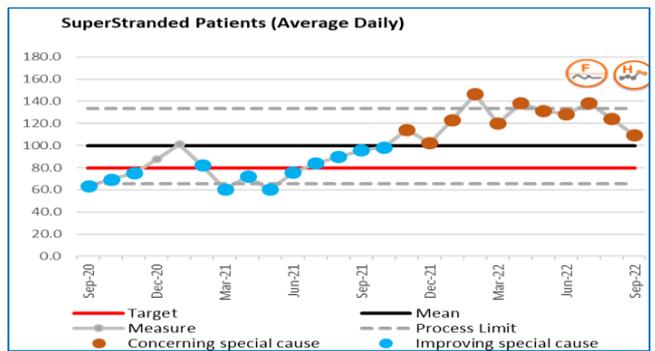


Sep-22
11.6%

Variance / Assurance
Metric is currently experiencing Common Cause variation and is consistently failing the target

Max Limit (Internal)
7%

Business Rule
Full Escalation as is consistently failing the target

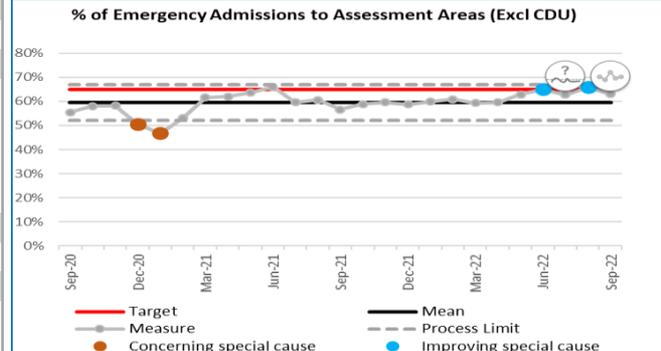


Seo-22
109

Variance / Assurance
Metric is currently experiencing Special Cause variation of a concerning nature and has failed the target for >6 months

Max Limit (Internal)
80

Business Rule
Shown for Info



Seo-22
63.0%

Variance / Assurance
Metric is currently experiencing Special Cause variation of an improving nature and variable achievement of the target

Target
65%

Business Rule
Not Escalated

Summary:

ED 4hr performance (inc MIU): This indicator is now experiencing common cause variation and has failed the target for more than six months. Despite this, the Trust is in the top 5 performing Trusts in the country during this time.

Ambulance Handover Delays of >30 minutes is experiencing common cause variation and has failed the target for more than six months.

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

% of Emergency Admissions to Assessment Areas: is experiencing special cause variation of an improving nature and variable achievement of the target. SAU emergency admission rates have improved however escalation still restricts flow for patients requiring trolley care. 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. Improved work in SDEC areas will support sustained improvement. Daily breach validation undertaken and clinic utilisation daily to improve performance.

Ambulance handover delays: Process of PIN entry now embedded, capacity issues remain in TW ED. Awaiting works on Ambulance window in reception

Super-Stranded Patients: 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: 3 x ACP's continuing with training to help improve flow and length of stay. 2 further nurses to be recruited to increase overnight staffing ensuring 24/7 admission from ED whilst escalated. Explore afternoon SDEC clinics to spread capacity through the day to avoid department becoming full.

Assurance & Timescales for Improvement:

ED 4hr performance (inc MIU): Continue with ED improvement huddles. Daily monitoring of UTC utilisation to increase use of available resource.

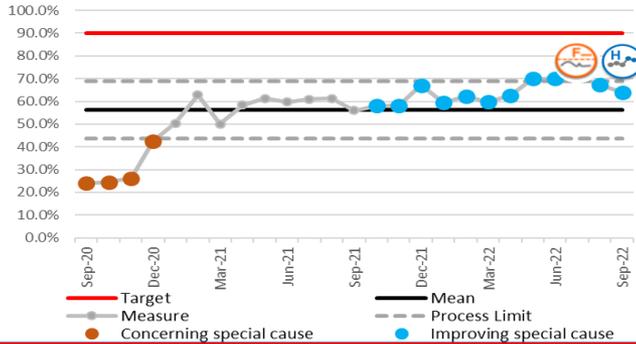
Ambulance handovers delays: Maidstone performed at 94.5% and TW 88.7% for less than 30 minute handover times an improved picture at both Maidstone and Tunbridge Wells compared to last month. Daily review of breaches maintained.

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

% of Emergency Admissions to Assessment Areas: Ongoing recruitment programme and introduction of the Physicians Associate role in November to pull from ED so patients are not placed in a ward beds before being assessed by the SAU team.

Patient Access – Transformation: Outpatients: CQC: Responsive

Calls Answered in under 1 min



Seo-22

64.0%

Variance / Assurance

Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target

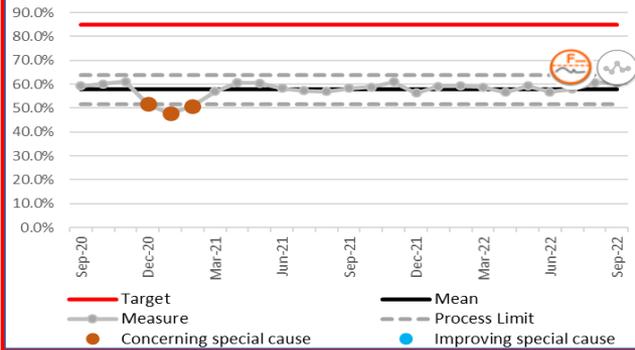
Target (Internal)

90%

Business Rule

Full Escalation

Percentage OP Clinics Utilised (slots)



Seo-22

60.8%

Variance / Assurance

Metric is currently experiencing Common Cause Variation and consistently failing the target

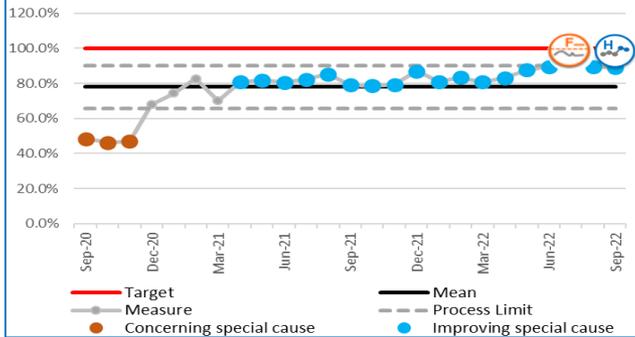
Target (Internal)

85%

Business Rule

Full Escalation

Calls Answered in under 3 minutes



Sep-22

89.0%

Variance / Assurance

Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target

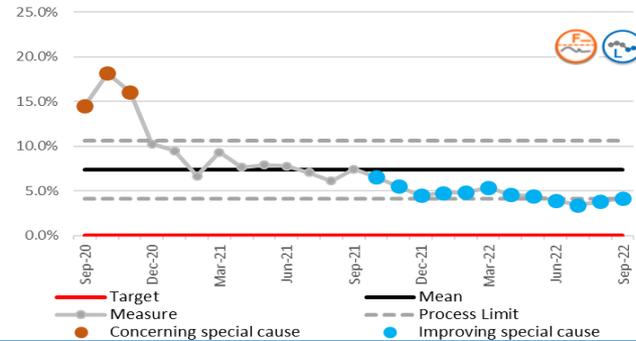
Target (Internal)

100%

Business Rule

For Information as linked to Calls <1min

Percentage of Calls abandoned



Sep-22

4.2%

Variance / Assurance

Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target

Target (Internal)

0%

Business Rule

For Information as linked to Calls <1min

Summary:

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

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

Actions:

Calls Answered: Oncology onto Netcall from 18/10. Interviews completed and staff appointed on conditional offers for triaging patient call service. Some to start in the next month subject to employment checks. Initially to be used as extra support for CAUs who report they are understaffed, to assist with calls, T&O pilot from the summer indicates a dedicated member of staff made a significant difference to waiting times.

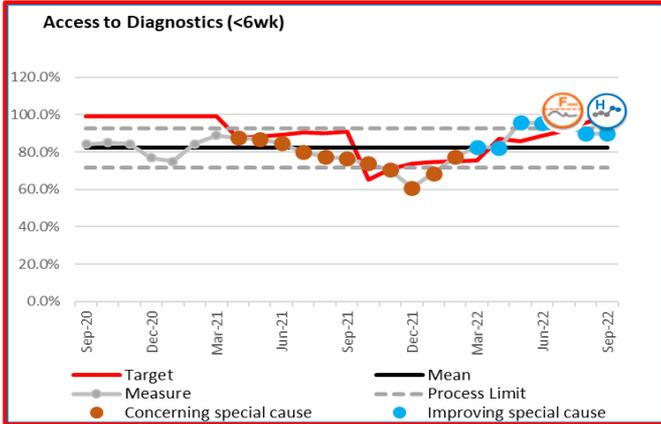
Outpatient Utilisation: Introduction of SOAP and Focal to the outpatient team to support management of utilisation of space.

Assurance & Timescales for Improvement:

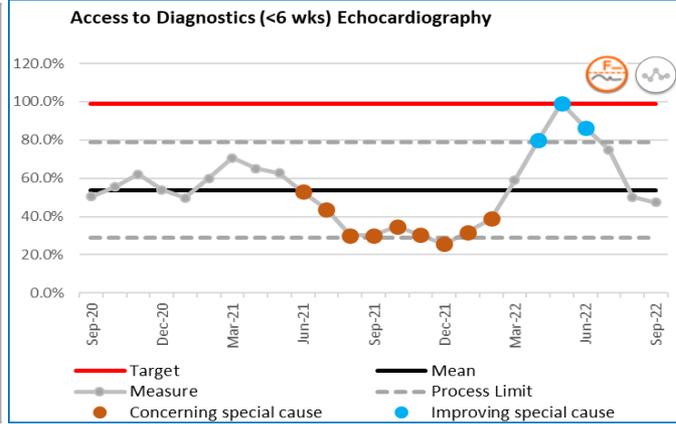
Calls Answered: Weekly meeting with specialties are undertaken to go through call KPIs to understand areas for improvement and reasonings for poor performance. Further actions are being progressed. Improvements expected when call triaging staff start.

Outpatient Utilisation: Engagement exercises booked with CAUs Specialities working with BI to unpick categorisation of clinics to address mismatch between reporting on utilisation and the reality.

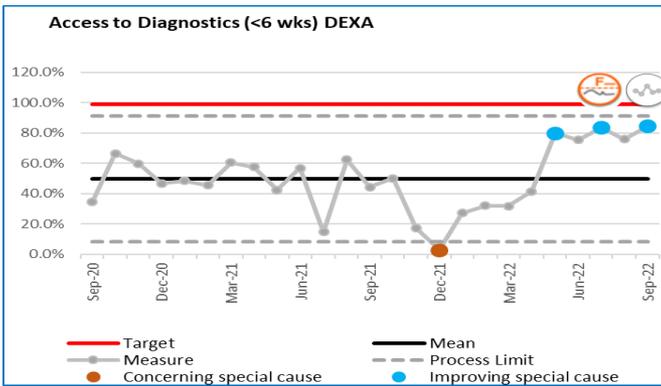
Patient Access – Diagnostics Waiting Times: CQC Responsive



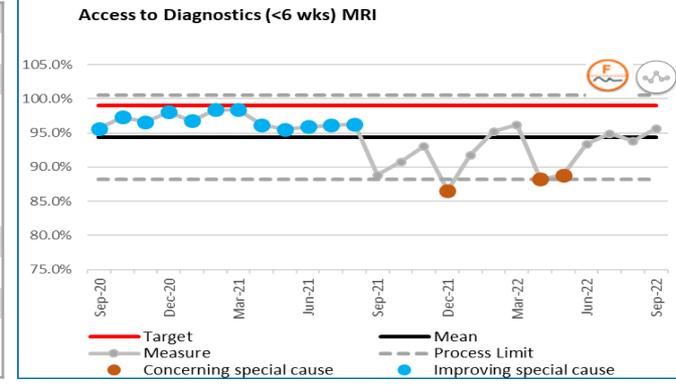
Seo-22	90%
Variance / Assurance	Metric is currently experiencing common cause variation and is consistently failing the target
Target (Internal)	88.6%
Business Rule	Full Escalation



Seo-22	47.5%
Variance / Assurance	Metric is currently experiencing common cause variation and consistently failing the target
Max Limit (Internal)	99%
Business Rule	For Information as Contributor to Overall



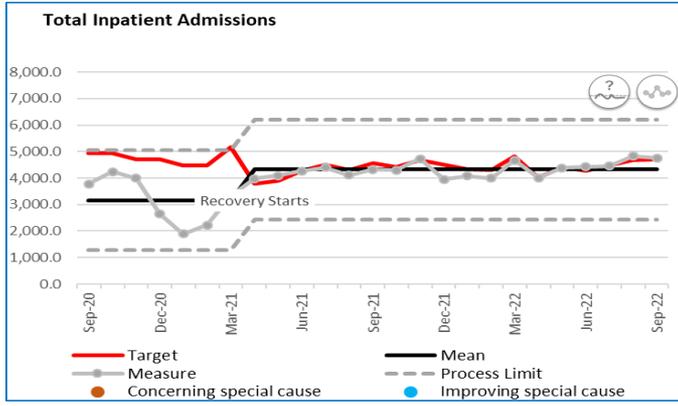
Seo-22	84.7%
Variance / Assurance	Metric is currently experiencing common cause variation and consistently failing the target
Max Limit (Internal)	99%
Business Rule	For Information as Contributor to Overall



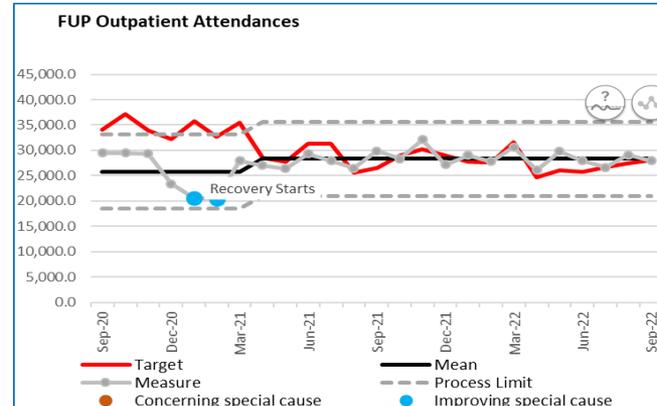
Sep-22	95.6%
Variance / Assurance	Metric is currently experiencing common cause variation and has failed the target for more than six months
Max Limit (Internal)	99%
Business Rule	For Information as Contributor to Overall

<p>Summary:</p> <p>Diagnostic Waiting Times: Performance (measured via DM01) is experiencing special cause variation of an improving nature and consistently failing the target. The three biggest contributors to this are Echocardiography, DEXA and MRI.</p> <p>Echocardiography: is experiencing common cause variation and consistently failing the target.</p> <p>DEXA: is experiencing common cause variation and consistently failing the target largely due to a lack of capacity, but is starting to show signs of recovery.</p> <p>MRI: is experiencing common cause variation but has now failed the target for more than six months</p>	<p>Actions:</p> <p>Echocardiography: The cardiology team have implemented an improvement plan.</p> <p>DEXA: New DEXA in place at TWH and activity commenced. Additional outsourcing agreement with Medway agreed and implemented.</p> <p>MRI: Monitoring equipment was expected Mid August however the components are not available and unable to give estimated delivery date.</p>	<p>Assurance & Timescales for Improvement:</p> <p>Echocardiography: Insourcing has commenced to support the internal recovery plan. The procurement of two Echocardiogram machines is in progress.</p> <p>DEXA: Recovery plan in progress and is monitored weekly with DCOO. The plan is on track to be DM01 compliant by the end of October 22 and show in Nov / Dec 22</p> <p>MRI: Discussions with Paediatric team for alternatives including diverting referrals to other providers as well as exploring previous methods such as Feed and Wrap.</p> <p>Overall DM01 Recovery Plan in progress.</p>
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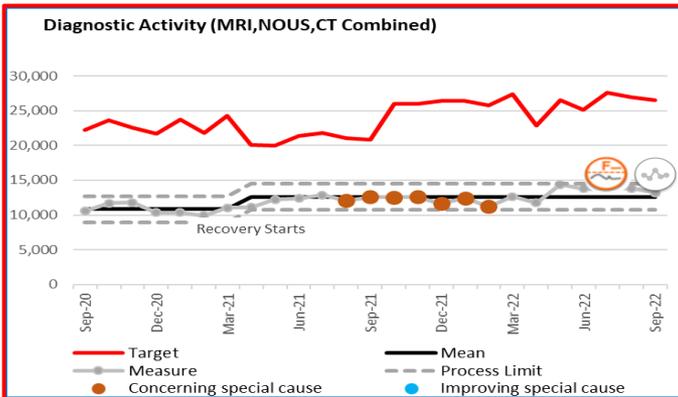
Patient Access –Activity Levels: CQC Responsive



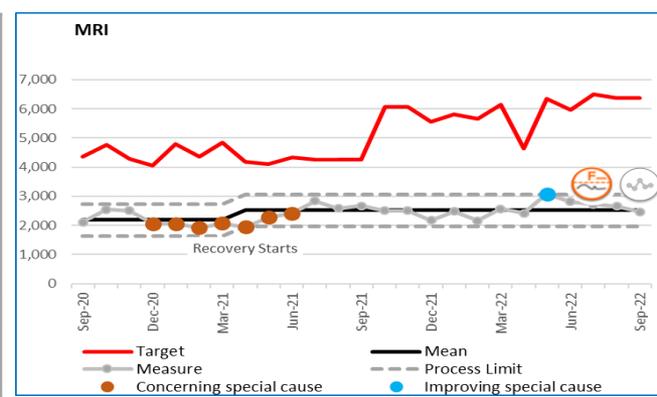
Sep-22
4752
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Target
4691
Business Rule
Not Escalated



Seo-22
27,977
Variance / Assurance
Metric is currently experiencing Special Cause Variation of a concerning nature and consistently failing the target
Target
28,009
Business Rule
Not Escalated



Sep-22
13,200
Variance / Assurance
Metric is currently experiencing common cause variation and consistently failing the target
Target
26,520
Business Rule
Full Escalation as consistently failing the target



Sep-22
2471
Variance / Assurance
Metric is currently experiencing common cause variation and is consistently failing the target
Target
6364
Business Rule
For Information as Contributor to Overall

Summary:

Elective Activity (DC/EL): This indicator is now experiencing common cause variation and variable achievement of the target. Performance has been above plan for June, July, August and September 2022. Performance is therefore above plan and at the same level of activity as 1920 YTD.

OP Follow Up Activity: The activity is experiencing common cause variation and variable achievement of the target. Activity levels for August 2022 were on plan and similar to 1920 levels.

Diagnostic Activity: Activity levels are currently above 1920 levels for MRI, CT and NOUS but are experiencing common cause variation and consistently failing the target. **MRI:** is experiencing common cause variation and consistently failing the target (however MRI is above the 1920 levels).

Actions:

Elective Activity (DC/EL): Activity continues to be monitored weekly which has assisted in developing a more robust forecasting plan.

A3s in progress.

Diagnostic: Monitoring equipment was expected Mid August however the components are not available and unable to give estimated delivery date.. Work underway with Temporary staffing team and recruitment to support NOUS team.

Assurance & Timescales for Improvement:

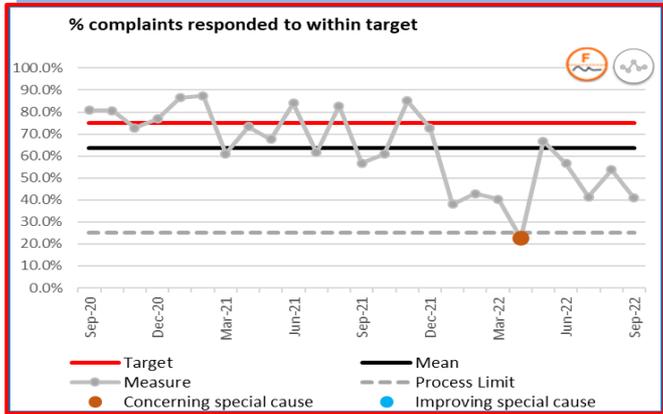
Elective Activity (DC/EL): Weekly focus on submitted activity plans with the speciality and directorate teams. 6-4-2 scheduling meetings in place and any capacity identified continues to be offered to speciality teams. Weekly focus on theatre utilisation and productivity continues via trust performance meetings. Cancellation SOP in progress. Action plan to be devised once A3s completed

Diagnostic Activity: Community Diagnostics Centre (CDC) business case has been approved and outputs of the business case are in progress.

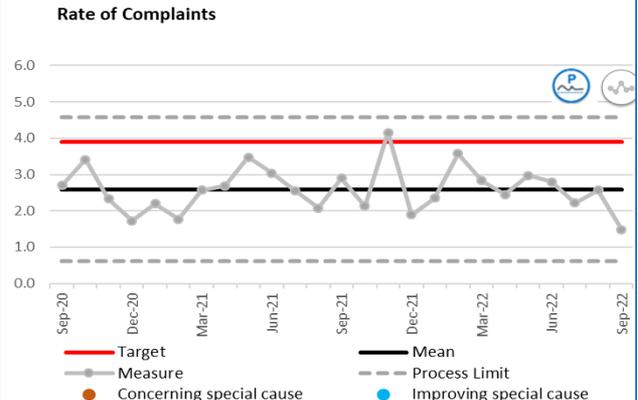
Strategic Theme: Patient Experience

	CQC Domain	Metric	Latest			Previous			Actions & Assurance			
			Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Caring	To reduce the overall number of complaints or concerns each month	36	28	Sep-22	36	50	Aug-22	Driver			Verbal CMS
Breakthrough Objectives	Caring	To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience.	24	28	Sep-22	24	32	Aug-22	Driver			No SPC
Constitutional Standards and Key Metrics (not in SDR)	Caring	Complaints Rate	3.9	1.5	Sep-22	3.9	3	Aug-22	Driver			Not Escalated
	Caring	% complaints responded to within target	75.0%	40.9%	Sep-22	75.0%	53.7%	Aug-22	Driver			Escalation
	Caring	% VTE Risk Assessment (one month behind)	95.0%	95.7%	Aug-22	95.0%	95.8%	Jul-22	Driver			Not Escalated
	Caring	Friends and Family (FFT) % Response Rate: Inpatients	25.0%	31.0%	Sep-22	25.0%	19.3%	Aug-22	Driver			Not Escalated
	Caring	Friends and Family (FFT) % Response Rate: A&E	15.0%	3.0%	Sep-22	15.0%	2.7%	Aug-22	Driver			Escalation
	Caring	Friends and Family (FFT) % Response Rate: Maternity	25.0%	9.6%	Sep-22	25.0%	8.8%	Aug-22	Driver			Escalation
	Caring	Friends and Family (FFT) % Response Rate: Outpatients	20.0%	5.3%	Sep-22	20.0%	3.7%	Aug-22	Driver			Escalation

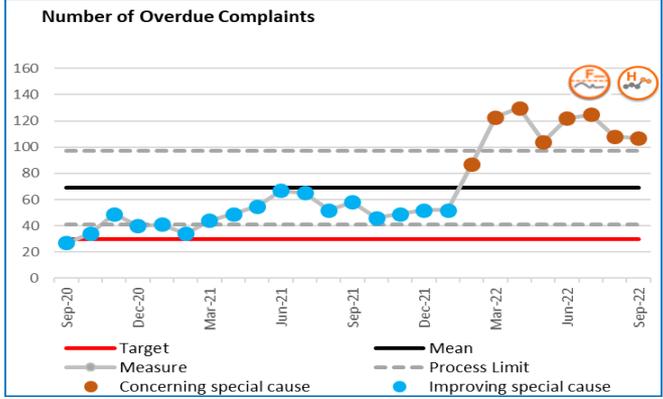
Patient Experience: CQC: Caring (Hit or Miss >6 months)



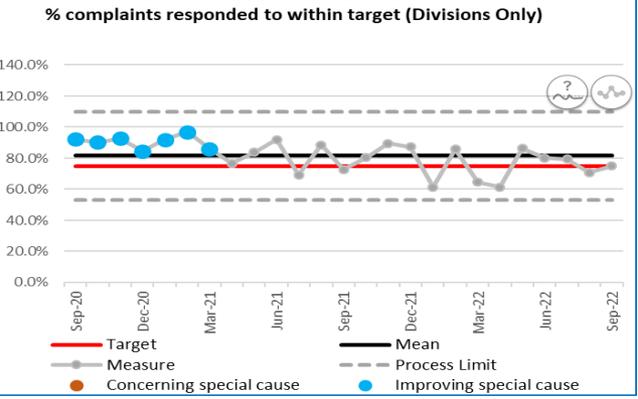
Sep-22
40.9%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of a concerning nature and variable achievement of the target
Target (Internal)
75%
Business Rule
Full Escalation failed the target 6+ months



Sep-22
1.49
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has achieved the target for 6 months
Max Limit (Internal)
3.9
Business Rule
For Information as linked to % Complaint Responded



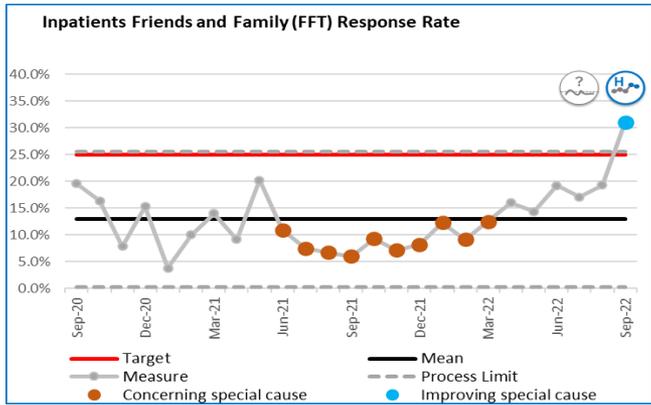
Sep-22
107
Variance / Assurance
Metric is currently experiencing Special Cause Variation of a concerning nature and consistently failing the target
Max Limit (Internal)
30
Business Rule
For Information as linked to % Complaint Responded



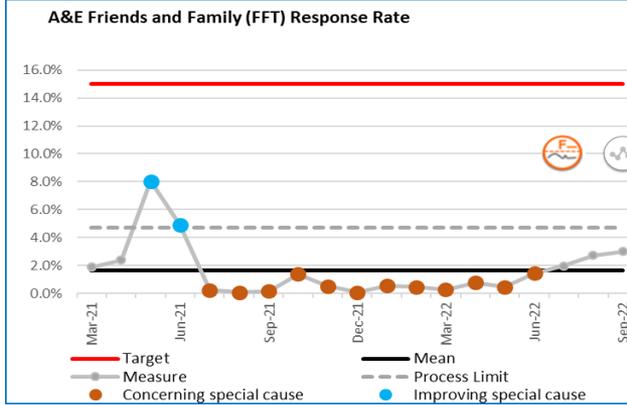
Sep-22
75.0%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Max Limit (Internal)
75%
Business Rule
For Information as linked to % Complaint Responded

<p>Summary:</p> <p>% Complaints responded to within target: this indicator is experiencing concerning cause variation and has failed the target for >6months, noting the target has not been met since November 2021</p> <p>Number of Overdue Complaints: This indicator is experiencing special cause variation of a concerning nature and is consistently failing the target since October 2020.</p>	<p>Actions:</p> <p>% Complaints responded to within Target: Complaints performance recovery and stabilisation actions include;</p> <ul style="list-style-type: none"> - Interim performance monitoring reported weekly to CN - Weekly oversight meetings led by CN and DQG - Additional temporary resource in place up to mid Nov 2022 - Successful recruitment to x2 12 month Complaint Lead posts - Weekly complaints huddles with directorates/divisions who have the biggest outstanding volume - Business case for revised complaints model (meeting new 2022 National framework) to be finalised by Jan 2023 - Targeted work plan in place with daily monitoring by management team - Complaints staff supporting A3 projects in Surgery and Women's to improve complaint response times - Introduction of new 40 day target to support more complex cases 	<p>Assurance & Timescales for Improvement:</p> <p>% Complaints responded to within Target:</p> <ul style="list-style-type: none"> - Sustained reduction in overall number of open complaints - Expect to see improvement in % compliance in October as a result of new 40-day timeframe
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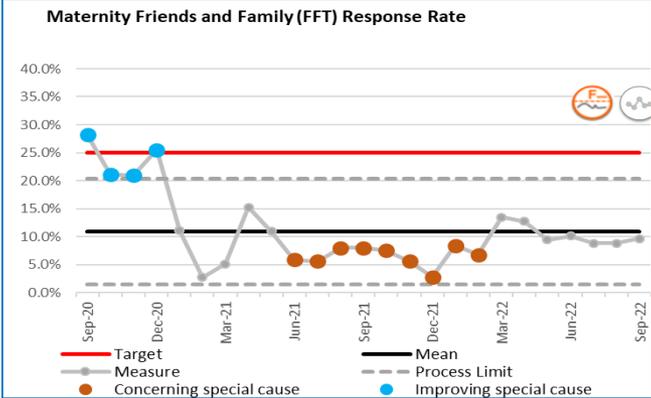
Patient Experience: CQC: Caring



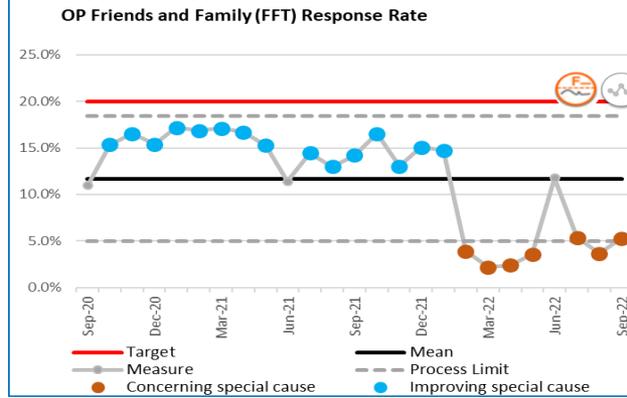
Sep-22
31.0%
Variance / Assurance
Metric is currently experiencing Common cause variation and is consistently failing the target
Target (Internal)
25%
Business Rule
Full Escalation



Sep-22
3.0%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and is consistently failing the target
Target (Internal)
15%
Business Rule
Full Escalation as consistently failing the target



Sep-22
9.6%
Variance / Assurance
Metric is currently experiencing common cause variation and is consistently failing the target
Target (Internal)
25%
Business Rule
Full Escalation as not achieved target for >6months



Sep-22
5.3%
Variance / Assurance
Metric is currently Special Cause Variation of a concerning nature and is consistently failing the target
Target (Internal)
20%
Business Rule
Full escalation as is consistently failing the target

Summary:

FFT Response Rate Inpatients: Metric is experiencing Special cause variation of an improving nature and variable achievement of the target

FFT Response Rate A&E: Metric is currently experiencing Common Cause Variation and is consistently failing the target

FFT Response Rate Maternity: Metric is currently experiencing common cause variation and is consistently failing the target

FFT Response Rate Outpatients: Metric is currently experiencing common cause variation and is consistently failing the target

Actions:

FFT Response Rate Inpatients: this is an improving picture.

FFT Response Rate A&E: ED is an improving picture.

FFT Response Rate Outpatients: SMS text messaging commenced on the 5th July, this has now replaced all phone call surveys. Overall numbers have dropped during the transition which we will continue to monitor. Imaging and diagnostics have gone live with SMS texts.

Assurance & Timescales for Improvement:

FFT Response Rate Inpatients: Push reports have now been published to the respective departments. Continue to monitor

FFT Response Rate A&E: To continue to monitor data in response to the SMS campaign with the ED team.

FFT Response Rate Outpatients; Assurance reports requested for the Netcall / BI SMS data to complete a deep dive into all elements of the campaign upload to ensure full capture of all OPD patients. Continuing with this work.

Strategic Theme: Systems

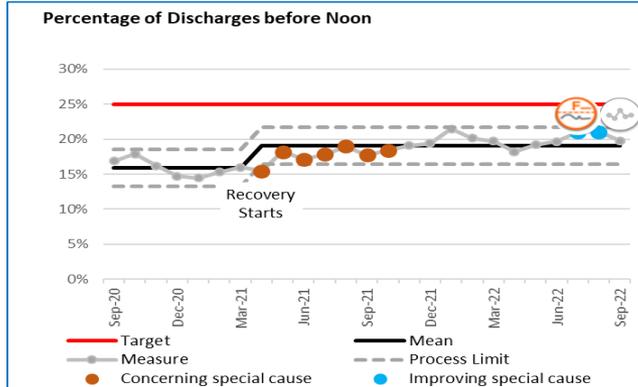
	CQC Domain	Metric	Latest			Previous			Actions & Assurance			
			Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Effective	Decrease the number of occupied bed days for patients identified as medically fit for discharge (shown as rate per 100 occupied beddays)	3.5	4.6	Sep-22	3.5	5.8	Aug-22	Driver			-
Breakthrough Objectives	Effective	To increase the number of patients leaving our hospitals by noon on the day of discharge	25.0%	19.8%	Sep-22	25.0%	21.1%	Aug-22	Driver			Full CMS

Breakthrough: Counter Measure Summary

Project/Metric Name – To increase the number of patients leaving our hospitals by noon on the day of discharge to 33%

Owner: Rachel Jones
Metric: discharges before noon
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Sep-22
19.8%
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Target (Internal)
33%
Target Achievement
Metric is consistently failing the target

Delay with the target to be amended on graph due to transfer of information from the US to Europe. Expected to be completed for the next month. **Agreement to use TT for more accurate/timely data**

3. Top Contributors

Area of Analysis	Considered a Top Contributor?
Hilton Pathway	The timeliness of this pathway due to the current process and mis-use of the service has deemed this to be a top contributor with 44% with a change in medically fit status after a referral has been made to Hilton results in patient not being accepted. There are specific wards that have higher levels of failed Hilton discharges and will be focussed on.
Criteria led discharge usage	The data has shown that CLD or nurse led discharge (NLD) was only utilised 1.3% of the time as recorded by sunrise. Although this value will need to be verified due to CLD being used on other systems also, there is an understanding that CLD pathways could be used more frequently than they are currently.
EDN completion times	Yes EDN completion times is a top contributor to delays in discharge time. The Core Clinical Service MDT Programme Group is focussing on this – including providing digital solutions and CoS support for EDNs being completed during ward rounds. A report from the group will feed into this report.
Pharmacy TAT for Dosssett's and TTOs / sent by couriers	Yes however EDN completion seems to be root cause for delays in this area. The Core Clinical Service MDT Programme Group is focussing on this - which will feed back into this report.
Discharge Lounge Usage	Although the discharge lounge is not utilised as fully as it can be, there is another project group looking at the discharge lounge of which a report will be included within this project stream. Business case in draft for discharge lounge – plans to increase establishment

Red to be carried forwards. Amber to be observed from other programmes

2. Stratified Data

Discharge Year	Discharge Month	Count Spells	Count Nurse Led Discharge	Percentage
2021	11	2322	27	1.2
2021	12	3291	51	1.5
2022	1	3143	60	1.9
2022	2	3109	33	1.1
2022	3	3753	36	1.0
2022	4	3253	30	0.9
2022	5	2587	40	1.5
2022	6	2231	22	1.0
2022	7	2253	39	1.7
2022	8	2223	35	1.6
2022	9	363	4	1.1
Total		28528	377	1.3



4. Action Plan

Workstream Overview	Key activities for the reporting period (03/10 – 19/10/22)	Activities for the next reporting period (19/10/22 – 31/10/22)
Discharges Before Noon On Track	<ul style="list-style-type: none"> HILTON - Trial one patient on a ward 2 to be selected the day before for the Hilton pathway – improving DBN. HILTON - Working with therapists to identify appropriate referrals/ improved compliance with form (Hilton auditing) HILTON - Information sheet re Hilton pathways to go to all wards CLD – define CLD & roll out comms (Info sheet awaiting sign off) 	<ul style="list-style-type: none"> HILTON – further embed W2 day before trial with consideration of other wards. HILTON – therapist referral compliance, work towards elimination of checklist Pathway 2 process mapping to be undertaken. CLD – information poster to be agreed detailing how to enable the CLD process on TT/ Sunrise. CLD – roadshow to all triumvirates Medicine – focus on wards who achieve discharge by 3pm
Core Clinical Transformation On Track	<ul style="list-style-type: none"> EDN – In relation to the EPMA roll out: agree processes, work with Sunrise team to roll out new process and send out user guides (mandatory/ nice to have). Therapies and pharmacy - clear plan for Teletracking use to help improve workflow. 	<ul style="list-style-type: none"> Continue to work with the EPMA team with the EDN adaptations. Pharmacy/ Therapies – embed TT

Extracted from Flow Improvement Board Action Log – 17.10.22

Strategic Theme: Sustainability

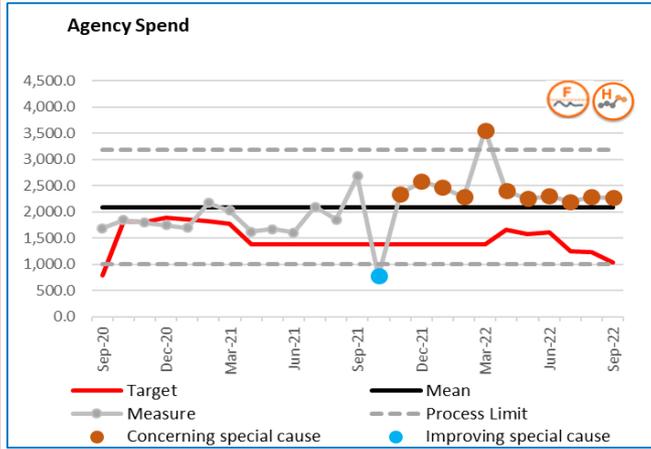
	CQC Domain	Metric	Latest			Previous			Actions & Assurance			
			Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Well Led	Delivery of financial plan, including operational delivery of capital investment plan (net surplus(+)/net deficit (-) £000)	-988	-987	Sep-22	-510	-509	Aug-22	Driver			Note Performance
Breakthrough Objectives	Well Led	Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000	1027	2265	Sep-22	1223	2288	Aug-22	Driver			Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Well Led	CIP	1517	1043	Sep-22	1513	1109	Aug-22	Driver			Not Escalated
	Well Led	Cash Balance (£k)	13475	25310	Sep-22	20175	33272	Aug-22	Driver			Not Escalated
	Well Led	Capital Expenditure (£k)	13249	2868	Sep-22	2404	7	Aug-22	Driver			Not Escalated

Vision: Counter Measure Summary

Project/Metric Name – Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000

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

1. Historic Trend Data

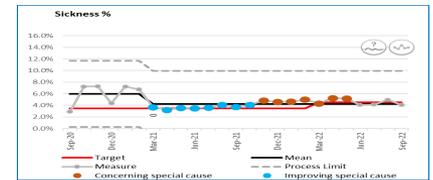
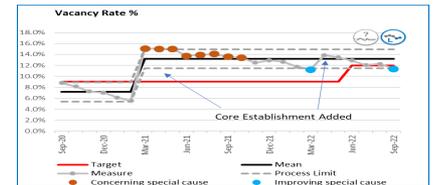


Sep-22	2,265
Variance Type	Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)	1,223
Target Achievement	Metric has not achieved the target for >6 months

2. Stratified Data

** This is an early view and further analysis will be undertaken

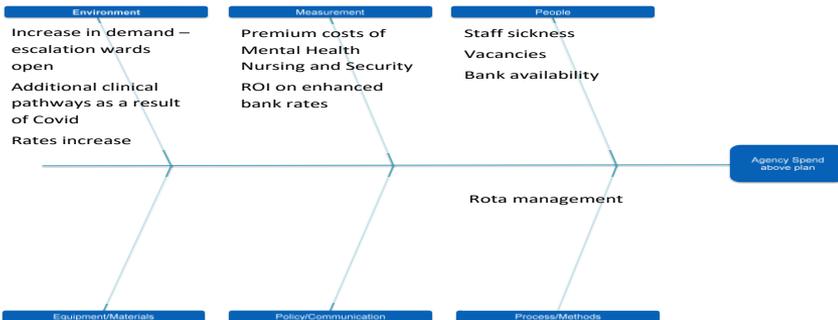
Reason	
Vacancy	48%
Back Filling	23%
Escalation / Demand	13%
COVID-19 Related	5%
Patient Special / Escort	5%
Other	4%
Sickness	3%



3. Top Contributors

** This is early analysis and full analysis will be undertaken shortly as part of the A3

Fishbone diagram for:



IC243
Mental Health and
Trustwide Safety
Rate 2021

4. Action Plan

A new A3 is being developed, with countermeasures identified and to be implemented.

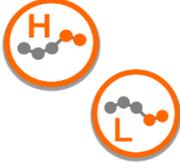
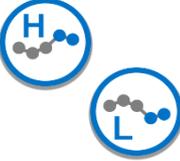
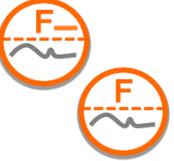
A steering group has been convened with fortnightly meetings, next meeting to review the data gathered to review top contributors and begin action planning.

Actions taken in support of other workstreams, particularly the People theme, will also support the planned reduction in premium temporary staffing. The Trust will also continue all of its ongoing business as usual actions that will have a bearing on this objective.

Appendices

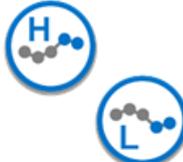
SDR Business Rules Driven by the SPC Icons

Assurance: Failing

Variation	Assurance	Understanding the Icons	Business Rule – DRIVER	Business Rule - WATCH
		<p>Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates consistently (F)ailing the target.</p>	<p>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</p>	<p>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</p>
		<p>Common Cause - no significant change. Assurance indicates consistently (F)ailing the target.</p>	<p>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</p>	<p>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</p>
		<p>Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates consistently (F)ailing the target.</p>	<p>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</p>	<p>Metric is Failing the Target, but is showing a Special Cause of Improvement. Note performance, but do not consider escalating to a driver metric</p>

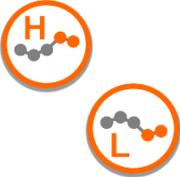
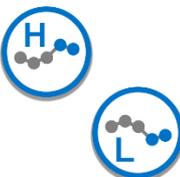
SDR Business Rules Driven by the SPC Icons

Assurance: Hit & Miss

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

SDR Business Rules Driven by the SPC Icons

Assurance: Passing

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

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 consistently **fail**  have:

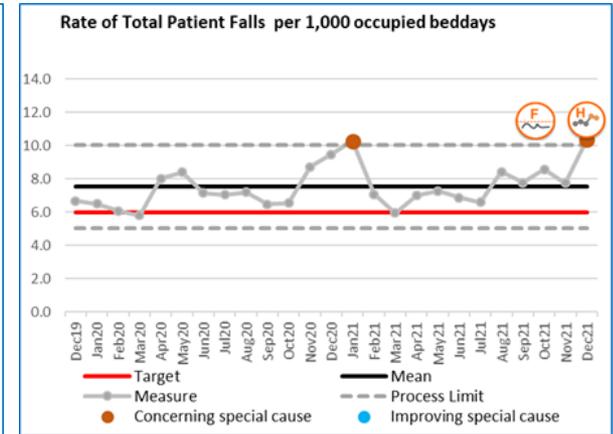
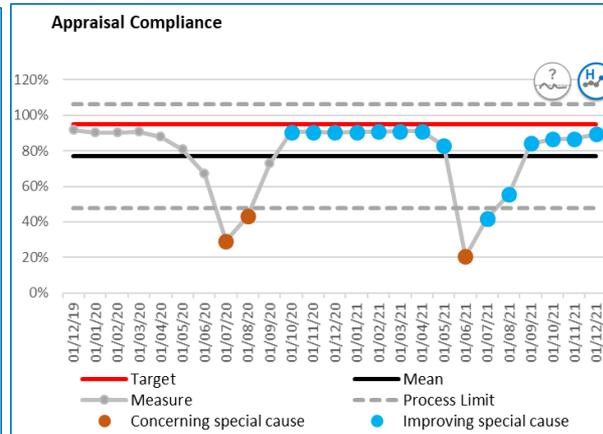
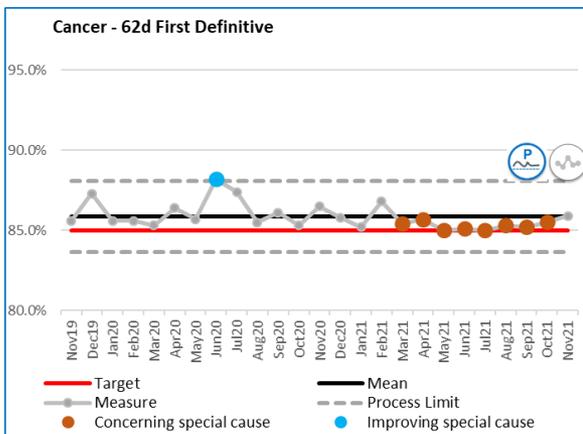
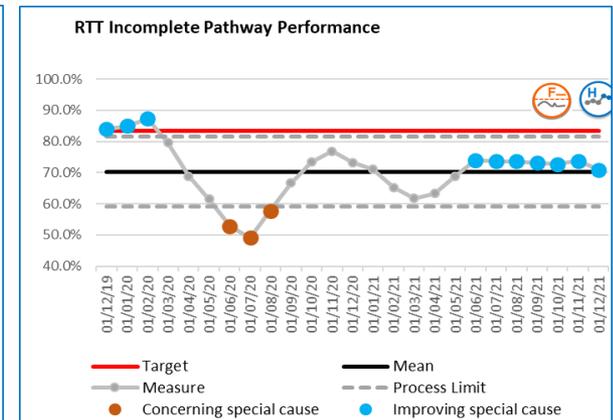
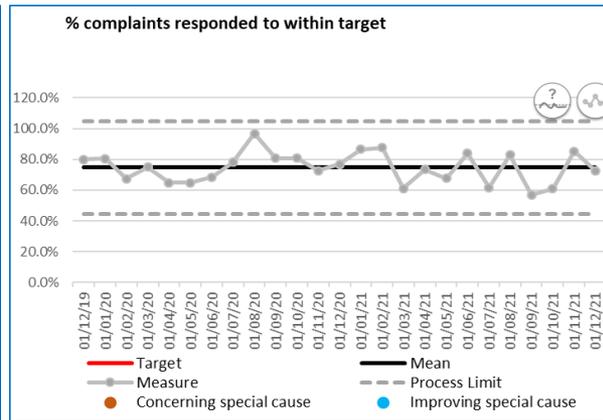
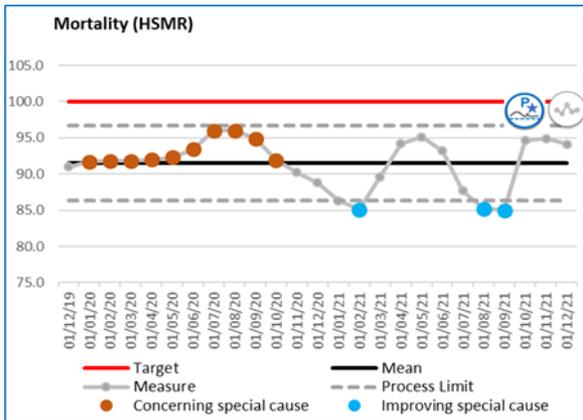
The **lower control limit above** the target line for metrics that need to be **below the target**

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 

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

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



Executive Summary

- The Trust has delivered the September Plan and the Year to Date plan by delivering a deficit of £1m in month and £7.1m year to date.
- The key pressure is within pay budgets which are adverse to plan by £1.4m, this is driven by overspends within Emergency Medicine medical staffing (£3.1m) and facilities staffing (£1.2m). These pressures were partly offset by underspends within Nursing (£1.7m). and support to clinical staff (£0.9m) and Admin and Clerical (£0.5m).
- The Trust has had to release £2.1m from reserves to help to part offset the pay pressures and CIP slippage.
- Cost Improvement Plans (CIP) are behind of plan with a year to date adverse position of £0.7m. The CIP plans are phased with stepped increases required from October.
- There is a risk of £6m associated with Elective Recovery Fund (ERF) clawback as the Elective Activity in April to September was below 104% of 2019/20 levels. However, there has been confirmation that the H1 ESRF clawback will not be applied at the System level and NHS Kent & Medway has confirmed this approach for local Providers in H1. There is however a risk that the Trusts other Commissioners may choose to clawback funds including Specialised Commissioning, the H1 financial risk for all the out of area Commissioners equates to circa £2.3m There is also a specific ESRF financial risk included within the £2.3m relating to Radiotherapy commissioned by NHSE Specialised
- The Trust is forecasting to deliver a breakeven position however this requires full delivery of the CIP plan.

Year to Date Financial Position

- The Trust was on plan, generating a £7.1m deficit.
- The key year to date variances is as follows:
 - **Adverse Variances**
 - Pay budgets overspent by £1.4m. The main pressures continue to be within Emergency Medicine medical staffing (£3.1m) and facilities staffing (£1.2m). These pressures were partly offset by underspends within Nursing (£1.7m). and support to clinical staff (£0.9m) and Admin and Clerical (£0.5m).
 - CIP Slippage (£0.7m)
 - Consultancy and professional fees (£0.3m)
 - Printing and postage pressures (£0.3m) which includes a 15% inflation increase for hybrid mail.
 - Additional security costs (£0.2m)
 - **Favourable Variances**
 - Release of £2.1m from reserves. The following reserves have been released: £1m from growth reserve to offset unfunded waiting list initiatives incurred, £0.5m from contingency and £0.6m from service developments to part offset some of the YTD pay pressures and CIP slippage.
 - Underspends within Clinical supplies (£0.4m) and Elective outsourcing due to Elective activity below budget (£0.3m)

Risks

- Elective Activity in April to September was below 104% of 2019/20 levels which could result in an Elective Recovery Fund clawback of c£6m. However, there has been confirmation that the H1 ESRF clawback will not be applied at the System level and NHS Kent & Medway has confirmed this approach for local Providers in H1. There is however a risk that the Trusts other Commissioners may choose to clawback funds including Specialised Commissioning, the H1

financial risk for all the out of area Commissioners equates to circa £2.3m There is also a specific ESRF financial risk included within the £2.3m relating to Radiotherapy commissioned by NHSE Specialised

Current Month Financial Position

- The Trust was on plan generating a £1m deficit in the month.
- The key current month variances are as follows:
 - Pay budgets (net of passthrough related costs) were breakeven in the month. The pay spend in month 6 includes back dated payaward arrears, the main pressures continue to be within Medical staffing (£0.3m) and Support staff (£0.1m), these pressures were offset by underspends within nursing (£0.3m) and admin and clerical (£0.1m). The Medicine and Emergency division continues to have the largest pay pressure (£0.7m adverse in the month) which is mainly relates to Medical Staffing in Emergency Medicine (£0.5m) and Support to clinical staff (£0.1m).
 - CIP slippage of £0.5m in the month.
 - Increase in doubtful debt (£0.2m)
 - Release of contingency reserves (£0.6m)
 - Depreciation underspend (£0.1m)

Cashflow

- The closing cash balance at the end of September 2022 was £25.3m which is higher by £11.8m compared with the revised plan resubmitted in June 2022. The increase in the cash balance is primarily due to the reimbursement of backlog costs by the funder of the development of accommodation for the Kent Medical School students following the contract being signed and capital spend is lower than plan, however orders are currently being placed so spend is expected to increase.
- The Trust is also working with its NHS colleagues to reduce all debtor/creditor balances. This also ensures the Trust is achieving the BPPC target of 95% that NHSE/I are reviewing regularly , the Trusts BPPC at the end of September is - Trade in value is 96% and by quantity is 96.9%; for NHS by value is 96.8% and by quantity is 87%

Capital Position

- The Trust's capital plan, excluding IFRS 16 items, agreed with the ICS for 2022/23 is £41.3m comprising:
- Net Internal funding (£8.6m):
 - £19.5m depreciation
 - less £2.5m in-year cash surplus (balancing to ICS control total)
 - less £8.4m of PFI finance and capital investment loan repayment
- PFI lifecycle per Project model of £1.3m - actual spend will be notified periodically by the Project Company.
- Donated Assets of £0.4m relating to forecast donations in year.
- System PDC of £1.95m for HASU (now approved by ICB but awaiting confirmation of mechanism to access) and
- National PDC of £29m for Barn Theatre (to be approved)
- The Plan figure of £41.3m includes:
 - Estates: Estates Enabling and Backlog schemes include contractual commitments from 21/22 relating to enabling works for Linacs and SPECT CT equipment, as well as MRI enabling/build works at MGH and TWH (relating to In-Health proposed contract). They also include carry forward spend from projects that were planned for completion in 2021/22 but have overrun e.g. Annexe and Oncology OPD.

- ICT: ICT schemes include EPMA costs relate to contractual commitments, IT for KMMS, iPro Anaesthetics, EPR infrastructure upgrade, eChemo prescribing and devices replacement.
 - Equipment: Includes contractual commitments from 21/22 relating to schemes that could not be delivered by 31st March due to supplier issues. The majority of schemes have been approved and orders are being raised. Other equipment schemes have been prioritised and business cases are in development.
 - Externally Funded schemes: Includes £1.9m for the HASU and £29m for the Barn Theatre (includes estates, ICT and equipment), both are waiting for the business cases to be approved. The CDC business case has been approved (£9.87m includes building, equipment and IT) and a Letter of Agreement has been received, MoU to follow. In addition, funding has also been confirmed for Digital Diagnostics (PACS and Home Reporting) of £382k.
- The Year to date spend on capital is £2.1m against the Plan of £7.83m. The majority of this spend relates to Estates and Equipment Backlog carry forward spend from projects commenced in 2021/22 e.g. Annexe & Oncology OPD and kitchen dishwasher. The month 5 position includes credits relating to VAT reclaims following a review carried out by the Trust VAT Advisors. The variance relates mostly to spend on the Barn project that was assumed in the plan to be continuing in the first quarter; currently it is on hold awaiting the BC approval. The Stroke business case has only recently been approved by the ICB, orders are now being placed.

Year-end Forecast

The Trust is forecasting to deliver a breakeven position however this requires full delivery of the CIP plan.

Finance Report

Month 6
2022/23

September 2022/23

	Current Month					Year to Date				
	Actual	Plan	Variance	Pass-through	Revised Variance	Actual	Plan	Variance	Pass-through	Revised Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income	56.9	56.0	0.9	0.1	0.8	319.3	317.0	2.3	(0.6)	2.9
Expenditure	(54.2)	(53.1)	(1.1)	(0.1)	(1.0)	(304.1)	(301.2)	(2.9)	0.6	(3.5)
EBITDA (Income less Expenditure)	2.7	2.9	(0.2)	0.0	(0.2)	15.2	15.8	(0.6)	0.0	(0.6)
Financing Costs	(3.7)	(3.9)	0.2	0.0	0.2	(22.6)	(23.2)	0.6	0.0	0.6
Technical Adjustments	0.1	0.1	(0.0)	0.0	(0.0)	0.3	0.3	(0.0)	0.0	(0.0)
Net Surplus / Deficit (Incl Top Up funding support)	(1.0)	(1.0)	0.0	0.0	0.0	(7.1)	(7.1)	0.0	0.0	0.0
Cash Balance	25.3	13.5	11.8		11.8	25.3	13.5	11.8		11.8
Capital Expenditure (Incl Donated Assets)	2.9	13.2	10.4		10.4	4.0	18.7	(14.8)		(14.8)
Cost Improvement Plan (Internal £30m target)	1.0	1.5	(0.5)		(0.5)	4.8	5.4	(0.7)		(0.7)

Summary Current Month:

- The Trust was on plan generating a £1m deficit in the month.

The Trusts key variances to the plan are:

- Pay budgets (net of passthrough related costs) were breakeven in the month. The pay spend in month 6 includes back dated pay award arrears, the main pressures continue to be within Medical staffing (£0.3m) and Support staff (£0.1m), these pressures were offset by underspends within nursing (£0.3m) and admin and clerical (£0.1m). The Medicine and Emergency division continues to have the largest pay pressure (£0.7m adverse in the month) which is mainly relates to Medical Staffing in Emergency Medicine (£0.5m) and Support to clinical staff (£0.1m).
- CIP slippage of £0.5m in the month.
- Increase in doubtful debt (£0.2m)
- The above pressures were offset by release of reserves (0.6m) and underspend on Depreciation (£0.1m)

Year to date overview:

- The Trust was on plan generating a £7.1m deficit year to date.
- The Trusts key variances to the plan are:

Adverse Variances:

- Pay budgets overspent by £1.4m. The main pressures continue to be within Emergency Medicine medical staffing (£3.1m) and facilities staffing (£1.2m). These pressures were partly offset by underspends within Nursing (£1.7m). and support to clinical staff (£0.9m) and Admin and Clerical (£0.5m).
- Additional security costs (£0.2m), consultancy and professional fees (£0.3m) and printing and postage pressures (£0.3m) which includes 15% inflation pressure associated with Hybrid mail.
- CIP Slippage (£0.7m)

Favourable Variances:

- Release of £2.1m from reserves. The following reserves have been released: £1m from growth reserve to offset unfunded waiting list initiatives incurred, £0.5 m from contingency and £0.6m from service developments to part offset some of the YTD pay pressures and CIP slippage.
- Underspends within Clinical supplies (£0.4m), Elective outsourcing due to Elective activity below budget (£0.2m) and depreciation underspend (£0.3m)

CIP (Savings)

- The Trust has a external (NHSE/I) savings target for 2022/23 of £20m but a internal savings requirement of £30m. Against the £30m internal target the Trust has delivered £4.8m savings year to date which is £0.7m adverse to plan.

Risks

- **ERF Clawback (£6m).** The cumulative ESRF assessment for H1 is currently estimated to generate a clawback of funds at circa £6.0m and represents a financial risk to the Trust achievement of the finance plan. However, there has been confirmation that the H1 ESRF clawback will not be applied at the System level and NHS Kent & Medway has confirmed this approach for local Providers in H1. There is however a risk that the Trusts other Commissioners may choose to clawback funds including Specialised Commissioning, the H1 financial risk for all the out of area Commissioners equates to circa £2.3m There is also a specific ESRF financial risk included within the £2.3m relating to Radiotherapy commissioned by NHSE Specialised Commissioning that equates to a clawback of £0.8m, this is being challenged by the Trust due to objections of the inclusion of Radiotherapy in the scope of the ESRF.

Forecast

- The Trust is forecasting to deliver a breakeven position however this requires near full delivery of the CIP plan.

Sep-22		DAY				NIGHT				TEMPORARY STAFFING		Bank / Agency Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand Unfilled -RM/N (number of shifts)	Overall Care Hours per pt day	Nurse Sensitive Indicators				Financial review		
Hospital Site name	Health Roster Name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Bank/Agency Usage	Agency as a % of Temporary Staffing					FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Budget £	Actual £	Variance (£ (overspend))
MAIDSTONE	Stroke Unit (M) - NK551	94.7%	76.8%	-	100.0%	102.9%	120.2%	-	-	35.3%	40.8%	197	13.62	23	8.1	26.4%	100.0%	15	1	325,915	349,223	(23,308)
MAIDSTONE	Cornwallis (M) - NS959	75.3%	89.7%	-	-	87.9%	213.6%	-	-	46.5%	30.7%	108	7.47	17	7.9	0.0%	-	4	0	183,466	131,101	52,365
MAIDSTONE	Culpepper Ward (M) - NS551	118.1%	80.8%	-	-	104.9%	140.0%	-	-	29.7%	30.9%	29	2.06	4	5.3	94.9%	97.3%	0	1	136,392	160,667	(24,275)
MAIDSTONE	Foster Clark - NS251	81.5%	54.0%	-	100.0%	88.3%	68.2%	-	100.0%	13.9%	29.2%	53	3.76	23	7.0	47.5%	96.5%	3	0	185,733	162,031	23,702
MAIDSTONE	John Day Respiratory Ward (M) - NT151	92.0%	94.3%	-	-	106.7%	110.0%	-	-	40.7%	44.8%	146	10.18	21	6.3	73.5%	100.0%	5	0	177,458	204,570	(27,112)
MAIDSTONE	Intensive Care (M) - NA251	94.9%	81.9%	-	-	89.5%	74.5%	-	-	3.2%	0.0%	44	2.02	10	65.6	200.0%	100.0%	0	0	303,257	256,597	46,660
MAIDSTONE	Pye Oliver (Medical) - NK259	103.2%	85.9%	-	100.0%	122.1%	109.0%	-	100.0%	36.6%	53.6%	115	8.11	24	6.2	27.5%	84.2%	5	0	153,329	168,805	(15,476)
MAIDSTONE	Whatman Ward - NK959	99.6%	88.6%	-	100.0%	118.2%	281.4%	-	100.0%	97.9%	51.8%	192	13.46	27	7.1	-	-	5	0	116,944	182,807	(65,863)
MAIDSTONE	Lord North Ward (M) - NF651	97.5%	97.1%	-	-	99.9%	99.9%	-	-	10.6%	18.8%	38	2.78	9	7.2	23.1%	100.0%	2	0	130,114	125,285	4,829
MAIDSTONE	Mercer Ward (M) - NJ251	86.7%	106.4%	-	100.0%	108.3%	115.0%	-	-	35.2%	49.8%	102	6.99	20	5.9	21.2%	85.7%	2	1	131,640	160,919	(29,279)
MAIDSTONE	Edith Cavell - NS459	100.9%	84.0%	-	100.0%	106.7%	108.3%	-	-	41.5%	32.7%	75	5.22	10	6.6	22.0%	88.9%	3	0	135,174	131,165	4,009
MAIDSTONE	Short Stay Surgical Unit (M) - NE751	91.6%	93.9%	-	-	86.9%	-	-	-	17.7%	7.4%	27	1.46	8	24.4	-	-	0	0	64,843	66,526	(1,683)
MAIDSTONE	Acute Medical Unit (M) - NG551	94.2%	90.2%	-	100.0%	116.7%	200.0%	-	-	35.7%	28.1%	88	5.96	17	9.6	-	83.3%	2	0	194,535	212,654	(18,119)
TWH	Ward 22 (TW) - NG332	76.6%	76.9%	-	-	124.4%	120.6%	-	-	52.8%	50.9%	177	12.80	74	5.8	27.5%	100.0%	8	2	169,650	174,034	(4,384)
TWH	Coronary Care Unit (TW) - NP301	72.9%	70.2%	-	-	80.5%	90.5%	-	-	20.5%	24.8%	75	5.50	40	9.7	96.4%	100.0%	0	0	83,238	83,594	(356)
TWH	Ward 33 (Gynae) (TW) - ND302	98.6%	93.1%	-	-	88.3%	100.0%	-	-	25.2%	14.6%	46	3.14	9	6.9	4.2%	100.0%	0	1	114,435	108,788	5,647
TWH	Intensive Care (TW) - NA201	97.1%	75.0%	-	-	99.7%	80.9%	-	-	10.4%	0.0%	110	6.38	5	30.5	450.0%	100.0%	0	0	442,625	387,872	54,753
TWH	Acute Medical Unit (TW) - NA901	86.0%	58.0%	-	100.0%	98.0%	67.4%	-	100.0%	24.7%	33.3%	169	12.27	69	7.2	22.7%	93.1%	7	0	278,269	251,119	27,150
TWH	Surgical Assessment Unit (TW) - NE701	83.3%	137.5%	-	-	84.8%	96.7%	-	-	30.0%	25.3%	79	5.14	30	20.5	-	-	0	0	87,443	80,984	6,459
TWH	Ward 32 (TW) - NG130	85.3%	90.1%	-	100.0%	74.5%	84.4%	-	-	23.5%	46.3%	139	9.56	51	7.9	42.9%	100.0%	3	2	170,325	156,624	13,701
TWH	Ward 10 (TW) - NG131	89.1%	102.3%	-	-	100.0%	152.5%	-	100.0%	34.9%	40.7%	130	8.97	31	6.8	1.9%	100.0%	7	0	167,258	186,676	(19,418)
TWH	Ward 11 (TW) Winter Escalation 2019 - NG144	87.8%	77.5%	-	-	154.7%	85.4%	-	-	79.6%	48.0%	311	20.74	85	6.0	2.2%	100.0%	12	0	173,102	197,286	(24,184)
TWH	Ward 12 (TW) - NG132	96.0%	79.9%	-	100.0%	130.0%	91.6%	-	100.0%	39.0%	45.3%	164	11.06	60	6.1	11.3%	87.5%	9	0	168,700	191,543	(22,843)
TWH	Ward 20 (TW) - NG230	102.0%	61.8%	-	-	150.6%	87.5%	-	-	37.6%	51.4%	170	12.46	62	6.2	-	-	12	0	198,978	199,111	(133)
TWH	Ward 21 (TW) - NG231	77.4%	86.1%	-	-	101.3%	108.3%	-	-	34.3%	58.5%	204	14.16	80	6.1	6.2%	100.0%	1	0	169,731	177,999	(8,268)
TWH	Ward 2 (TW) - NG442	68.0%	70.5%	-	100.0%	116.7%	144.3%	-	-	39.0%	56.0%	151	10.44	63	7.2	82.4%	85.7%	8	2	207,559	178,380	29,179
TWH	Ward 30 (TW) - NG330	77.8%	84.4%	-	100.0%	128.6%	142.4%	-	-	52.5%	50.7%	209	13.74	70	6.0	15.2%	85.7%	9	2	144,910	190,851	(45,941)
TWH	Ward 31 (TW) - NG331	88.9%	90.4%	-	100.0%	118.2%	103.5%	-	-	32.3%	38.0%	150	9.52	53	6.1	40.0%	100.0%	5	0	160,979	192,056	(31,077)
Crowborough	Crowborough Birth Centre (CBC) - NP775	63.3%	92.0%	-	-	53.3%	86.1%	-	-	12.5%	0.0%	49	2.75	2	147.4	73.3%	100.0%	0	0	158,675	107,524	51,151
TWH	Midwifery (multiple rosters)	73.0%	66.6%	-	-	84.4%	77.3%	-	-	13.5%	6.4%	648	36.76	200	9.9	22.2%	96.5%	0	0	874,821	937,262	(62,441)
TWH	Hedgehog Ward (TW) - ND702	82.6%	102.7%	-	-	101.7%	-	-	-	28.3%	42.3%	123	8.63	25	9.8	6.3%	100.0%	0	0	166,813	211,006	(44,193)
MAIDSTONE	Maidstone Birth Centre - NP751	108.0%	96.4%	-	-	100.8%	94.8%	-	-	9.8%	0.0%	20	1.04	0	46.6	93.8%	100.0%	0	0	83,329	94,148	(10,819)
TWH	SCBU (TW) - NA102	82.2%	52.6%	-	-	89.1%	56.7%	-	-	15.2%	0.0%	89	5.23	7	12.0	14.3%	100.0%	0	0	223,279	230,582	(7,303)
TWH	Short Stay Surgical Unit (TW) - NE901	83.5%	67.5%	-	100.0%	56.5%	103.4%	-	100.0%	11.6%	21.1%	35	2.44	12	11.0	-	-	1	0	93,481	89,375	4,106
MAIDSTONE	Accident & Emergency (M) - NA351	100.1%	103.6%	-	100.0%	102.0%	97.4%	-	-	42.5%	45.3%	443	31.15	25	-	4.4%	92.6%	1	0	428,406	515,972	(87,566)
TWH	Accident & Emergency (TW) - NA301	91.0%	78.4%	-	100.0%	96.4%	86.6%	-	100.0%	37.5%	41.7%	445	30.88	75	-	1.7%	79.7%	9	0	463,887	542,011	(78,124)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	83.6%	74.5%	-	100.0%	83.3%	100.0%	-	100.0%	19.9%	7.8%	21	1.42	4	12.5	55.7%	98.0%	0	0	67,500	63,669	3,831
MAIDSTONE	Peale Ward COVID - ND451	85.8%	102.5%	-	100.0%	105.7%	129.7%	-	-	28.5%	32.4%	53	3.82	15	9.8	24.0%	83.3%	4	2	143,203	115,175	28,028
TWH	Private Patient Unit (TW) - NR702	101.5%	72.5%	-	-	68.3%	96.7%	-	-	17.7%	6.7%	51	3.46	22	8.6	46.2%	100.0%	0	0	87,164	81,448	5,716



Total Established Wards	7,766,560	8,057,437	(290,877)
Additional Capacity beds	62,452	38,278	24,174
Other associated nursing costs	5,840,996	5,272,521	568,475
	13,511,333	13,260,711	250,621

Review of the draft winter plan for 2022/23

Chief Operating Officer

The purpose of the Winter Plan is to bring together all relevant activities across the Trust which relate to planning for winter 2022/23, to ensure that all associated actions are being progressed to deliver safe and effective care for our patients whilst delivering performance and finances as planned.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 25/10/22
- Finance and Performance Committee, 25/10/22

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

Information and discussion

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

Maidstone & Tunbridge Wells

Winter Plan

2022/23

V3 DRAFT

Contents

Section	Heading	Page
1	Executive summary	4
2	Emergency Department (ED) activity	7
3	Trust ED attendances split by Walk in/GP/Ambulance	10
4	Walk In attendances	11
5	Ambulance attendances	13
6	Bed Modelling	14
7	Elective Modelling	16
8	Core Bed Availability	18
9	Closing the Gap – mitigation of shortfall	19
10	'Safer Better Sooner' programme	24
11	Closing the Gap Waterfall	28
12	Financial Allocation and Prioritisation	29
13	Live Data	33
14	Full Hospital Capacity Protocol	34
15	Care Coordination Centre	35
16	Wellbeing	36
17	COVID 19	38
18	Vaccinations	39
19	Severe Weather	40
20	Workforce	41
21	Out of Hospital Capacity	42
22	Festive Plans	45

23	Finance	46
24	Appendecies	47

1. Executive summary

Purpose

- The purpose of the Winter Plan is to bring together all relevant activities across the Trust which relate to planning for winter 2022/23, to ensure that all associated actions are being progressed to deliver safe and effective care for our patients whilst delivering performance and finances as planned

Development of the Winter Plan

- The Plan is a live document that will be continuously updated, especially in light of demand and capacity modelling
- There was not the usual Winter De-Brief for last winter due to demands on service delivery however Lessons Learnt from the winter period have been collated and fed into the planning process
- A West Kent Urgent Care Delivery Board & HCP Winter Planning event took place on 20th July with good representation from all stakeholders including SECamb, KCHFT, KMPT, GP Federation, CCG and NHSE
- The Plan is under constant review and development and identifies the actions that will maintain patient safety and clinical quality over the period of expected surge in demand during winter
- The Draft Trust Winter Plan has been shared with K&M CCG colleagues The Trust recognises that the winter period will be challenging with anticipated continuing high demand, continued Covid-19 presentations, influenza, paediatric respiratory viruses and possible severe weather. The Trust is committed to working together to manage these challenges, learning from our experience of previous winters and the Covid-19 pandemic
- NHS England has set out core objectives and key actions for operational resilience for winter in a letter dated 18th October as set out below. The full letter can be found in Appendix 1.
 - 1) Prepare for variants of COVID-19 and respiratory challenges, including an integrated COVID-19 and flu vaccination programme.
 - 2) Increase capacity outside acute trusts, including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter.

- 3) Increase resilience in NHS 111 and 999 services, through increasing the number of call handlers to 4.8k in 111 and 2.5k in 999.
- 4) Target Category 2 response times and ambulance handover delays, including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged trusts.
- 5) Reduce crowding in A&E departments and target the longest waits in ED, through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services.
- 6) Reduce hospital occupancy, through increasing capacity by the equivalent of at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway.
- 7) Ensure timely discharge, across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the '100 day challenge'.
- 8) Provide better support for people at home, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.

Executive summary (cont.)

- **Data driven management:** we will use real-time information systems to anticipate capacity pressures and manage them effectively to support best possible flow through our sites for all patients, using the principles of the national Operational Pressures Escalation Levels (OPEL) framework. This ensures a consistent approach and supports communication with the ICS
- **Effective co-ordination:** This year, the Trust has transitioned to the Central Command Centre (CCC). This function is now Business as Usual and will ensure maximum use of resources, clear communication, rapid resolution to issues and promote effective partnership working
- **Proactive communications:** We will work with system partners to implement a Communications Plan which includes promotion of alternatives to the Emergency Department through targeted use of social media and other channels for specific population groups
- **Demand management:** Two sources of modelling assumptions have been used this year to triangulate the most likely bed requirements. These sources are the Trust's BI modelling and the ICB modelling undertaken by Lightfoot
- **Acute capacity:** we will continue to focus on the current work being undertaken to maximise Same Day Emergency Care (SDEC) services. The Trust does not have empty wards to open for escalation.
- **Hospital Flow and discharge:** The 'Safer Better Sooner' programme of work will continue to strive for a reduction in length of stay (LOS) on inpatient wards, improve flow and ensure the right patient is in the right bed for their condition.
- **Festive weeks:** we will produce detailed operational plans for the Christmas and New Year period
- **Covid-19 and Influenza:** although no Covid modelling is available this year, the Trust continues to ensure resilience is in place for managing peaks and trough in these numbers. There will be modelling on likely Influenza assumptions and this will be considered in the overall operational plan. Details of the vaccination programme for both covid booster and influenza will be incorporated within the Winter Plan
- **Severe weather:** Current predictions are that the winter will be mild and dry however notification of adverse weather will be proactively communicated by the Emergency Planning team

2. Emergency Department (ED) Activity

The Covid pandemic has significantly altered ED attendances since March 2020 resulting in activity being difficult to model. Factors including potential further waves of Covid, impacts from the cost of living crisis, vaccination rates, prevalence of influenza and RSV will all impact on the level of attendances.

Capacity modelling for this year has been undertaken using three different sources of information to try and ensure the most likely Scenario is used for internal use. The ICB modelling has not looked at ED attendances, only admissions, therefore the ED demand is modelled with Trust data only.

- Trust Business Intelligence (BI) suggest that when all models are reviewed, it's become clear that activity is pretty much where it would have been anyway if the Pandemic hadn't happened
- Current forecast for this winter is around 13% up on the winter of 2019, which represents a 4.2% increase. This is effectively the same as the average growth rate observed between Jan-15 and Dec-19
- Attendances were generally higher than this straight line growth between May-21 and Jul-22, but seem to have settled back down again. It is possible that this represents a post-pandemic rebound that's now easing off. It's also possible that this is a temporary lull (like the one seen in Dec-21 & Jan-22), and attendances will be back up again in a few weeks.

So, in practice, the weekly non- elective attendance forecast for Jan-23 is around 3,700. This is made up of:

- Raw baseline, extrapolating Jan 2010 to July 2022 line forwards puts us around 3,700 per week
- Amended baseline, hitched up by the 4.2% currently being seen increases this to a maximum of 4000 per week
- Mid-January (we 15th) is typically 5.9% down, so this drops the forecast to 3,469 for that week
- The 80% confidence interval is 4.5%, so we estimate an 80% probability that the actual will be between 3,277 and 3,662

Table 1 – Graph showing predicted Trust ED attendances Apr-19 to Apr-23 (Updated 13th September)

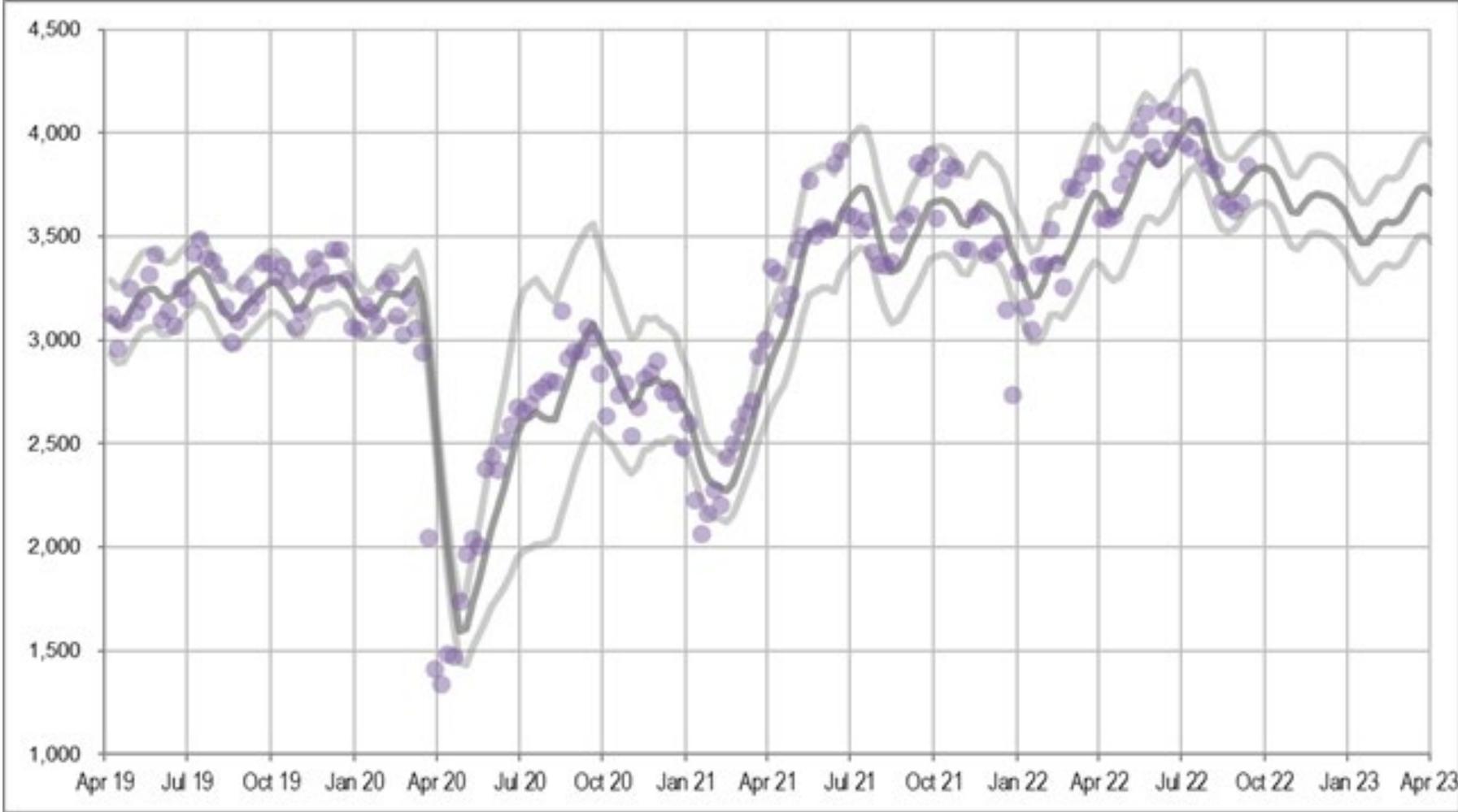
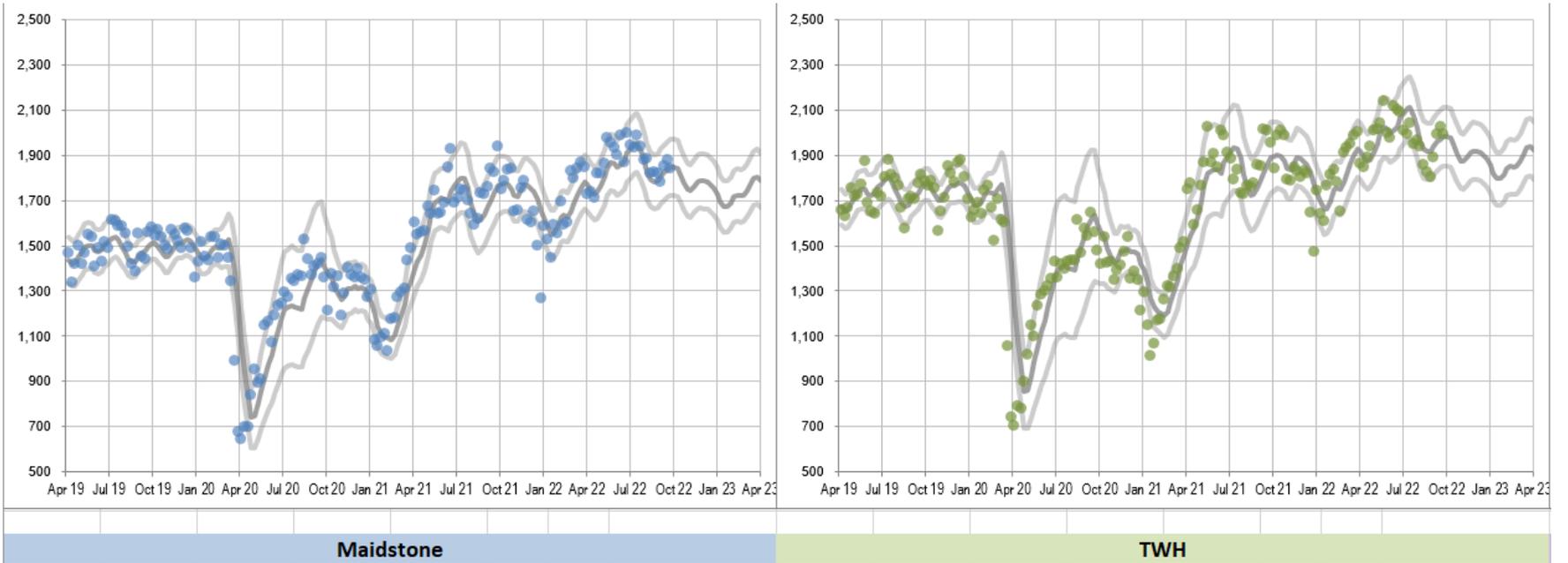
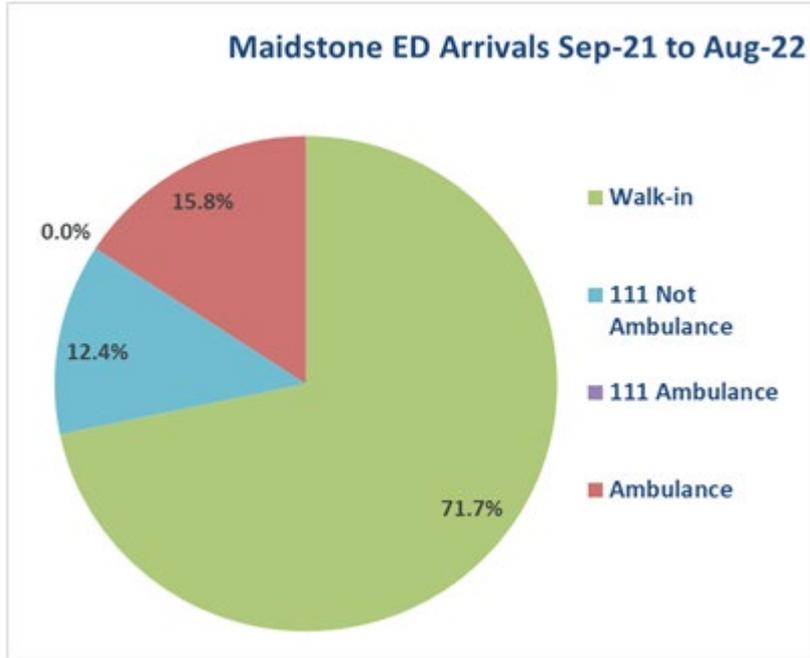


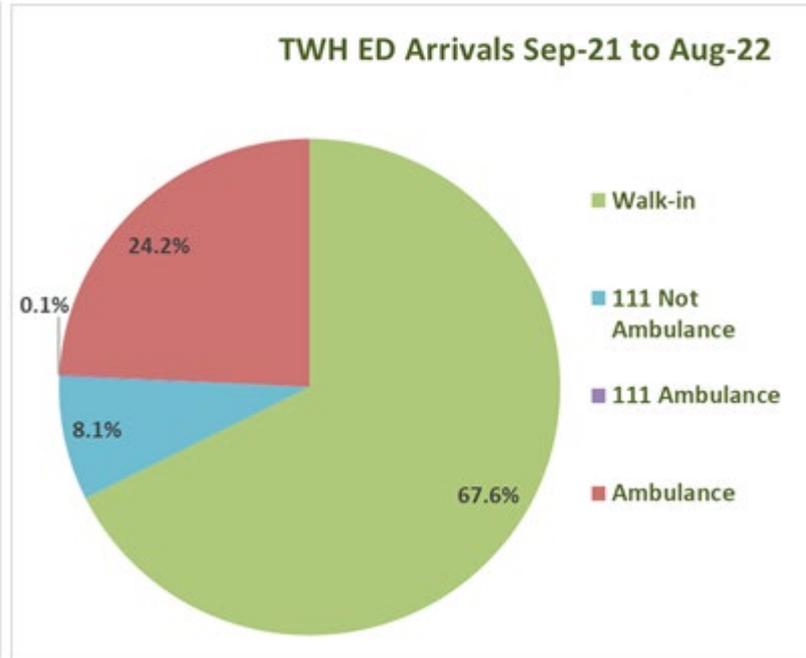
Table 2 – Graph showing predicted Maidstone/Tunbridge Wells ED attendances Apr-19 to Apr-23 (Updated 13th Sept)



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



Maidstone : 64,308 total



TWH : 69,070 total

Table 1: MH ED attendance by source Sept 21 – Aug 22

Table 2: TWH ED attendances by source Sept 21 – Aug 22

4. Walk in Attendances

Introduction

The way that self-presenting patients attend the ED has changed due to the introduction of the Urgent Treatment Centres (UTC) which has been mandated centrally by NHS England. There is an appointments system in place for 111 to book patients into the most appropriate UTC via a timed booking. West Kent has three UTCs, one at each Acute Trust Site and one at Sevenoaks Hospital.

System Approach

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

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

Walk in Attendance (cont.)

As can be appreciated, this approach is confusing for patients and healthcare professionals alike. By filtering all requests for Urgent Care through 111, and as the Direct Booking system develops, 111 will be able to direct patients to the most appropriate service for their needs reducing the pressure on the Acute Trust sites ED's. This has commenced and is working well allowing for streaming of self-presenting patients to booked appointments. The level of 111 referrals has not changed and is approximately 10% of all attendances

Modelling

Modelling is available to provide a west Kent slide pack containing the following

- 1) Current west Kent urgent care data flows (111/ED/UTC etc. and flows through to urgent care services, SDEC, GP in A&E, OOH etc.)
- 2) New modelling numbers based on the above assumptions and principles
- 3) K&M modelling projections (based on data and statements planning and assumptions across K&M)

Risks

- The “Think 111 First” campaign did not get widespread coverage, public unaware of the new pathway to access emergency and urgent care, 111 have a lack of call handlers and clinicians leading to higher than expected abandoned call rates.
- CAS's ability to manage the increase in call volumes
- GP provision at Sevenoaks remains stable at present but concerns over sustainability over winter due to other areas in Kent and Medway/Sussex/Surrey paying higher amounts per hour for GP provision.

5. Ambulance Attendances

Focused work has been undertaken by the Trust and South East Coast Ambulance Trust (SECamb) to improved handover delays at both ED sites over the past 4 years. Significant improvement has been made and there remains a focus on this. The Trust has minimal >60 min breaches and the ED team are working towards a zero tolerance. Monthly meetings take place with SECamb to monitor performance, evaluate new processes and ensure handovers are minimised.

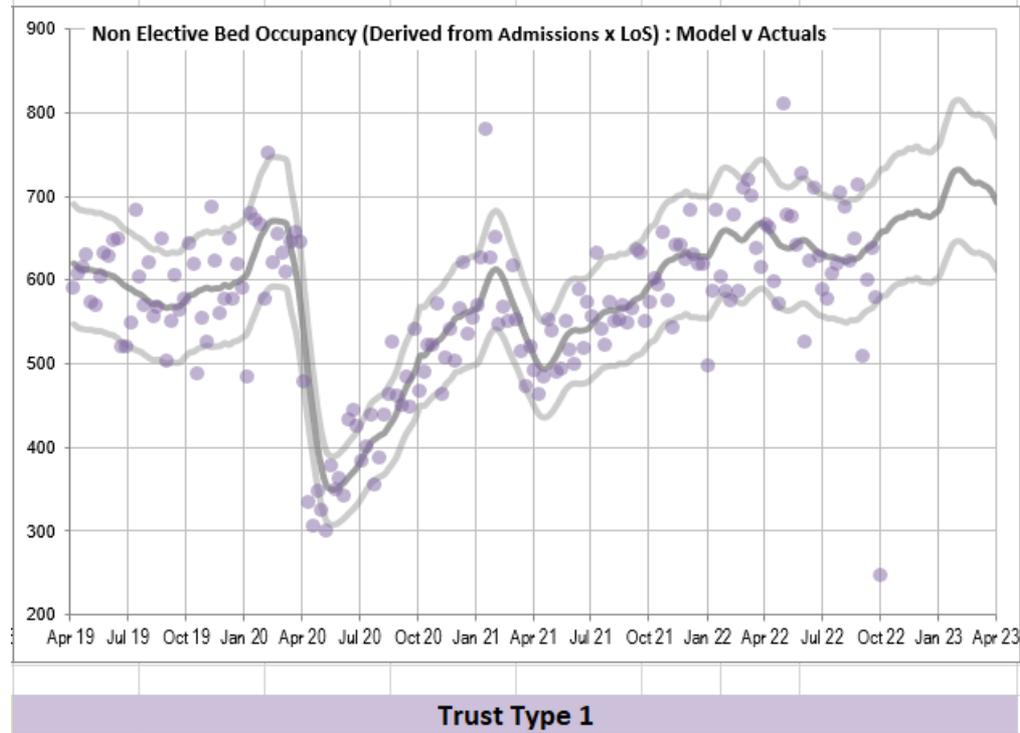
Plans to support offloading ambulances without delay over the winter period include:

- Ensuring consultant or senior registrar presence in RAP to assess patients, document and enact a management plan and triage patient to the most appropriate area of ED for their on-going care
- Since 13th September a new process has been implemented where SECamb crews handover directly to the senior clinician in RAP prior to booking the patient in. This is having a positive impact on <15 min handovers. >60 min delays remain a challenge, particularly at TW. Reinforcement of the process is underway with the clinical teams to ensure timely PIN entry
- The flow from RAP is not impeded by a lack of major cubicles and that any patients needing admission are allocated a bed and transferred as quickly as possible
- The Clinical Site Team are responsible for allocating beds once a Decision to Admit is made to keep flow within the ED and avoid ambulance handover delays
- Direct referrals to SDEC avoiding the ED

Total Ambulance handover delays for 2022:

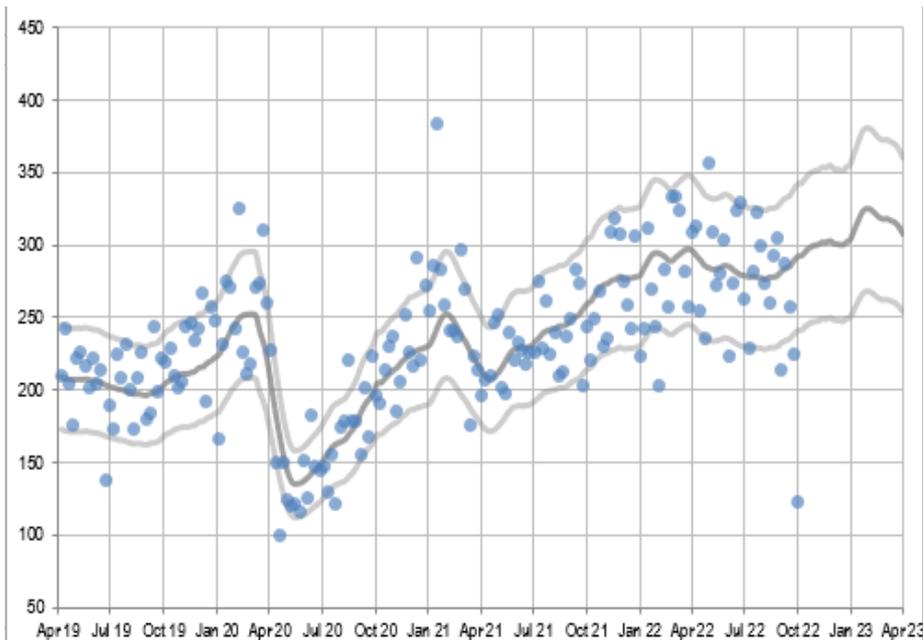
Up to 5th October	Total Conveyences	Less than 15		15-30		30-60		Over 60	
TW	20186	39.40%	7489	46.90%	8912	12.90%	2460	0.80%	157
MGH	12744	50.30%	6168	43.70%	5353	5.70%	702	0.30%	38
MTW	32930	41.50%	13657	43.30%	14265	9.60%	3162	0.59%	195

6. Bed Modelling

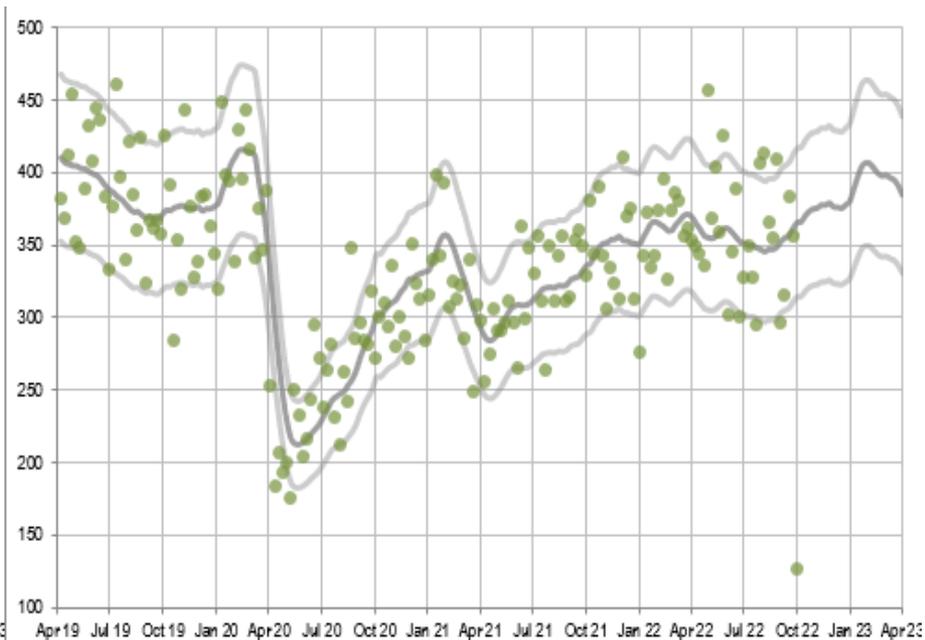


Modelling for the beds required for non-elective patients this winter are shown in the above table. This is the total for the Trust and all specialties. The model suggests a requirement of 714 beds during January peaking at 731 in February (upper confidence level of 816).

Bed Modelling (cont.)



Maidstone



TWH

7. Elective Modelling

Total elective activity modelling (excluding Independent Sector (IS)) suggests the following

Month	Day case	Elective	Total
Dec-22	1982	405	2387
Jan-23	2082	436	2518
Feb-23	2002	397	2399
Mar-23	2277	444	2721
Total	8343	1682	10025

Daily Planned Attendances

Month	Day case	Elective	Total
Dec-22 Daily Activity	99	20	119
Jan-23 Daily Activity	99	21	120
Feb-23 Daily Activity	100	20	120
Mar-23 Daily Activity	99	19	118

With an average Length of Stay of 3.2 days for elective patients this requires 2 elective beds per month

Additional funding required for Surgery to meet all of the winter requirements equates to £445,097 (full details in embedded file)

Directorate	Division ref	Scheme	Comment / Extra Information	Costs in fun	Total
General Surgery	W2223 - 1	Speciality doctor - FTC 6 months x2	To reduce bank and agency spend through winter sickness and add a spot on the rota for twilight to solely help flow in SAU leaving the other doctor to be solely CEPOD. 12pm-9am, 2 doctors required to run 7 day service	No	£ 70,000
General Surgery	W2223 - 2	B3 Admin Clerk - SAU, Bank, 5 months	B3 Admin Clerk for weekend cover - currently only a 5 day service - +2 w/e shifts to assist with admin duties, Bank cost = 0.5 WTE B3	No	£ 14,243
General Surgery	W2223 - 3	B3 Admin Clerk - Ward 10 & 32, Bank, 5 months	Evening admin support for the Ward to release nurses of admin duties, 4-8pm = 0.75 WTE B3, Bank cost	No	£ 28,487
General Surgery	W2223 - 4	Additional ward cover - 2 x Specialist doctors each day at the weekend Saturday and Sunday 8-6 to facilitate weekend discharges maintaining flow from ED	Last year additional weekend ward cover was arranged and assisted in ensuring the higher number of post take patients were seen in a timely manner at the weekend.	No	tbc
Ophthalmology	W2223 - 5	Medical Staffing Bank to cover absences	Doctors, additional bank spend to keep Rapid Access and injection clinics running - to backfill leave over Christmas/New Year period and also to backfill any absence due to Covid isolation rules. (similar to August spend)	No	£ 8,000
Specialist Surgery	W2223 - 6	Foster Clark escalation	10 medical outliers on Foster Clark ward (cost transfer to Medicine needed IF ward changes don't go ahead)	Yes	tbc
Specialist Surgery	W2223 - 7	Increased breast capacity for winter surge	WORST CASE SCENARIO BREAST AWARENESS WEEK IN OCTOBER 2022 :- Sat & Sun insourcing at £11k per day, weekly during Nov, Dec, Jan; apply 50% risk	No	£ 154,000
Specialist Surgery	W2223 - 8	Increased Urology capacity for winter surge	WORST CASE SCENARIO PROSTATE AWARENESS INCREASE :- Sat & Sun insourcing at £11k per day, weekly during Nov, Dec, Jan; apply 50% risk	No	£ 154,000
T&CC	W2223 - 9	extra Agency/bank Nursing staff ITU both sites	ITU bank and agency likely to increase to covid 2 level both sites; 2-3 per shift B6 rate; similar to wave 1 expenditure	Yes	£ 50,000
T&CC	W2223 - 10	extra ITU disposables both sites		yes	£ 15,000
T&O	W2223 - 11	B4 Trauma Co-ordinator support, Bank backfill, 5 months	5 month secondment, B4 into the Trauma Co-ordinator team, to improve flow, act up internally, backfill from Bank	No	£ 16,367
					£ 510,097

8. Core Bed Availability

Core Medical Beds				Core Surgical Beds			
Tunbridge Wells		Maidstone		Maidstone		Tunbridge Wells	
AMU	28	John Day	30	Foster Clark	28	W10	30
CCU	7	Culpepper	13			W32	20
W2	26	CCU	6			W30	30
W12	30	Mercer	26			W31	30
W20	30	Pye Oliver	28				
W21	29	AAU	22				
W22	32	Stoke Unit	46				
		Whatman	22				
		Edith Cavell	22				
		Peale	14				
Total Beds	182	Total Beds	171	Total Beds	28	Total Beds	110
Escalation in Use		Escalation in Use		Escalation in Use	0	Escalation in Use	18
W11	30	Cornwallis	19			Wells Suite	9
						SSSU 1-9	9
Inpatient Total	212	Inpatient Total	190	Inpatient Total	28	Inpatient Total	128
Medicine Non-Elective Bed Capacity							402
Medicine and Surgery Non-Elective Bed Capacity							558
January Mean Demand							714
February Worst Case Demand							731
Shortfall of Beds on Mean January Demand							156
Shortfall of beds on February Worst Case Demand							173

9. Closing the Gap

On the modelling undertaken to date, the Trust has a shortfall of non-elective beds of between 156 and 173 beds over the coming winter

In previous years escalation capacity has been available on both sites (Ward 11 at TWH and Cornwallis at MGH) as a result of the pandemic and increased demand these wards have now been in constant use for the past eighteen months. The only escalation are available to the Trust for this winter will be the Stroke Unit at MGH once the refurbishment of HASU has been completed. This escalation area will be available from December and planned to open after the Christmas Bank Holidays.

The lack of escalation capacity is a significant risk to the Trust this year. With continued non elective demand higher than in previous years, the plan to manage patient safety and flow over the winter months needs to focus on three areas:

1. Admission avoidance
2. Reduced LOS for admitted patients
3. Capacity in out of hospital providers to reduce the number of patients who do not meet the Criteria to Reside (new terminology for Medically Fit)
 - Launch of **Safer Better Sooner** programme
 - Senior Decision Makers at the front door for all specialties – ED and Same Day Emergency Care (SDEC)
 - Full utilisation of Hospital @ Home
 - Continued embedding of Teletracking
 - Increasing hours of opening in all SDEC areas (SAU/ AFU/ AEC)
 - Twice daily Board Rounds with at least one being consultant led
 - Criteria for Discharge documented in medical notes
 - Clear and accurate documentation of Criteria to Reside recorded in medical records
 - Implementation of the principles outlined in the Hospital Discharge Policy
 - Close working with KCHFT and KCC to ensure sufficient capacity in all Discharge to Assess pathways at all times
 - Forward Planning meetings weekly to monitor progress of plan and mitigate any unforeseen issues that may arise which will impact flow
 - CCC in operation 24/7

Community Capacity

As part of MTW winter resilience planning funding was agreed to run a pilot scheme focusing on double handed and hard to procure packages of care in order to be able to discharge patients and maintain flow through the winter period

The lead in time for mobilisation is up to 12 weeks and the organisation that we are working with needs agreement from MTW to start the process with the aim of having a soft start in December and a ramp up in the New Year of 2023

MTW have been in discussions with Pulse Home care which is an agency under the Acacium umbrella, we already use Care Home Selection (another Acacium organisation) to support our finding of care homes and care agencies that do not fall under the HILTON banner (e.g. fast track patients going home to die). Pulse have recently established similar schemes in other hospitals but not in our region

The pilot plan is to run a scheme supporting these difficult to place patients for 4-5 months, with a slow roll out in December to iron out any issues and then implementation from January to March, and then a tail off of current recipients of the scheme into April. This should give us sufficient data to decide if the service is of benefit to both patients and the flow within the organisation

A conservative estimate would be that there are at least 10 patients per month and that these patients wait an additional 2 weeks in a hospital bed, the data will show us whether this is correct

The cost for this additional service would be **£291,723 + VAT**

Hawkhurst House Additional Beds

MTW are discussing a risk sharing agreement with the ICB, extending the criteria and the ability to put East Sussex patients in Hawkhurst House and working with East Sussex to understand their ability to fund to include this cohort of patients.

One issue is that we have had several voids over the last 6 months and the most patients we have ever had in the beds is 12 at any one time, so part of the risk share is that we guarantee to place more patients. The ICB have ultimately agreed that they should carry on funding 10 beds on a 50:50 risk share agreement with the Trust.

There is an option to commission a further 10 beds on top of the 5 in the risk share. There will be a requirement for MTW to ensure we fill these additional beds which is our risk.

The cost is 1723.40 per patient per week.

Cost

20 x beds @1723.40 = £34,468 per week

If ICB continue to fund the 5 beds then

15 x beds @1723.40 = £25,851 per week

Total cost = £336,063 for 12 weeks

Urgent Care Therapy Team Increase for Admission Avoidance

To increase the capacity of the urgent Care therapy teams by 1 therapist on each site from 8am to 8pm seven days a week would require an additional 6wte. This would enable increased presence in ED and AFU and enable proactive identification of patients who would benefit from a therapy assessment rather than waiting for patients to be referred. This would enable 8am to 8pm presence in ED and AFU.

Proposal: Urgent Care Therapy Additional Staff in Post Phasing

	Jan-23	Feb-23	Mar-23
Band 7 Locum	5	3	3
Band 7 Substantive	0	2	2
Band 4 Substantive	1	1	1
Total Staff in post	6	6	6
Cost	£37,613	£33,103	£33,103
		£103,819	Total

The additional substantive posts will be part of 2023/24 business planning.

Sourcing of additional candidate required:

- 2.00wte Band 7 recruitment process underway with interviews planned for 7/10/22.
- 1.00wte Band 4 to include in existing Band 4 recruitment activity.

Benefits

- Promote earlier discharge for AMU Ward 2 and Whatman.
- Capacity to see 700 additional patients from November 2022 to March 2023.
- Avoid admission or reduce length of stay for 50% of the additional patients seen saving 350 bed days from November to March.
- Improved staff welfare, team resilience and sustainability reducing risk of staff sickness and turnover.

TADS Service Increase to Ensure Responsive Service to Reduce Length of Stay

To achieve the TADS key performance indicators, maintain a responsive TADS service, optimise patient recovery and reduce handovers of care to community rehabilitation teams additional staffing is required.

To deliver an average of 4.8 hours of direct clinical care to 64 additional patients a month would require an additional 312 direct clinical care hours a month. Allowing for 21% leave cover and an average of 15% SPA will require an additional 3.00wte to accommodate this increase in direct clinical care and return to the performance level in 2019/20.

In addition, the demand for TADS is expected to increase again over winter. Prior to Covid there increase was a 6% increase in the caseload between November and March. This would be an additional 23 patients, requiring 110 direct clinical hours each month.

To meet this, need a further 1.00wte of capacity is required during the winter months.

To optimise efficiency of the TADS service a skill mix of experienced therapists and Band 4 Assistant Practitioners are required.

Proposal: TADS Additional Staff in Post (Phasing)

	Jan-23	Feb-23	Mar-23
Band 7 Locum	2	1	1
Band 7 Substantive	0	1	1
Band 6 Substantive	1	1	1
Band 4 Substantive	1	1	1
Total Staff in post	4	4	4
Cost	£16,613	£14,358	£14,358
		£45,329	Total

The additional substantive posts will be part of 2023/24 business planning.

Sourcing of additional candidate required:

- 1.00wte Band 6 recruitment process initiated with a TADS therapist who left the Trust within the last year has contacted TADS requesting opportunity to return.
- 1.00wte Band 4 to include in existing Band 4 recruitment activity.
- 1.00wte Band 7 recruitment to be started.

Benefits

- Reducing length of stay for an additional 23 patients a month by at least one day. Over 5 months saving 115 bed days.
- 95% of TADS patients seen within 24 hours of discharge home excluding early visits declined by the patient, inability to gain access and late receipt of referrals.
- 75% of TADS patients achieving rehabilitation goals during TADS intervention.
- Less than 10% of TADs patients requiring further therapy on discharge from TADS.
- Improved patient experience and outcomes associated with admission advance/reduced length of stay in hospital.
- Improved staff welfare, team resilience and sustainability reducing risk of staff sickness and turnover.
- Earlier access to TADS assessment for equipment and care need review to facilitate reduction in care package requirements.

10. Safer Better Sooner Programme

WHAT ELSE IS HAPPENING TO SUPPORT WINTER FLOW

1. West Kent Winter Planning task and finish group

This group is chaired by the ICB and the membership includes all key stakeholders in W Kent, i.e MTW, KCHFT, KMPT, KCC, West Kent GP Federation, SECAMB, ICB. The themes identified at the July flow/ winter planning event (hosted by MTW) are being worked up to develop short and long term actions to support patients. The groups are:

- Admission Avoidance (lead Frances Schmocker)
 - provision of hot clinics (MTW)
 - community referrals to virtual wards
 - review of data around avoiding admission interventions
- D2A and Bed Mgt (lead Martin McCahon)
 - Agree 5 processes under P3
 - Develop KPI's for P3
 - Agreement for border patients
 - Explore opp for personal health budgets
 - Agree joint tariff ICB and KCC
 - Review of ECIST actions following visit and implementation where appropriate
 - P1 focus
- Escalation (Alex Thompson)
 - Review of SHREWD requirements and additional data
- Mental Health (Sue Excell)
 - Set up trigger for patient admission to acute hospital to ensure Priority House aware – provide info re discharge
 - Orientation for new KMPT staff to include shadowing acute teams
 - Additional contact numbers & escalation chart
 - Revamp leaflet clarifying what patient and families can expect when people are admitted
 - Urgent crisis line 111 option 2 go live March 23
 - Crisis house – business case written
 - Triage at ED front door to prevent attendance

2. Breakthrough Objectives - Discharges by noon and Out of Hospital Capacity

Discharges by noon - This sits under the MTW Strategy and Partnerships strategic theme as a breakthrough objective sitting under the Director for Strategy & Partnerships (Rachel). This means that the A3 improvement methodology is followed. Target is 33%. Data has been pulled to identify issues and top contributors which are as follows:

Area of Analysis	Considered a Top Contributor?
Hilton Pathway	The timeliness of this pathway due to the current process and mis-use of the service has deemed this to be a top contributor with 44% with a change in medically fit status after a referral has been made to Hilton results in patient not being accepted. There are specific wards that have higher levels of failed Hilton discharges and will be focussed on.
Sunrise team criteria led discharge usage	This is an area that is understood to be a top contributor as patients could be discharged from the ward earlier on in the day. Data shown that the NLD button on sunrise is used with 1.3% of all discharges however this may be inaccurate as button on sunrise may not have been being used.
EDN completion times	Yes EDN completion times is a top contributor to delays in discharge time. The Core Clinical Service MDT Programme Group is focussing on this – including providing digital solutions and CoS support for EDNs being completed during ward rounds. A report from the group will feed into this report.
Pharmacy TAT for Dossett's and TTOs / sent by couriers	Yes however EDN completion seems to be root cause for delays in this area. The Core Clinical Service MDT Programme Group is focussing on this - which will feed back into this report.
Discharge Lounge Usage	Although the discharge lounge is not utilised as fully as it can be, there is another project group looking at the discharge lounge of which a report will be included within this project stream. Business case in draft for discharge lounge – plans to increase establishment

Out of hospital capacity - This sits under the MTW Strategy and Partnerships strategic theme as a breakthrough objective sitting under the Director for Strategy & Partnerships (Rachel). This means that the A3 improvement methodology is followed. No metric at this stage. Nick B will give you more detail.

3. Weekend discharges

This is the key focus for the Safer Better Sooner Corporate Project which sits under the COO. Again A3 etc. Top contributors below

Area of Analysis	Considered a Top Contributor?
Poor skill mix in nursing team at w/e	Yes - Considered a top contributor - a pilot of additional B6/7 nurses on 3 wards for short period to enable more senior decision-making.
EDN completion times	Yes - EDN late completion times are a top contributor. Being reviewed by the Core Clinical Services Flow programme feeding into this project.

Possibly - data has identified that the service at the weekend is low but needs further investigation. The pharmacy TAT meets targets. Will sit within Core Clinical Service MDT Programme Group

4. Key actions

Workstream Overview			Key activities in current reporting period (20/09 – 03/10/22)	Key activities for the next reporting period (03/10 – 19/10/22)
Workstream	Lead	Current RAG		
Weekend Discharges	Fiona Redman	On track	<ul style="list-style-type: none"> • Trial additional senior nursing staff at weekend • Ensure minimum of 1 Flow Co per site at weekend • Increase in pending/ confirmed • Develop Fri handover meeting (Medicine) • Ortho discharge process embedded 	<ul style="list-style-type: none"> • Roles / processes for medical on call team at w/e • Review data for patients not identified for discharge on Fri • Roll out Sunrise Transformation on one version of truth (Sunrise patient lis
Discharges Before Noon	Nicola Peters/ Sarah Smith	On Track	<ul style="list-style-type: none"> • HILTON – process mapping session • HILTON – identify 3 areas of improvement following ECIST/ process mapping/ GEMBA • HILTON – trial 1 patient pre booked • CLD – audit of 4 wards with matron engagement • CLD – comms in Pulse • CLD – review of Trust/ NHSE work • CLD – change button on Sunrise to CLD not NLD 	<ol style="list-style-type: none"> 1. HILTON - Trial 1 patient pre booked for Hilton (Frailty) – mtg 3/10 2. HILTON - Working with therapist to identify appropriate referrals/ improved co 3. HILTON - Information sheet re non Hilton pathways to go to all wards 4. CLD – define CLD & roll out comms 5. CLD – agree process TT/ Sunrise
Core Clinical Transformation	Becky Grantham/ Fiona Redman/ Nicola Peters	On Track	<ul style="list-style-type: none"> • EDN – discuss compliance/ process - CD's mtg • EDN – user guide identifying mandatory and nice to have • Therapies – commence interviews Therapy Associate • Therapies – clear plan for TT rollout/ use • Therapies – identify additional staff wte for SDEC/ EC • Pharmacy – trial of amending not rejecting TTO requests • Pharmacy – process map Dosset box • Pharmacy – clear plan for TT rollout/ use 	<ul style="list-style-type: none"> • EDN – agree process and distribute to clinical staff • EDN – work with Sunrise team to roll out new process • EDN – send out user guide (mandatory/ nice to have) • Therapies – clear plan for TT use • Therapies • Pharmacy – clear plan for TT use if required • Pharmacy -
Admission Avoidance	Fay Johnstone	On Track	<ul style="list-style-type: none"> • Criteria to Admit rollout both sites • 14 day LOS cohort of patients – plan in place 	<ul style="list-style-type: none"> • Criteria to admit embedded in practice with the PTWR in ED. • Identify the cohort of pts (14 day +) TW NH and r/v opportunity for admission • CLD to be included for those pts identified in ED by the PTWR.

WHAT WILL IT COST?

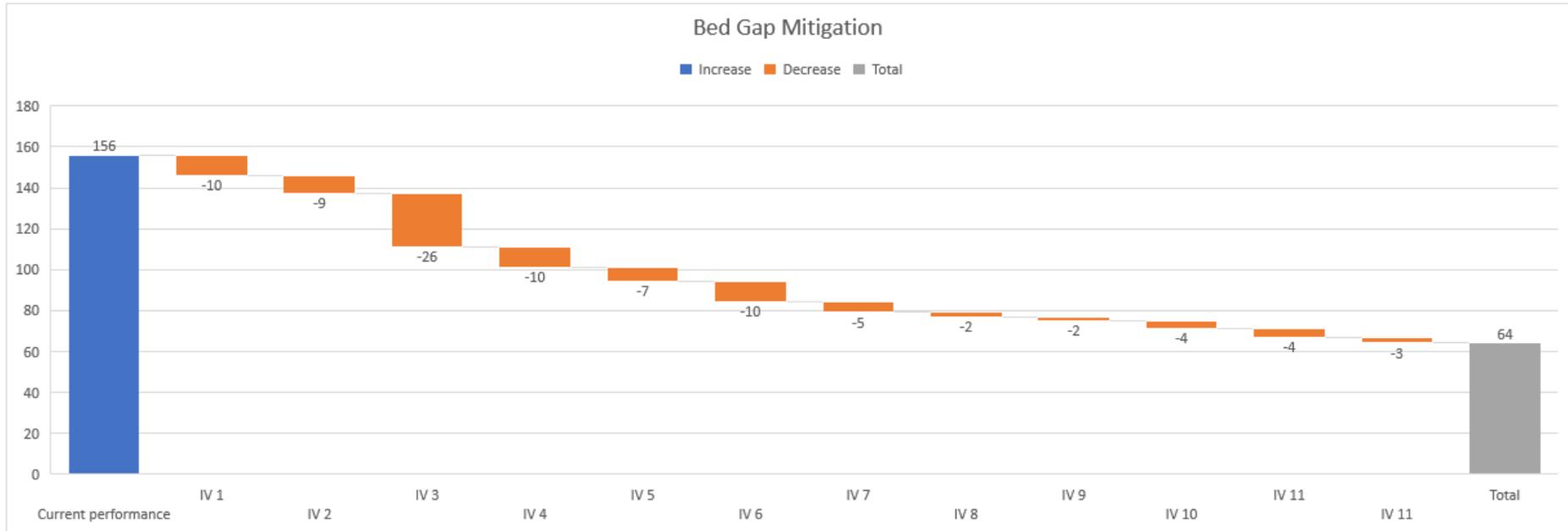
None of these schemes currently have any cost associated.

WHAT IS THE IMPACT?

KPI's being monitored are

- 33% target discharges by noon – have asked Andy to calculate how many additional patients are needed to be discharged by noon if we were to hit 33% and hence how many bed days
- Weekend discharges – improvement across discharge profile across 7 days. Aiming to get an additional 1 per site per weekend day initially which would save 6 days per week or 312 days per year. Would then increase target.
- OOHC – no metric identified at present
- Qualitative improvements for patients discharged earlier in the day
- Reduction of DTA in ED
- Patient outcomes due to reduced delay in ED

11. Closing the Gap Waterfall



Nb. Intervention detail described below

12. Financial allocation and prioritisation

Bed Releasing

Intervention	Scheme	Objective	£	Beds saved
1.	Additional Pathway 1 provision for more complex patients (double handed packages of care)	To discharge more dependent patients who currently have an extended length of stay in the acute due to lack of domiciliary care in the community	£291,723 + VAT	10
2.	Discharge Lounge at T-Wells	To facilitate a bedded area within the current Discharge Lounge to allow bed bound patients to be discharged from an acute bed earlier in the day Increase opening hours to include weekends Courtesy calls to undertaken to all patients discharged within 48 hours to reduce re-admissions	£385,000 (already funded via CCG)	9
3.	Escalation ward	To open additional general medical beds (MH)	£541,000 Facilities £29,519	26

4.	Additional Pathway 3 capacity	Currently 15 beds commissioned by CCG (since Dec 2021). CCG propose to move to 10 beds funded on a 50:50 risk share basis with MTW	5 x beds @1723.40 = £8617 to maintain current level excluding voids. Opportunity to commission a further 10 x beds @1723.40 = £17, 234 per week TOTAL = £336,063 for 12 weeks (Jan to March)	10
5.	HIT and TADS		£103,819 for HITS £45,329 for TADS Jan to March	7
6.	Virtual Ward		Already funded	10
7.	Admission avoidance practitioner		£65,000	5
8.	T&O SDEC		Already Funded	2
9.	Weekend Discharges		Already Funded	2
10.	Edith Cavell	Estates work required and additional staffing tbc	TBC	4
11.	Improved use of TeleTracking RTM and Dropbox		No Cost	4
12.	Enhanced Recovery Beds in Ward 32	Reduced Length of stay due to enhanced care	No cost	3
Total			£1,412,453 (Inc MEC Escalation)	92

Non-bed releasing

Intervention	Scheme	Objective	£
1.	Domestics at TWH	Increased Cleaning provision for IPC,PII, footfall and bad weather	£68,384
2.	Equipment for cleaning	Specific cleaning equipment for specialised areas	£7,600
3.	Domestics at MGH	Increased Cleaning provision for IPC,PII,	£88,372

		footfall and bad weather	
4.	Increased Porters at MGH		£37,987
5.	4x4 vehicles	For bad weather to ensure critical staff attend work (2 x vehicles for 90 days)	£8,041.60
6.	ED Additional staff including UTC Provision	Nurses for corridor care and Ambulance off load. Increase in GP provision in UTC to allow for increased streaming to UTC	
7.	Additional Mortuary Capacity	24 weeks for 25 body capacity	£21,260
8.	7 Day Pharmacy Service	Support weekend discharges	£103,250
9.	Increased Radiologist cover	Support improved reporting capability and reduce delays to reporting following on call team covering the TMC	£171,360 £9000 (Capital 2 x laptops)
10.	RDA Support	Prep of patients to improve room turnover	£42,735
11.	Increase phlebotomy	8 hours bank cover per site per day	£5,595
12.	B3 Admin Clerk - SAU, Bank, 5 months	B3 Admin Clerk for weekend cover - currently only a 5 day service - +2 w/e shifts to assist with admin duties, Bank cost = 0.5 WTE B3	£14,245
13.	B3 Admin Clerk - Ward 10 & 32, Bank, 5 months	Evening admin support for the Ward to release nurses of admin duties, 4-8pm = 0.75 WTE B3, Bank cost	£28,485
14.	Additional ward cover - 2 x Specialist doctors each day at the weekend Saturday and Sunday 8-6 to facilitate weekend discharges maintaining flow from ED	Last year additional weekend ward cover was arranged and assisted in ensuring the higher number of post take patients were seen in a timely manner at the weekend	£56,700
15.	Medical Staffing Bank to cover absences	Doctors, additional bank spend to keep Rapid Access and injection clinics running - to backfill leave over Christmas/New Year period and also to backfill any absence due to Covid isolation rules. (similar to August spend)	£8,000
16.	Medicine and Emergency Care	Various schemes to cover ED, escalation, senior cover and 900 attendances a day For more detail see appendix 1 and 2	
Total			£662,014.60 (excl MEC)

13. Live Data Systems

What is SHREWD Resilience

- SHREWD Resilience is a real time view of system pressure, which informs system response and individual provider actions
- SHREWD Resilience enables front line teams and operational leaders including the CCG to identify 'where' pressure is across the health system within a few seconds.
- Data is captured live or in real time wherever possible and shared with all providers across the health economy.
- Data is accessible on any computer, smart phone or tablet
- Currently not fully embedded in use by operational teams however work being undertaken to promote this system and its benefits particularly over winter when on call managers participate on system calls as necessary

Power BI

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

TeleTracking

- TeleTracking provides us with a real time bed state position with integrated porter and bed turn around team allocation
- Synapse provides a full analytics system using all the data from the TeleTracking solution
- Predictive analysis of admissions in real time are available via Synapse
- Full audit of all data input on wards or via the Care Coordination Centre are available to investigate discharge profiling, delay reasons for transport/discharge/diagnostics
- Provision of standardised board round structure
- Real time visibility of KCHFT community beds and streamlined referral process
- Availability via the "Synapse" app downloadable from the App Store

14. Full Hospital Capacity Protocol

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

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

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

In order to effectively manage the above scenario, the Full Hospital Capacity Protocol has pulled together the various strands of work that has supported improved flow over the past 4 years at MTW into one document that details specific escalation triggers, roles and responsibilities and actions to be taken in order to resume 'flow' as soon as possible. **For the Full Protocol please see appendix 3.**

15. Care Coordination Centre (CCC)

Purpose:

- In 2020, as a result of the Covid-19 pandemic the Trust established an Incident Control Centre. After a review, the function was felt to be beneficial to the Clinical Operations function this has subsequently merged with the Care Coordination Centre which is open 24/7. This will continue over the winter period to ensure maximum use of resources, clear communication, rapid resolution to incidents and issues and promote effective partnership working
- This unit will perform a 24/7 function and incorporate the TeleTracking system to support rapid decision making and the ability to identify issues that are developing before they become a major operational issue.
- It has become a single point of contact for partners and trust departments to impart information and allow rapid dissemination of information across the organisation.
- It will also have a horizon scanning function to be able to identify potentially disruptive issues such as travel delays, adverse weather, industrial action, supplies shortages and other factors
- It will be the first line co-ordination and management of incidents up to major incidents

16. Wellbeing Programme

Approach

The psychosocial health and wellbeing programme for MTW has been extended following the COVID 19 Pandemic and in response to the current cost of living crisis.

Current offer

Current Support available to our People



<p>Wellbeing Partners</p> <ul style="list-style-type: none"> -Direct support to wards -Mental Health Navigation -Financial Support navigation -Access to resources -Support for managers & teams with wellbeing practice <p>Health & Wellbeing Team</p>	<p>In-reach & Bespoke Support</p> <ul style="list-style-type: none"> -Staffed email inbox --SIS Debriefs -Management support Mental Health First Aid Health and Wellbeing Team Psychological Team Occupational Health OD Team L&D Staff Engagement & EDI 	<p>Wellbeing Lounges</p> <ul style="list-style-type: none"> -Recharge -Access Support -Mental Health Navigation <p>Health and Wellbeing Team</p>	<p>Employee Assistance & NHS Staff Support</p> <ul style="list-style-type: none"> -Clear signposting for staff to access emotional support via EAP & NHS phone/ text line -Occupational Health MDT & Psychology input for treating staff with more complex needs <p>External contract</p>	<p>Resources</p> <ul style="list-style-type: none"> -For individuals, teams & managers -NHS self management and wellbeing resources -MTW specific resources <p>Staff Engagement & EDI L&D Libraries & Knowledge Health and Wellbeing Team</p>	<p>Wellbeing Practice</p> <ul style="list-style-type: none"> -Acupuncture -Meditation -Mindfulness -Exercise -Craft activities <p>Psychological Team Health and Wellbeing Team L&D</p>	<p>Escalation & Live Learning</p> <ul style="list-style-type: none"> -Regular feed back on staff wellbeing to relevant committee structures <p>Staff Engagement & EDI OD Health & Wellbeing Team FTSU</p>	<p>Kent Wellbeing Hub</p> <ul style="list-style-type: none"> -Access to wellbeing and Psychosocial support <p>KMPT</p>	<p>Welfare Support</p> <ul style="list-style-type: none"> -Financial support guidance internally and externally -Hardship funding for staff in need <p>Workforce Team Health and Wellbeing Team</p>
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Further support is identified below with the full detail in **appendix 4**.

Cost of Living Support requiring funding for our People



Item	Investment
Supermarket voucher scheme – hardship support. £50 voucher, once a month for 10 months = £500 fund per person	£40,000 would fund 80 staff in significant financial crisis
Free soup and roll @ lunchtime – working with Catering to identify potential cost	Cost Pending
End of day food in canteen – sell at discounted rate, or offer for free? working with Catering to identify potential cost	Cost Pending
Parking vouchers – on site free allocation for up to 6 months set period. £10 per month = £60 fund per person	£4,800 would fund 80 staff in significant financial crisis
Lunch vouchers – canteen lunch free for set period; up to 6 months up to 5 hot lunches per week = c£684 fund per person	£54,720 would fund 80 staff in significant financial crisis
Blue Light card administration/ registration fee funded for Bands 2-5; £4.99 for 2 year subscription.	£7,485 would fund 1,500 staff
Total Investment requested (pending additional catering costs)	£107,005*

*Funding is proposed to be requested through the Charitable Trust Funds.

17. COVID-19

This is now monitored and managed as respiratory conditions not specifically COVID 19. This will include Influenza which is predicted to have a more significant impact based on recent years. This data comes from a higher prevalence of Influenza seen in the Southern hemisphere this year.

The Trust is well practiced in managing respiratory and non-respiratory pathways, whilst at times it can cause a temporary challenge on capacity operational teams are now skilled in working with clinical and infection control teams to ensure risk is mitigated as far as possible and patient and staff safety is maintained.

18. Influenza and Covid Vaccination

Monitoring and updates of all flu vaccinations are being entered directly into the national NIV system- this ensures data is accurate- for the trust to meet the cquin target as defined below :

Of the denominator, those who receive their flu vaccination.

Denominator

Total number of frontline healthcare workers (HCWs) between 1 September 2022 and 28 February 2023, in line with the widened definition of frontline HCWs used during the 2021/22 flu season, which includes non-clinical staff who have contact with patients

Exclusions

- Staff working in an office with no patient contact
- Social care workers
- Staff out of the providers for the whole of the flu vaccination period (e.g. maternity leave, long term sickness)

BI will support to determine the precise numbers of frontline workers within MTW to have a clear idea of numbers of vaccines we need to deliver.

Occupational health will be taking on the running and organising of the flu campaign from November

19. Severe Weather

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

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

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

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

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

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

20. Workforce

Vacancy WTE Sept 2022	Division										
	Cancer Services	Chief Finance Officer	Core Clinical Services	Corporate and Support	Estates	Medical + Emergency Care	Medical Director	Operations and Facilities Management	Surgery	Women, Children and Sexual Health	Grand Total
Add Prof Scientific and Technic	0.00		8.11	2.20		5.44			9.84	1.93	27.52
Additional Clinical Services	13.24		-4.14	-3.27	4.30	46.98	-1.00	-3.44	26.50	11.14	90.32
Administrative and Clerical	29.18	13.21	10.24	16.85	15.16	20.06	1.61	1.63	28.52	3.84	140.29
Allied Health Professionals	11.18		34.04	0.30		5.55	0.00		4.72	4.09	59.88
Estates and Ancillary	1.00	0.90	0.00		-3.40	-3.00		65.00	1.43		61.93
Healthcare Scientists	5.52		16.76	-1.00		4.94			-0.69		25.53
Medical and Dental	13.01	0.10	1.04	-0.90		53.54	7.50	2.00	20.74	-2.09	94.95
Nursing and Midwifery Registered	32.89	-1.00	1.66	2.05		148.25	8.85	12.25	80.08	35.41	320.44
Grand Total	106.02	13.21	67.71	16.23	16.06	281.78	16.95	77.44	171.14	54.32	820.87

- Vacancies: The Trust vacancy rate (11.4%) has been falling in recent months as recruitment activity remains high and we forecast this to continue. However, Nursing/Midwifery (15.3%) and AHPs (12.7%) are outliers to this and represent a concern as we approach Winter. From a divisional level, Medical & Emergency Care (16.8%) and Core Clinical Services (15.5%) are the two outliers.
- Senior teams work closely and regularly with HR Business Partners and Resourcing colleagues to forecast and plan future turnover, gaps and recruitment activity. The team also work closely with nursing colleagues to ensure live recruitment activity and staff allocation is looked at to respond to live demands across teams.

21. Out of Hospital Capacity

The Hospital Discharge Policy was published by the Department of Health & Social Care on 21st August 2020. This document provides a new framework for implementation of the Discharge to Assess model that was successfully used at the beginning of the Covid-19 pandemic to clear beds in acute hospitals.

The policy gives a national picture of the numbers of patients discharged on Pathways 0 – 3 and work is being undertaken with partners to confirm if this split is representative of West Kent. **For full policy see appendix 5.**

Discharge to Assess pathway model:

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

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

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

Pathway 3: 1% of people – require ongoing 24-hour nursing care, often in a bedded setting. Long-term care is likely to be required for these individuals

For MTW, commercial care home beds are used across a number of settings to provide ongoing care and assessment. These beds are funded via the CCG but managed by the MTW Discharge Manager.

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

- All patients on Pathway 0 are the responsibility of MTW. It should be noted that the current model enables the wards to directly refer for Pathway 1. The Integrated Discharge Team (IDT) do not have sufficient capacity to deal with all Pathway 1 referrals and this would also cause a slowing of the process, which would be a deviation from the national guidance
- Board rounds need to take place twice daily with at least one of those having a consultant in attendance

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

Out of Hospital Capacity (cont.)

- Criteria led discharge to become normal practice with documented, clear, clinical criteria for discharge that can be enacted by the appropriate junior doctor, qualified nurse or allied health professional without further consultant review. Arrangements to be in place to contact the consultant directly for clarification about small variances from the documented clinical criteria.
- MTW will need to clarify the role of 'Case managers' in the acute trust (every person will be allocated a case manager as soon as the decision to discharge is made by the consultant). The duties described are a mix of Flow co-ordinator, IDT and P3 Team

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

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

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

22. Festive Period Plans

Christmas and New Year Targeted planning:

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

23. Finance

Please see appendix 6

Appendix 1: Divisional Winter Action Plans

Medicine and Emergency Care: Appendix 7

Planned Care: Appendix 8

Women's and Children's: Appendix 9

Therapies: Appendix 10

NHS England letter

For full letter please see Appendix 11

MEC Winter Plan		
Included		
Initials	Name	Role
TH	Tim Hubbard	Interim DDO
SW	Steve Williams	Head of Performance & Delivery
GV	Gemma Viner	DDNQ
KHA	Kate Hallelwell	Lead Matron AMG
SK	Seeth Krishnamurthy	GM AMG
KC	Katie Cornwell	GM Med Spec
MG	Mansiri Gurung	Lead Matron Med Spec
KHO	Kate Holmes	GM ED
GS	Glenda Sonquit	Lead Matron ED
AW	Amanda Weightman	Matron AMG
LM	Laurence Maiden	Chief of Service

Number	Theme	Action	Updates	Target Dates	Assigned	Open/Closed	Cost	
1	Capacity	Link with Safer Better Sooner team on frequent flyers with LOS over 14 day - see what specialist support can be offered to primary care	Hot clinics in place.		SW		0	Neutral
2	Capacity	Discuss potential virtual ward pathways with AAM / AAU consultants	Have specific conversation re admissions from AAU to virtual ward to ensure would work before any work put into it. Keep TH in loop (represents division at VW meetings)		KHA / SK		0	Neutral
3	Covid pathway	Ensure plans remain ready to be stood up should demand increase	Demand already increased, plans activated.		GV / TH	Closed	0	Neutral
4	Elective activity	Understand impact of cath lab escalation on activity at Maidstone	KC has info from IP to look at.		KC / MG			Outsource costs
5	Elective activity	Confirm divisional preference re escalation into ASU footfall rather than Maidstone cath lab	Old stroke unit to be used for escalation once moved into new unit; staffing being scoped.		GV / TH		20,000	Cost 1 month of outsourcing cost (Until Stroke Unit work completed)
6	Capacity	Additional capacity - accelerate virtual ward	TH to engage with this. Respiratory pathway in place. AEC patients to VW as next step. Cohort area to scope - ? Wingman tent, though rather isolated. Tentative enquiries to be made.		TH		0	Separate funding stream
7	ED	Management of ambulance handover over winter	Otherwise in corridors with additional staffing as last year. GS has done walkround with IPCT re space.		KHO / GS		0	Neutral
8	ED	Coping with 800-900 attendances - robust surge plan to be shared with Division	Plan made, waiting for costings. Matron TWH		KHO / GS		71,400	3.4 matrons at TWH,
		Coping with 800-900 attendances - robust surge plan to be shared with Division	Plan made, waiting for costings. Nursing B6				93,600	5.2 24/7 Triage nurse at TW
		Coping with 800-900 attendances - robust surge plan to be shared with Division	Plan made, waiting for costings. Nursing B5				352,663	20.8 Pre and Post RAP corridor 24/7
		Coping with 800-900 attendances - robust surge plan to be shared with Division	Plan made, waiting for costings. Paed Nursing B5				132,257	7.8 - Enable 24/7 Riverbank
		Coping with 800-900 attendances - robust surge plan to be shared with Division	Plan made, waiting for costings. ENP/ACP				175,500	30000
		Coping with 800-900 attendances - robust surge plan to be shared with Division	Plan made, waiting for costings. MG				300,000	90000
		Coping with 800-900 attendances - robust surge plan to be shared with Division	Plan made, waiting for costings. SHO				157,500	54000
9	ED	Coping with 800-900 attendances - work up 24/7 GP UTC clinics, look into pre-business case funding via winter monies	Plan made, waiting for costings. GP		KHO / GS		90,000	90000
10	Capacity	Admissions avoidance / SDEC - can more be done? Protect Hilton spaces for frailty	Maidstone now running to 10pm. TWH - extension of hours / new doctors - achievable. Frailty escalation is biggest issue. Outreach info being collated, working with ECIST. Protected spaces for frailty - live on 4.10.22 - to monitor and potentially expand.		KHA / AW		0	Funded
11	Capacity	Admissions avoidance / SDEC - increase into and more robust speciality in reach in ED	Improved although somewhat consultant-specific. TH to discuss further with LM		KC / KHO TH / LM		0	Neutral
12	Discharge planning	Robust Friday weekend plan / discharge planning meeting, consultant led / criteria led	Friday meeting of varying quality, focus needed to improve. Consultant engagement - ? SOP to be written by senior reg. Need MDT approach with IDT. To revamp and embed.		KC / SK		0	Neutral
13	Discharge planning	Trial two wards with senior cover at weekend to see if discharges improve	John Day being put forward to Safer Better Sooner team		KHA / MG / GV / SK / KC		10,000	Snr Nursing cover - spk to GV
14	Teletracking	Encourage one version of truth - all Board Rounds / mop up board round decisions to be robustly recorded	TT completed effectively when flow coordinators are around. Are nursing staff deskilled? Need to be able to update after 4pm. Sally was to speak to teams re this - refresher training.		MG / KH		0	Neutral check whether TT works on an IPAD
15	Teletracking	Weekend meeting plan to be reflected on teletracking	See action 12 above - once revamped meeting in place can action. Skills mix - ENP and B6 confidence in sending to GP and minors clinics out of hours.		KC / SK		0	Neutral
16	ED	Management out of hours, particularly at TWH - action plan to be brought to meeting (incorporated in surge plan)	Senior cover out of hours trialled for a week - issues raised the same as when they leave at normal time. May bid for additional winter monies, but would have to use staff already in dept due to timescales with recruitment.		KHO / GS		N/A	3 wte BA - 3 months
17	Escalation	Understand impact of cath lab escalation and decide divisional escalation plan	Info to be included in surge plan at action 8 above asap Escalation policy being worked on - there is a plan. SK reviewing medical cover and equipment.		TH / GV / LM		N/A	see 4
18	Escalation	Explore potential nursing leadership for escalation on ASU over winter	As action 17		KHA / MG		390,000	
19	Escalation	Understand medical plan	As action 17		TH / LM		151,000	
20	System support	Reminder to on call managers that mutual aid support needs to be agreed at Exec level	To be reinforced to rest of system. Comms to go out via ICC		TH		0	Neutral
21	Annual leave	Joint work with medical staffing over winter period	Comms to be sent to consultants re their team's annual leave		TH		0	Neutral
22	Discharge	Implement 7 day respiratory ward rounds	Awaitig start date from resp lead		TH		15,000	Cost of putting on w/e Cost up Sat & Sun (8-12) bank rate for Consultant and JCF for worst
23	Discharge	Implement 7 day Gastro ward rounds	job planning start date 31st Oct		TH		0	Neutral
24								
25								
26								
							1,958,919	

Theme	Action	Updates	Target Dates	Assigned	Open/Closed	Cost	Narrative	£/m
ED	Coping with 800-900 attendances - robust surge plan to be shared with Division	Plan made, waiting for costings. Matron TWH		KHO / GS		71,400	3.4 matrons at TWH,	7,000
	Coping with 800-900 attendances - robust surge plan to be shared with Division	Plan made, waiting for costings. Nursing B6		KHO / GS		93,600	5.2 24/7 Triage nurse at TW	6,000
	Coping with 800-900 attendances - robust surge plan to be shared with Division	Plan made, waiting for costings. Nursing B5		KHO / GS		352,663	20.8 Pre and Post RAP corridor 24/7	5,652
	Coping with 800-900 attendances - robust surge plan to be shared with Division	Plan made, waiting for costings. Paed Nursing B5		KHO / GS		132,257	7.8 - Enable 24/7 Riverbank	5,652
	Coping with 800-900 attendances - robust surge plan to be shared with Division	Plan made, waiting for costings. ENP/ACP		KHO / GS		175,500	30000	
	Coping with 800-900 attendances - robust surge plan to be shared with Division	Plan made, waiting for costings. MG		KHO / GS		300,000	90000	
	Coping with 800-900 attendances - robust surge plan to be shared with Division	Plan made, waiting for costings. SHO		KHO / GS		157,500	54000	
ED	Coping with 800-900 attendances - work up 24/7 GP UTC clinics, look into pre-business case funding via winter monies	Plan made, waiting for costings. GP		KHO / GS		90,000	90000	

	YTD Spend	Average WTE worked	
Band 5	3,540,190	104	5,652
Band 6	48,800	8	6,000
			7,000

900 attendances per day

Across both the TW and Maidstone sites there is a limitation by estate to significantly further increase attendances to the Emergency Departments. At the Maidstone site consideration would need to be given to a purpose-built UTC at the front door. This would enable both the increase in estate but also provide the UTC at the front door in line with NHS England's vision. At TW the UTC could be moved to the outpatient area but this would both disrupt out patient activity and the flow of the ED.

With the estate limitation flow out of the department would be essential. With this in mind consideration would need to be given to the increase in admissions this would lead to and the need for additional SDEC support. All SDEC areas would need to be extended to 24 hours and appropriately resourced. Senior decision makers from all specialities would need to be based in ED to reduce conversion to admission.

Within ED

- Ambulances

This will lead to a 25% increase in ambulance attendances, approximately 140 to TW site and 80 per day to Maidstone. Working on the assumption of 10 ambulances can be process through every 1 RAP space, both TW and Maidstone would be able to cope with the increase. Maidstone would need to be provided 24/7, currently uncovered medically 10pm to 10am.

- Triage

With the additional walking wounded there would be a significant increase of self-presenters to the department. In order to manage the increase each department would require additional triage trained staff. Maidstone would require an additional RN 24/7 and TW would require two additional RN 24/7.

- UTC

We can see 456 patients by reducing the appointment times and adding an extra 11.5 ENP hours at Maidstone, 11.5 hours ENP for paed's on both sites, 11.5 physio hours on each side (this would be less the current physio establishment that we should aim to assimilate in to our workforce) an 11.5 hour ACP to work between both UTC streams on each site and 8 GP hours on each site.

We don't think there is a need to increase the nursing establishment in the UTC's as we have the Clinical Support workers but would need to consider extra triage nurses to accommodate the increase of walk-in patients.



UTC Capacity -
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- Medical staffing

Increased attendances will require additional medical cover to manage. Across both site this will be an increase of 10 registrars and 7 SHO according to safe staffing levels. This will include the operation of RAP 24/7 and Paediatric cover 24/7 on the Maidstone site.

SPA time cancellation for consultant body to enable increased senior clinical cover

- Nursing Staffing

24 hour matron cover for ED to cover at the required site.

Additional Nursing staffing would be required to manage both the pre and post RAP corridors plus additional RN in both RAP's to process the additional ambulance attendances.

- Consumables

More patients will require more equipment, pathology resource, radiology resource, transport, portoring etc.

Outside ED

- Increased SDEC operating hours of Frailty, AEC, SAU, Paed 24/7
- Orthopaedic in reach for injuries
- In reach of senior clinical decision makers from all specialities within ED

		WTE	Cost	
Medical Staffing	Registrar	10		Enable RAP and Riverbank 24/7 at Maidstone. Additional patient assessment
	SHO	7		Additional patient assessment
	GP	3		Increase UTC capacity
ACP	ENP	7.8		Increase UTC capacity
	ACP	5.2		Increase UTC capacity
	Physio	5.2		Increase UTC capacity
Nursing	Matron	3.4		24/7 cover TW
	Band 6	5.2		Triage nurse at TW
	Band 5	20.8		Pre-post RAP corridor plus additional triage nurse at both TW and Maid
	Paediatric	7.8		Enable 24/7 riverbank

FULL CAPACITY PROTOCOL	2.0
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Developed in response to:	
CQC Fundamental Standards:	

Consulted With:	Post/Committee/Group:	Date:
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Contents

1.	Purpose of Protocol	3
2.	Aims and Objectives.....	4
3.	Scope	5
4.	Responsibilities.....	6
4.1.	<i>Chief Executive</i>	6
4.2.	<i>Chief Operating Officer</i>	6
4.3.	<i>Director On-Call</i>	6
4.4.	<i>Senior Clinicians and Managers</i>	6
4.5.	<i>Emergency Department Escalation</i>	6
5.	Alerting System	8
6.	Initial Briefing	9
7.	Definitive Actions:.....	10
8.	Delaying transfers of care from Ambulance Service to ED.....	10
9.	Leadership.....	10
10.	Specialty In-reach to the Assessment Units	10
11.	Specialty In-reach to Assessment Units	12
12.	Specialty Diagnostic Plan	13
13.	Transfer of Patients to Wards whilst awaiting a Bed (Boarding)	13
14.	Twice Daily Senior Review of ALL ‘Medically Active’ Patients	15
15.	Admission from Clinics	15
16.	Cancellation of Non-Urgent Elective Activity	15
17.	Portering	16
18.	Opening of Escalation Areas	16
19.	Discretionary Actions:	17
20.	Stand Down.....	20
21.	Training	21
22.	Audit and Monitoring.....	21
23.	References.....	21
24.	Appendix 1 – Full Capacity Checklist	23
25.	Appendix 2 - Roles and Responsibilities of Staff.....	24
25.1.	<i>All Internal MTW Staff</i>	24
25.2.	<i>Chief or Deputy Chief Operating Officer / On Call Director</i>	25
25.3.	<i>Site Director and Senior Manager on Call</i>	26
25.4.	<i>Clinical Site Team</i>	26
25.5.	<i>ED Nurse in Charge</i>	27
25.6.	<i>Ward staff</i>	28
25.7.	<i>Ward Managers/Leads/Ward Nurse in Charge</i>	29
25.8.	<i>Directors of Nursing and Quality / Lead Matrons</i>	30

25.9.	<i>Divisional Management Teams</i>	31
25.10.	<i>Medical Staff</i>	31
25.11.	<i>Divisional Directors of Operations and Clinical Directors</i>	32
25.12.	<i>The Integrated Discharge Team (IDT)</i>	32
25.13.	<i>Therapy Responsibilities</i>	33
25.14.	<i>Portering Team</i>	33
25.15.	<i>Catering Team</i>	34
26.	Appendix 3 - Command and Control in Critical Incident.....	35
27.	Appendix 4 – ‘Boarding Guidelines’	33
27.1.	<i>Triggers for activating patient boarding</i>	34
27.2.	<i>Activating patient boarding</i>	34
27.3.	<i>Transfer of boarded patients to ward areas</i>	34
27.4.	<i>Criteria for transferring boarded patients to ward areas</i>	35
27.5.	<i>Monitoring of compliance against guidance</i>	36
28.	Appendix 5 – Emergency Department Escalation	37
29.	Appendix 6 – Quick Reference Action Cards.....	38

1. Purpose of Protocol

- 1.1. The provision of 'High Quality, Safe Healthcare' leading to good patient experience is a key organisational priority. This should be at the forefront of our work at all times, however, organisational pressures and operational workload can limit the ability of key areas to provide this along with expected patterns of care. When this pressure inhibits normal daily functioning, it significantly increases the risk of failure in care occurring.
- 1.2. When the Trust begins to operate at a heightened escalation status, the Trust as a whole needs to adapt and operate differently. This balances and shares the clinical risk across the whole of the Trust as risk mitigation is part of the organisation's key action in upholding its duty of care to patients. Escalation of the Trust's response however should begin independently of the Trust's Operational Pressures Escalation Levels (OPEL) status depending on the apparent risk, rather than waiting for a specific escalation status or level.
- 1.3. Unlike many departments and clinical areas, the Same Day Emergency Care (SDEC) and in particular the Emergency Department (ED) is unable to cap demand and close its doors when all available patient care spaces are occupied. The risk of serious incidents happening not only increases with every additional patient that arrives over and above capacity but this is concentrated in one geographical area. This represents a significant risk to all that is described above. As such the risk needs to be shared across the whole organisation and the Trust response is one from the whole organisation and not just the ED.
- 1.4. The purpose of this protocol is to describe the mandated actions necessary when the Emergency Department (as the main point of entry for emergency admissions) has more patients than it can potentially safely care for.
- 1.5. While a key aim of this protocol is to prevent from triggering unsafe levels of escalation at OPEL 4 / Black; although the Trust recognises and accepts that, during periods of extreme operational capacity pressures the Trust's employees will be required to accept a higher level of risk in relation to patient care than would usually be the case under normal circumstances and will subsequently be obliged to make decisions that would potentially not be made during 'business as usual'. Any form of triage presents ethical and moral dilemmas to clinicians; and a balance has to be struck between the interests of an individual patient and the 'common good' or interests of the wider patient population served by the Trust. The greater the common need, the greater the urgency of decision making and need for triage and this should change the emphasis of a clinician's prioritisation accordingly. Clinicians finding themselves in an ethically difficult position should discuss the matter with a senior colleague such as the Clinical Director, Chief of Service or Divisional Directors of Nursing and Quality (DDNQ) or Senior Manager on Call out of hours via switchboard. Provided that such

decisions are properly recorded, the Trust will support such decisions and will accept responsibility for any consequence arising from such a decision.

2. Aims and Objectives

2.1. This protocol is a default list of actions to be taken when the Trust is operating at full capacity. It is not necessarily exhaustive. Other measures or situations could still affect the operational safety of the hospitals and are not specifically described here and so should not be excluded. It should also be appreciated that some measures should be adopted early at relatively lower levels of escalation in order to prevent the risks from occurring in the first place.

2.2. The document aims to deliver safe and improved patient flow through the organisation incorporating measures which, as far as possible, have a reasonable evidence base for being effective nationally or locally. Innovation, or the implementation of a new idea to improve patient flow, is often poorly measured and ineffective so the focus in this document is on measures which are known good practice and considered to be helpful. There should be an optimisation of:

- Front-end assessment and initial treatment activities (and also admission avoidance).
- A focus on discharge to consistently prioritise discharge activities.
- A focus on workforce presence and skill mix to ensure the right people seeing patients at the right time.

2.3. Specifically this protocol aims to deliver:

- Early identification of capacity problems;
- Proactive rather than reactive responses;
- Concise and clear actions for staff;
- Defined roles and responsibilities;
- Early escalation to community partners for support;
- Feed into system level escalation and response;
- Minimise OPEL 4/ Black escalation by recovering earlier.

2.4. Objectives

The specific objectives of this protocol are to provide:

- Optimisation of clinical care and patient safety throughout the Trust
- Ensure systems and processes are present to identify staffing levels at times of escalation and ensure safe skill mix
- Enhance the patient experience through the Same Day

Emergency Care Pathways

- Maximise and maintain patient flow
- Release emergency ambulance vehicles to enable a response to patients in the community
- Reduce the risk from of overcrowding in the ED & SDEC areas`
- Achieve and maintain the national standard of 95% of patients assessed, treated and discharged or transferred within four hours
- Avoid 12 hour trolley waits (Decision to Admit)

Maintaining key indicators as below:

Indicator	Operational Standard
Four hour access	95%
Ambulance Handover	<15 minutes 95%
Bed Occupancy	<92%
Cancelled elective surgery relating to bed capacity	<1%
Patient Flow	SAFER

3. Scope

3.1. This protocol is relevant for all staff working in patient facing areas. This Protocol is also relevant for all other clinical areas of the Trust and non-clinical support services. It applies to all permanent, locums, agency, bank and voluntary staff of the Trust, and external partners such a G4S and IC24, whilst acknowledging that for staff other than those directly employed by the Trust the appropriate line management or chain of command will be taken into account. Whilst the protocol outlines how the Trust will manage escalation levels, implementation does not replace the personal responsibilities of staff with regard to issues of professional accountability for governance. The protocol covers all patients, 'in hours' and 'out of hours' discharges and delayed transfers of care.

3.2. In the event of an infection outbreak, flu pandemic or major incident, the Trust recognises that it may not be possible to adhere to all aspects of this document. In such circumstances, the advice of the infection control team via the Incident Coordination Centre (ICC) will be sought and all possible action will be taken to maintain ongoing patient and staff safety throughout the Trust.

4. Responsibilities

4.1. Chief Executive

- The Chief Executive has overall responsibility for ensuring and supporting the development, implementation and monitoring of the Protocol, to meet its legal obligations and to adopt policies and practices which promote safe practice.

4.2. Chief Operating Officer

- The Chief Operating Officer is the delegated lead for this protocol. In hours the activation of the protocol will be the responsibility of the Chief Operating Officer / Deputy Chief Operating Officer or their delegated Senior Manager.

4.3. Director On-Call

- When out of hours the request will be escalated by the ED on-call Consultant/Nurse in Charge through to the Clinical Site Team who will discuss early interventions with Senior Manager on call.
- The decision to instigate the protocol will be made by the Director on-call.
- The Clinical Site Manager will act as the facilitator fulfilling the role of the Operational lead in support of Senior Manager on-call manager.
- The Director On-call is responsible for leading the activation of the protocol and procedure for out of hours.

4.4. Senior Clinicians and Managers

- Input from the Divisional Directors and Heads of Departments is also expected, along with the Directorate Managers of the day and Clinical Directors. These members of the team (or nominated deputies) will be present within the Trust during normal working hours.
(Refer to Appendix 2 for a full list of responsibilities for ALL staff)

4.5. Emergency Department Escalation

- The Emergency Department (ED) has a published escalation and surge plan which will inform the full capacity process, site team and duty managers as to the status of the department at any time. This is published in Appendix 5 for reference.

- 4 Hourly board rounds are held in the ED as standard throughout the 24 hour period. Increasing these board rounds to 2 hourly conveys no benefit over the 4 hourly processes and instead takes clinicians away from treating patients and improving patient flow. However what does yield increased efficiency are the rounds being joined by the Specialty teams as described below in Acute Assessment and SDEC in reach.

4.6. When the ED has reached its maximum number or is rapidly approaching this safety of the patients and staff may be at risk and therefore the delivery of safe effective care is not possible. It should be noted that a decision to escalate and activate the 'Full Capacity Protocol' should not be made by one individual alone but made together with the clinical site team liaising with the Site Director (in hours) or Senior Manager on Call (out of hours). The Chief Operating Officer / Deputy Chief Operating Officer (in hours) or Director on Call (out of hours) will, in consultation with the Operational and Tactical leads, provide the decision to activate this protocol.

4.7. It is anticipated that all actions have been taken to prevent the ED reaching this point and escalation triggers have been acted upon. A summary of the actions in the Full Capacity Protocol is detailed below

4.8. The Full Capacity Protocol is NOT governed by OPEL status but will be activated when 5 or more of the below apply:

- Majors is full with one space in resus and no ability to de-escalate patients due to acuity
- Ambulance offload is delayed for longer than 60 minutes for >2 patients.
- There are >20 unplaced patients waiting for a bed at 8:00am
- ED areas fully escalated
- Escalated areas of AMU (SDEC, AEC) have more than 4 patient transfers waiting to be moved to a specialty ward.
- Base wards (including AMU / AAU) collectively have more than 10 patients awaiting transfers to Discharge Lounge, Hospital at Home, HomeFirst or Community.
- Any patient in ED >8 hours from attendance without a definitive specialty management plan
- Wait to be seen by ED Clinician >3 hours for >10 patients
- Threat of cancelling (1 list a day) urgent and cancer activity
- Funded capacity and 75% of escalation areas are occupied
- All Critical / High Care areas are full with >1 de-escalated patient awaiting discharge to a base ward.

4.9. All available staff will help with four key elements, any or all of which can be activated independently depending on the circumstances.

These elements are:

- Transfer of triaged patients from AMU or Specialty Care areas to the wards into an empty bed
- Transfer of patients from ED directly to admitting wards
- Transfer of patients from ED to AMU
- Assisting in areas which is experiencing higher than usual activity

4.10. To avoid unnecessary activation of the protocol it is essential to ensure that the capacity issues are not transient as a result of a surge in activity. Therefore, only the COO / DCOO or Director on-call (out of hours) can initiate the full capacity protocol. The COO / DCOO or Director on-call will maintain discussion with Ambulance Service representatives.

4.11. When out of hours, the request will be escalated by the ED on-call Consultant/Nurse in Charge through to the Clinical Site Team (CST). The CST will take all immediate measures as detailed in the ED Escalation Plan and discuss the evolving situation with the Senior Manager on-call. The decision to instigate the protocol will be made in conjunction with the Director on-call. The Clinical Site Manager will act as the facilitator fulfilling the role of the Operational lead in support of the Senior Manager on-call.

4.12. The Full Capacity Protocol may be instigated at lower levels of escalation and/or demand if this is deemed clinically necessary by the ED Consultant in-charge in conjunction with the Site Director (or Senior Manager on-call out of hours). Examples of such situations include considerations of overall levels of acuity of illness in the ED regardless of absolute numbers.

4.13. The decision to deactivate the protocol or step-down certain elements of it will also be made by the COO / DCOO or Director On-Call.

5. Alerting System

5.1. When the Full Capacity Protocol is activated, the following arrangements will be implemented:

5.2. Switchboard Actions:

- When alerted, Switchboard will cascade an alert message via the Trusts 'Everbridge' alert system, to all Chiefs of Service, Divisional Directors of Operations, Divisional Directors of Nursing & Quality, Clinical Directors, Clinical Site Leads, Executive Directors, Senior Managers on call, Head of Incident Co-ordination Centre and Emergency Planning and Preparedness on call stating the Full

Capacity Protocol has been activated (details of the exact message will be confirmed by the COO/DCCO or Director on-call out of hours).

- The 'Everbridge' system will rapidly alert all those relevant staff on the pre designed template contacts list (as stated above). It will attempt to reach each individual until it receives a response by cycling through different forms of communication (SMS, Email, Voice, App). Those receiving the alert should choose the appropriate message response and follow their relevant actions for full capacity. Using 'Everbridge' ensures management across the Trust are aware of the hospitals situation quickly and efficiently. Those who receive the alert should then disseminate information to staff within their department/service/area.

5.3. Divisional Actions:

- The Chiefs of Service, Divisional Directors of Operations and Nursing in partnership with Clinical Directors and Clinical Site Leads will be required to identify which medical staff within the Divisions will be required to report to the Site Management Office and ensure that the relevant Clinicians are contacted. Out of Hours this role will be undertaken by the Consultants on call for each Specialty at the request of the Senior Manager on-call

5.4. Communication Team Action:

- The Communications team will issue a message to all staff via email and will support this using the Trust intranet.

6. Initial Briefing

6.1. Upon activation of the protocol, all teams who have been alerted via the initial Everbridge message must respond to Site Management Office to await further instruction.

6.2. In hours the COO /DCCO or delegated representative and out of hours the Director on-call will be on site. The expectation is that all teams will report within 60 minutes of receiving the initial message. The representation in the out of hours period so that this response can be maintained at all times will lie between the Senior Manager on Call and the Director on Call supported by the Site Manager and Nurse in Charge in ED.

6.3. All necessary tasks will be explained to the relevant teams during the briefing with clear instructions of what is required, when it is required and who to report back to when the task is complete. This will not necessarily have to be via attendance at Site Management Office but may be via Microsoft Teams or telephone. The COO / DCCO or delegated representative (Director on-call out of hours) will chair the meeting supported by the Site Director (Senior Manager on call out of hours).

7. Definitive Actions:

7.1. The following actions must be taken within 30 minutes in addition to usual operating procedures.

8. Delaying transfers of care from Ambulance Service to ED

8.1. As the available capacity within the ED diminishes, the ability for the Trust to take patient handovers from the South East Coast Ambulance Service (SECAMB) within the 15 minute standard can be impaired. This in turn impairs SECAMB's ability to respond to 999 calls within the local area.

8.2. The Trust has agreed to work in partnership with SECAMB by adhering to their ambulance offload protocol and it should be ensured that this is fully instigated at the earliest available opportunity.

8.3. If the ED pressures suggest that Ambulance handover delays may occur >30 minutes then SECAMB should be informed of this situation via their control room at the earliest opportunity. This situation should trigger consideration of activation of the full capacity protocol if not already being implemented.

9. Leadership

9.1. There will be three tiers of leadership for the delivery of the Full Capacity Protocol following national standards of incident management. Further details are outlined in Appendix 3:

1. **Strategic:** Chief / Deputy Chief Operating Officer in hours, Director on call out-of-hours
2. **Tactical:** Head of Care Coordination Centre (CCC) / Incident Coordination Centre (ICC) or Director of Operations -Patient Flow (in hours), Senior Manager On call (out-of- hours)
3. **Operational:** Site Director (in hours) and DDoO & DDNQ's for each respective Division

9.2. Out of hours the Senior Manager on call should be present in the Trust within 60 minutes of activation of the protocol. Where this is not possible, the Senior Manager on call must put in place an agreed equivalent interim solution to ensure the smooth activation of the protocol until arrival to site of usually the Clinical Site Manager in Charge.

10. Specialty In-reach to the Assessment Units

10.1. Each specialty specified below shall provide a senior clinical decision maker (Consultant/ Registrar/nurse specialist) inreach into the ED / AAU / AMU at a

minimum of three times daily and liaise with the ED Nurse in Charge (NIC) / Emergency Consultant in Charge (DrIC) and as required AMU/SAU co-coordinators.

10.2. Attend ED in person:

- Acute Medicine / Physician on Call
- General Surgery
- Orthopaedics
- Geriatrics & Frailty
- Paediatrics

10.3. Attend AMU in person:

- Cardiology
- Respiratory Medicine
- Gastroenterology
- Oncology

10.4. Attend SAU in person:

- General Surgery
- Urology
- Upper & Lower GI Surgery
- Trauma & Orthopaedics

10.5. Provision of contact details to site office / In reach to ED by telephone only

- Critical Care
- Obstetrics & Gynaecology
- Radiology
- ENT

10.6. Example times of expected attendance should coincide with ED board rounds and include: 0900, 1300 and 1700. Teams will be expected to provide a rota to the site office; specifying the name and contact details of the responsible decision maker who can make themselves immediately available to attend the ED as required throughout the period of activation of this protocol. This immediate availability is essential to ensure the Full Capacity Protocol is effective and only in place for the minimum period possible.

10.7. Co-ordination and explanation of tasks required by each of the in-reach specialties will be performed by the ED NIC and ED Consultant, in conjunction with the Senior Manager on-call when the full capacity protocol is activated on a weekend or bank holiday.

- 10.8. The ED NIC and Flow Coordinator will assist with the provision of intelligence to the specialties via a circulated list of what the pressures are for each specialty to help target resources appropriately and avoid clinicians visiting needlessly.
- 10.9. Potential activities that could be required include the review of specialty-type patients (regardless of a decision to admit, 'straight to specialty'), triage, admission avoidance actions including the provision of early/immediate outpatient/ambulatory care clinic appointments, expediting procedures and investigations, and reviewing patients on the wards aiming to facilitate discharges. Clinical Nurse Specialists will be expected to assist with this in-reach and ward work in association with their medical colleagues.
- 10.10. The recommendation is that patients from SAU, AAU/AMU, ED should be the first areas for identification of suitable patients for boarding. There will remain direct admissions from ED to Ward 31 (# NOFs) and Ward 33 (Gynaecology) and the Frailty assessment trolleys.
- 10.11. The CoS in conjunction with Site Director will act as a Clinical Arbiter for cases where there is potential dispute as to which team looks after which patients. Out of hours this will be led by specialty Consultants on call and the Tactical senior manager to agree.
- 10.12. On-call Consultants will be expected to be present on site in the Trust from at least 17:00 – 20:00 as a minimum during the period of activation of the Full Capacity Protocol. They must check in with the Site Management Office (via telephone or in person) and be directed to the location they can be of greatest use to the whole system. This may be in the Emergency Department or on the wards. The COO / DCOO or Director on-call out of hours may allow specialties and individual teams to step down if they are no longer required.

11. Specialty In-reach to Assessment Units

- 11.1. To attempt to maintain the flow of patients, available clinicians will be sent to their relevant assessment units to review patients and attempt to clear these areas via appropriate decision making (facilitating discharges or reviewing patients so that they can be transferred from the assessment unit to the ward or investigations/management expedited).
- 11.2. For the duration that the protocol is implemented, it would be expected that either the on-call team or available clinicians are present within the assessment areas to continue the process of prompt review and decision making.

12. Specialty Diagnostic Plan

- 12.1. To support the plans to maintain flow of patients a dynamic and flexible Specialty Diagnostics Plan is crucial for decision making in terms of the highest acuity patients and those patients waiting a safe discharge decision.
- 12.2. On activating the Full Capacity Protocol the Diagnostics teams will be working in close partnership with the clinical teams in the EDs and wards to ensure those patients whose treatment and/or discharge are dependent on imaging are identified and escalated. A priority list will be collated by the Clinical Site Team to ensure that the radiology booking teams have a twice a day update as to those patients needing urgent images. The booking team will liaise directly with assessment areas and wards; keeping them appraised as capacity becomes available to ensure internal delays are minimised.
- 12.3. The Chief of Service in partnership with CDs will instigate a review of lists of activity for that day, overbook or reschedule less urgent cases and where possible move patients to the IS to liberate internal capacity to support urgent cases.

13. Transfer of Patients to Wards whilst awaiting a Bed (Boarding)

- 13.1. In extreme circumstances and for the risk-sharing rationale stated above it may be necessary to transfer patients with a clear decision-to-admit to a ward without a bed being immediately available but there is a clear expectation that a discharge has been identified and a bed will become available.

The Boarding of patients should be considered when a number of the following criteria are met.

- No care space in the ED
- The Trust escalation status is >OPAL 3
- The ED escalation status is >AMBER
- More than 20 unplaced patients waiting for a bed at 8am
- Resus is full with level 2 dependency patients with incoming priority call and no immediate allocated bed space
- There are more than 3 ambulances being held for more than 45 minutes.
- Potential 12 hour ED trolley breach.

Levels of Boarding

Level One -

Boarding against identified discharges will be considered when ED has 20-25 unplaced patients with decisions to admit (DTA's), plus 2 of the triggers above

Level Two -

Boarding patients on wards without identified discharges when DTA's are 25-30 and one of the above triggers.

Level Three-

Boarding of patients will occur when there are 35+ patients with a decision to admit unallocated at 08:00.

Note: in the first instance

Matching boarded patients to their specialty will always be considered but may be overlooked at level 4 if the number of DTA's at 08.00 is plus 35

- 13.2. The nurse-in-charge will explain all of the above to the affected patients, including the rationale described above.
- 13.3. A central record maintained of any patients placed into clinical areas above the normal capacity and for how long.
- 13.4. Where possible the patient should be visited by CST in their boarding area to support nursing teams, escalate safety issues and answer any additional questions relatives and families may have about the rationale for this process.
- 13.5. If the expected bed availability ceases to be the case, then this will be escalated to the CCC immediately and an alternative bed be sought as a matter of priority. The relevant Matron or Lead Matron / DDNQ will be informed.
- 13.6. In the event of any problems, the nurse-in-charge will escalate the situation immediately to the relevant Matron or Lead Matron / DDNQ.
- 13.7. The ward areas will take one extra patient each under the circumstances detailed in the 'Boarding Guidance' document (Appendix 4)

14. Twice Daily Senior Review of ALL ‘Medically Active’ Patients

- 14.1. The 7 day services ambition describes that every medically active patient in every bed on every ward should be reviewed by a senior doctor (minimum registrar or consultant, ideally consultant) twice daily, including weekends and bank holidays. It is realised with our current medical staffing levels this may not be possible. Priority should be given to the patients who are most unwell and those that could potentially be discharged as suggested by the NIC. Activities that should be considered include the early discharge of patients who do not need a hospital bed but who need further investigations or assessment that could be undertaken via an alternative mechanism, including ambulatory care or early outpatient review (even if clinics are over-booked as a result).

15. Admission from Clinics

- 15.1. All patients who need admission from an outpatient clinic or similar venue must be reviewed by a consultant from the specialty team, fully clerked and have a drug chart, and first-line investigations ordered. A management plan must be clearly documented in the case notes. Ideally, the patient should be transferred to the appropriate specialty bed without going to the Emergency Department, AMU or SAU. It is imperative that a gatekeeper is used in times of extremis so as to ensure beds are not double booked if being accessed from clinic. All requests need to go via the CCC. In the event of any dispute, the final decision will be made by the relevant Divisional Director of Nursing and Quality.

16. Cancellation of Non-Urgent Elective Activity

- 16.1. A case by case decision will be made about the cancellation of all “non-urgent” elective surgery that is not day-case. It must be appreciated that day- case activity has little impact on patient flow in unplanned care; elective surgery that takes place for seriously unwell patients including cancer cases (urgent elective surgery) cannot be routinely cancelled without a risk- assessment being made. Such decisions are to be made only by the respective Divisional triumvirate leadership teams in conjunction with the specialty teams as appropriate and agreed with the COO / DCOO. The COO / DCOO will seek clinical advice from the Medical Director or Chiefs of Service if required.
- 16.2. Some lists may also be consolidated releasing staff to assist on the wards, in the ED or elsewhere in the Trust. Staff will continue to facilitate emergency work and labour ward so will prioritise emergency theatre lists, assisting in ITU and then supporting wards.
- 16.3. A case by case decision will be made about the cancellation of all “non-urgent” clinics to free up additional staff. It should be remembered however that a number of clinics perform a vital role in preventing admissions from the community to the hospital via ED. Particular examples of these include Cardiology, Respiratory

Medicine, Fracture clinic, Urgent General Surgery clinics, and these should be allowed to run. The role of the released staff should also be considered for example the additional benefit from releasing Neurologists and Rheumatologists from clinic to assist in managing the increased pressures is minimal compared to the benefit to their patients from letting them run.

- 16.4. Cancellation of routine follow up slots in clinic to provide 'Hot slots' that could prevent a hospital admission should also be considered in a case by case basis.
- 16.5. All staff released from elective work should be redeployed to areas of need. This should be coordinated by the site office and facilitated by the Divisional management team. It is not acceptable for staff released from elective work to take leave or carry out administrative tasks if they are required clinically elsewhere in the Trust.

17. Portering

- 17.1. Additional porters should be deployed to the ED to assist with transfers from and within the emergency department.
- 17.2. The Portering Supervisor will be present in the CCC and will support CCC Supervisor as directed.
- 17.3. Consideration should be given to the use of Management and Administrative staff in this role (Portering) at the discretion of the COO /DCOO.

18. Opening of Escalation Areas

- 18.1. By the time a Full Capacity Protocol is activated, a number of escalation beds should have been made available in line with the Escalation Sequence, in the Trust Internal Escalation Protocol. After 20:00 if ED Department remains unsafe, prior to activating Full Capacity Protocol every effort should be made to utilise identified escalation areas:
- Short Stay Surgery (ITU expansion as required)
 - Theatres recovery
 - Cath lab
 - Discharge lounge
 - Frailty assessment trolleys (with COO / DCOO or on-call Director approval)
- 18.2. To mitigate the increased risk of using escalation areas, the following requirements must be put in place at each area:
- Patient requirements

- ✓ NEWS less than 3
- ✓ Not be acutely confused
- ✓ Not receiving continuous cardiac monitoring
- Pharmacy
 - ✓ Provision of emergency drugs / stock drugs to area as required
- Staffing
 - ✓ Adequate for case mix and area
 - ✓ Staff to have swipe card access to the area (Cath Lab)
 - ✓ Staff are orientated to the area and are aware of emergency procedures and nearest available resus trolley and fire exit.
 - ✓ Consideration of additional SHO / SHOs assigned to ward medical teams
- Estates
 - ✓ Provision of food
 - ✓ Linen
 - ✓ Evacuation plan in event of fire (awareness that the area is in use out of hours)
- Site
 - ✓ Number of patients and location recorded on bed board
 - ✓ Telephone numbers for area accessible and passed to on call teams
 - ✓ On call teams made aware of location and number of patients

19. Discretionary Actions:

- 19.1. The following actions may also be taken if circumstances dictate in addition to all of the above and usual operating procedures:
- 19.2. **Cancellation of ALL non-essential meetings** – Staff should be freed up to respond to the rising demand for hospital services. Accountability, Governance, Complaint meetings with families and Disciplinary meetings should go ahead. All others should be cancelled; diaries cleared and staff to report to their divisional leads to be redistributed to other tasks. These should be reported to the site office as actions that have been taken along with information as to who has become available and where they have been redeployed to.
- 19.3. **Cancellation of ALL Consultant SPA Activity** - The above additional clinical workload involving consultants will be expected to be shared between consultants via mechanisms such as an on-call rota and the cancellation of

occasional sessions not requiring Direct Clinical Care. The Trust Medical Director (or deputy) however may judge that all such activity should be cancelled by all consultants such that all consultant expertise is diverted to direct patient care such as assisting colleagues with ward rounds, clinics or activity on the Emergency Department

- 19.4. ***Cancellation of Junior Doctor Teaching*** – Regular delivery of teaching is a requirement of having junior doctors train at MTW. In times of extreme pressure it may be permissible to either delay, rearrange, shorten or even cancel teaching sessions. This must be assessed on a case by case basis by the Medical Director or nominated deputy. When considering this action there must be specific tasks required to be immediately performed by the individuals released. The impact must be reviewed with the Director of Medical Education and Guardian of Safe Working after each occasion to ensure the Trust is meeting its minimum training commitments, as failure to do so may impact on our ability to retain doctors in training in the future.
- 19.5. ***Cancellation of other teaching / training*** – At any one time a variety of on-site courses or training may be taking place. In times of extreme pressure it may be permissible to either delay, rearrange, shorten or even cancel teaching sessions. This must be assessed on a case by case basis by the Medical Director, Chief Nurse or nominated deputies. When considering this action there must be specific tasks required to be immediately performed by the individuals released. Consideration should also be given to the impact on staff and to the trust of not receiving the scheduled training including not achieving mandatory training targets and affect it may have on morale and retention.
- 19.6. ***Critical Care Department to take over running cardiac arrest teams*** – In times of heightened Trust activity, the pressure often falls unevenly on Directorate groups with the ED, On call & Acute Medicine and On call Surgery teams often taking the brunt of the increased workload. Resuscitation is a required competency for ALL anaesthetic staff and forms a part of their mandatory training compliance matrix. This action takes staff reallocated anaesthetic staff from cancelled lists in theatres and uses them to relieve some of the pressure on the on call teams, freeing the Acute Medical on call team who mostly make up the majority cardiac arrest team to carry out other duties, improving efficiency and flow within the hospital.
- 19.7. ***Reallocation of ALL Clinical Staff from office or supernumerary duty*** - During normal working hours and in some areas out of hours there may be a number of clinical staff carrying out administrative or other supernumerary duties. This action mobilises this resource by allowing the divisional teams and their Operational commander to reallocate them to areas of need.

- 19.8. **Additional provision of transport services** – This may need to be purchased or requested from partners to enable transport of increased numbers of patients able to be discharged from the acute Trust to their onward destination.
- 19.9. **Formation of a medical outliers team** – Medical outliers are often reviewed less often and at a later point in the day than those on the base wards. It may be possible for Medicine and Emergency Care Division to create a team consisting of a decision maker (Consultant or Senior Registrar) and an SHO from redeployed staff, to facilitate rapid review of all medical outliers with a view to identifying potential discharges and improving patient safety. This will also ease pressure on the base wards staff.
- 19.10. **Allocation of Site Directors, and senior staff to support board rounds** – In times of increased demand on services it may be helpful to provide additional support and challenge to the board rounds. Clinical Directors will often be directly involved in seeing patients at this point so this roll would most usefully be carried out by Site Directors, in addition to Divisional Directors of Operations and Directors of Nursing and Quality for all services.
- 19.11. **Maximum use of external support / working with Partners** – Good escalation management happens when health and social care partners come together to resolve pressure system-wide. ED Performance is one measure of a whole health and social care system experiencing pressure, but it is not the only one. An ED could be experiencing isolated difficulties but the rest of the system is coping well; there are sufficient beds available and there is good flow through the system. Alternatively, an ED could be managing well whilst the rest of the hospital, and the wider system; community beds, community services and social care are experiencing high pressures due to a lack of capacity. Local ED Delivery Boards have aligned their existing systems to the escalation triggers and terminology used within OPEL
- It is important that the Trust is able to assure healthcare partners that all internal measures have been taken before escalating to the highest escalation status
 - Full escalation to whole system OPEL 4/Black will be decided in conjunction with Partners
 - A list of all required external beds should be constructed with patient level detail ready to pass to partners for action. This should include details of patients waiting for social care, complex POC, equipment, inter-hospital transfers, EoL pathways, anything that could benefit from spot purchasing.
 - Communications to local GP surgeries of trusts current status
 - Notification of 111 provider of trusts current status
 - Support for MTW in widening the criteria for commissioned community beds, enabling more patients to be transferred from the Acute Trust site

- 19.12. **Provision of additional emergency operating lists to create surgical ward capacity (Ortho, General surgical,)** – At any point the surgical wards have numerous patients admitted awaiting emergency or urgent surgery. By cancelling elective work, additional emergency lists can be run clearing this backlog and creating surgical beds.
- 19.13. **Request ambulance diverts** - This should be one of the final options when the Trust is in a critical internal incident. The decision to request a divert can only be made by an Executive Director
- 19.14. **'Boarding' Protocol** – The Trusts Boarding Guidelines define this as “A patient residing on a ward without an allocated bed space”. Protocol describes the placing of an additional patient on each ward despite there being no upcoming discharge. It is a far from ideal situation and puts an additional strain on ward staff, poses patient safety risks and delivers poor patient experience. It therefore should only be carried out in extremis, essentially when all other options have been exhausted and the ED is non-functional presenting a greater risk to patient safety within that department. The Boarding of patients should be considered by the Operational and On Call teams when a number of the following criteria are indicated:
- No care space in ED
 - Trust escalation status >OPEL 2
 - ED escalation status >AMBER
 - >20 unplaced patients (DTAs) in ED at 8am
 - Resus full with level 2 dependency patients with incoming priority call and no immediate allocated bed space
 - >3 Ambulances being held for >45 minutes
 - Potential 12 hour ED trolley breach

The full 'Boarding Guidelines' document is included as Appendix 4.

20. Stand Down

- 20.1. The stand down of the Trusts Full Capacity Protocol response will by necessity be phased across responding departments and areas. Stand down will be led by an executive and or agreed with by the COO / DCOO which will be communicated to staff via the Trusts Everbridge alert system, phone and email.
- 20.2. Review of the 'Step Down' and final 'Stand Down' of the Full Capacity Protocol will be instigated by the COO/DCOO within 24 hours of activation (or sooner if reasonably practicable) to ensure that all measures are in place and being taken in a timely manner. It remains the responsibility of the COO/DCOO to minimise the time the Full Capacity Protocol is enacted for to ensure the Trust can return and maintain its core business for as long as possible.

- 20.3. Review will take place after 24 and then 48 hours (or sooner if practicable). It is not expected that the Full Capacity Protocol will be in operation for more than 48 hours in any one time. If this is required then urgent review should be led by the COO/DCCO as to the actions being taken across the Divisions to ensure they are ambitious in terms of outcomes and clinically led in terms of effectiveness.
- 20.4. Key areas for consideration will include:
- Staff Welfare through response and recovery phases
 - The reinstating of any cancelled elective or urgent activity
 - The re-opening any closed clinics
 - The need to re-stock equipment and consumables used in the response
 - The financial impact of the response
- 20.5. Upon stand down it is the responsibility of local managers to ensure that all responding staff receive a basic immediate debriefed; the department is restocked ready for resumption of 'normal' business and all records and logs created during the response are secured for future reference in the ICC.
- 20.6. The Incident Coordination Centre will continue to operate with Strategic Command until the hospital is able to return to safe activity levels.

21. Training

- 21.1. It is an essential element of this plan that all staff members are aware of their role in the Trust's response. It is the responsibility of all managers to ensure that appropriate training is made available to their staff. Support is available for local training at team meetings and regular training sessions.
- 21.2. It is highly recommended and encouraged for new staff members to spend at least a day with the CST as part of their induction. In addition staff such as Senior Managers on call and Executive on call will have training through a simulation exercise prior to this protocol going live and on a regular basis moving forward.

22. Audit and Monitoring

- 22.1. When this protocol is activated, at de-escalation there will be a debrief which will include lessons learnt which will form part of the audit process. This will be reviewed every 3 months.
- 22.2. Key findings and learning points will be disseminated to relevant staff.

23. References

- CQC Fundamental Standards 2014.

- Full Capacity Protocol, Portsmouth Hospitals NHS Trust, 2017
- Full Capacity Protocol, Liverpool and Broadgreen University Hospitals NHS Trust, 2013
- Full Capacity Protocol, Barking Havering and Redbridge University Hospitals NHS Trust, 2014
- ECIP

24. Appendix 1 – Full Capacity Checklist

The COO / DCOO (or Executive on-call out of hours) (or nominated deputy) should be present in the Trust within 60 minutes of activation of the Full Capacity Protocol	
Twice Daily Senior Review of ALL Patients	
Transfer of Patients from Assessment Units to Wards whilst awaiting a Bed	
Specialty In-reach to the Emergency Department – Contact details <ul style="list-style-type: none"> • Acute Medicine • Cardiology • Respiratory Medicine • Gastroenterology • Obstetrics • Frailty Team • Critical Care • General Surgery • Trauma & Orthopaedics • Urology • ENT • Gynaecology • Paediatrics • Radiology • Discharge Team • Therapy/Pharmacy Team • Social worker 	
Admission from Clinics	
Cancellation of Non-Urgent Elective Activity	
Cancellation of all Non-Urgent Meetings, Sub-Committees and Committees	
Cancellation of Educational Activities	
Additional Nursing Support	
Portering	

25. Appendix 2 - Roles and Responsibilities of Staff

25.1. *All Internal MTW Staff*

It is the responsibility of **all** Trust employees to adhere to the protocol and deliver the process to the best of their ability and ensure:

- As clinically appropriate, emergency patients requiring hospital admission via the ED are allocated and safely transferred within four hours of attending the ED ensuring compliance with the 4 hour wait access standard (95%).
- No elective admissions are cancelled due to lack of bed availability.
- Ensuring the Trust's ability to receive Critical Care patients which includes; Intensive Care, Respiratory NIV patients and Stroke will be assured at all times.
- Divisions will manage their daily workload - both elective and emergency within their bed base, and will develop strategies for reducing/eliminating reliance on outlying of patients.
- Divisions will have robust processes / a plan in place for ensuring escalation capacity is made available at times when respective Divisional bed base is fully utilised.
- The overarching accountability for the safe movement / transfer of patients is managed and coordinated appropriately by the Site Team and compliance with Infection Control Policies and guidance will be adhered to at all times.
- All requests for patients being transferred from other hospitals, overseas, or those with suspected or confirmed infection must be coordinated via the Site Team.
- Every effort will be made to limit the movement of infectious patients across the hospital site and only do so when the patient's clinical condition requires it.
- That the Trusts' bed stock will be used efficiently and effectively.
- Patients are moved to the wards from ED/Assessment Areas within 30 minutes of the bed being vacated.
- Symphony, Allscripts and TeleTracking will be updated simultaneously and in real time.
- The Trust bed base should remain in positive balance each day (for

every patient admitted there needs to be a patient discharged)

- Ensure that patients with an infection prevention and control alert are not transferred to other wards unless clinically indicated or advised by the IPC team.
- Ensure that information about patients is communicated to receiving wards and departments in advance to ensure that appropriate facilities are available and any special arrangements are in place.
- Datix any identified incident as appropriate.
- Undertake risk assessments for patients they identified that need to be moved within the Trust that is not on the patient's usual pathway.
- Risk assessments for patient moves are completed prior to any patient movement taking place.
- Minimise the number of bed moves per patient.

25.2. Chief or Deputy Chief Operating Officer / On Call Director

- Attend Ops meetings at times of heightened Escalation
- Be able to recognise trigger points and strategically plan to mitigate risk of escalating further
- Act as an escalation resource for the Operational Site Director and or the Senior Manager taking the strategic lead and lead decision making to resolve issues
- Early intelligence gathering from Emergency Planning team to ensure current, accurate information for decision making stakeholders
- Lead on external discussions with partners at Director and Chief of Service level
- Authorise use of escalation capacity with Divisions
- Lead discussion and planning of cancellation of elective patients for all surgical and medical specialties
- Responsible for all Capacity and Escalation activity within the Trust and responsible for making the decision to escalate to Trust OPEL 4/Black following conversation with appropriate stakeholders.

25.3. *Site Director and Senior Manager on Call*

- Attend cross site meetings at all times and at the heightened escalation state base in site office to ensure plans are in place to manage patient safety and flow.
- Be able to recognise trigger points and work with the site team in mitigating further escalation
- Act as an escalation resource for the Clinical Site Team site team
- Lead on external discussions with partners at senior manager level during heightened escalation
- Escalate where appropriate to the COO / DCOO / On Call Director, keeping them updated on the current position
- Ensure the daily site report is current, accurate and distributed by CST

25.4. *Clinical Site Team*

- The Clinical Site Team is responsible for overseeing and promoting effective day-to-day operational co-ordination of Trust-wide capacity flow. This includes monitoring of departmental escalation statuses and delivering the overall Trust OPEL actions in partnership with the Site Director.
- During Critical Incidents the CST will advise the Care Coordination Centre (CCC) on the management of the available beds within the Trust, and will be supported by CCC team to maximise patient flow and create additional capacity.
- Lead the 3 x daily cross site meetings and provide a summary of actions and feedback
- To hold an overview of the Trust's position with regards to capacity and to keep the CCC up to date
- Capacity activity data will be entered at least on a four hourly basis at which times the internal escalation status is reviewed, and communicated as appropriate internally and externally and ensure Divisions and partners are working to the same triggers
- To be available to receive escalations from all staff across the Trust
- To liaise with South East Coast Ambulance Service NHS Foundation Trust (SECAmb) in ensuring Ambulances are not being held on the site

- To liaise (and meet regularly) with ED Nurse in Charge, utilising HealthRoster to ensure staffing is addressed if patients are queuing in ED
- To coordinate the resolution of any potential 12 hour DTA breaches
- To undertake /oversee risk assessments for patients that are moved within the Trust that is not on the patient's usual pathway as identified by the non-clinical team.
- All requests for inappropriate patient moves are highlighted and challenged with the person requesting the patient transfer.
- Request that clinical staff also complete risk assessments and transfer of care processes between wards prior to any patient moves taking place, and that all documentation is complete prior to movement.
- Only private ambulances/taxi's may be authorised through the Site Team

25.5. ED Nurse in Charge

- To monitor and escalate following the ED trigger escalation tool and be prepared to initiate further escalation measures alongside the senior ED Doctor responsible for ensuring timely processes: Redeploying staff as appropriate
 - Triage
 - Treatment
 - Referral
- Inputting correct DTA's on the system, anticipating timely patient moves out of the department, (regular liaison and meet with CST)
- Report concerns of operational, clinical or patient safety compromise to the Emergency Consultant in Charge or On Call Consultant, to work in conjunction with the ED teams to mitigate risk and respond to demand and to flag concerns or safety issues to the ED Matron, DDNQ and CST.
- To ensure the continued application of the 15-minute assessment to all ambulance arrivals including those held within ambulance handover and in ambulances
- To follow and implement the ED Triggers and plan to ensure Ambulances are not held with patients and those patients continue to have the required 15-minute assessment.

- Are responsible for implementing internal escalation plan actions when delays to processes are known.
- To liaise with CST to deliver flow of referred patients into the Trust under the Full Capacity Escalation Plans.
- Responsible for escalating to the CST when activating internal ED escalation plan

25.6. Ward staff

- The Nurse looking after the patients is responsible for the proactive management and care including individual discharge arrangements, ensuring that:
- A full assessment of the patients clinical condition including infectious status
- The relevant documentation is completed on admission, and updated throughout the patients stay
- The patients physical 'norm' is identified on admission and when it is achieved so that discharge is not delayed due to non-recognition of their maximum capabilities
- Early communication with relatives, carers and or other internal and external agencies
- Referrals to the relevant multi-disciplinary team members are made in a timely fashion and the team is kept updated regarding the patients progress
- Communicate Expected Date of Discharge to ward clerks for accurate Allscripts recording, aiding accurate capacity planning
- A full assessment of social circumstances is undertaken on admission
- To undertake nurse led discharges as indicated by medical teams (Criteria Led Discharge)
- To promote safe and timely discharges so that the majority of activity occurs before 12:00
- Once a decision to discharge has been confirmed, the ward has 30 minutes to discharge patients directly or utilise the Discharge Lounge. Beds must be used in a timely manner to ensure safe

patient flow.

25.7. Ward Managers/Leads/Ward Nurse in Charge

- At the start of each shift, any empty bed must be rung through to the CST immediately to check they're aware of its availability.
- The NIC is clearly identified on ward allocation boards and carries the ward bleep / phone.
- The NIC is responsible for ensuring that accurate, timely information around beds is communicated either by telephone, or in person.
- Follow and achieve the targets within the Patient Flow Bundle SAFER for the ward area
- Ensure flow is maintained by declaring beds within 15 minutes of being vacant, updating Allscripts and TeleTracking and pulling patients into empty beds within 30 minutes
- Ensure any blocks to discharge are escalated to relevant CST team and through to CCC
- To promote the identification of outliers and flag on white boards as appropriate
- Ensure all staff are aware of Trust Escalation status as appropriate
- Follow the relevant Trust Escalation Action Card
- Be prepared to support the medical team to identify outliers, accept off specialty patients, where clinically appropriate and review bringing forward discharge times and dates in times of heightened escalation
- It is imperative that all Trust policies for discharge are followed and that an Expected Discharge Date (EDD) is a confirmed part of the patient journey.
- To promote / request ability for nurse led discharges if medical team happy to instruct (Criteria Led Discharge)
- The NIC must ensure the Discharge Lounge is utilised unless the patient can be discharged directly from the ward within a maximum of 30 minutes.
- The Ward Manager has overall responsibility of ensuring ward staff adhere to the capacity and patient moves principles.

- Capacity Information required will include:
 - Current bed availability
 - Definite discharges planned for that day, and approximate timings of when those beds will be available for use
 - Potential discharges where proactive nursing intervention is required to expedite the process
 - Patients who are suitable for step down / escalation areas upon request and who are identified on the white board.

25.8. Directors of Nursing and Quality / Lead Matrons

- The senior nursing role is to proactively manage issues identified within their areas of responsibility and to promote safe and timely transfers and discharges.
- They also provide support and advice to ward teams and to support those teams in the management of effective discharges and identifying appropriate outliers.
- The senior nurses will work on the wards (as Ward Liaison Officers) when the Trust is experiencing high pressure on capacity to expedite discharges where possible.
- To work with lead medical teams to promote nurse led discharges (Criteria Led Discharge)
- The responsibility for progressing patients journey through MTW once medically fit belong the below nurse groups:
 - Ward Manager~ up to 7 days MFFD to leave acute bed date
 - Matron ~ 7 – 14 days MFFD to leave acute bed date
 - DDNQ ~ over 14 days MFFD to leave acute bed date
- The Trust may deploy a range of methods to resolve unnecessary delays of length of stay that exceeds patients fit to leave acute bed dates. Nursing staff should be aware that actions and attendance at meetings may be required. It is therefore important that nursing teams follow processes and devise ways of highlighting and minimising patient delays.

25.9. Divisional Management Teams

- The designated 'Operational Lead' to attend cross site meetings when alert level dictates or if requested to do so by CST
- Support clinical staff in achieving Patient Flow Bundle SAFER
- Be able to recognise trigger points within the escalation process which affect their own Division and liaise as appropriate
- Hold plans within the Division to mitigate the risk of rising escalation or as a way to recover from heightened escalation
- Receive escalations from the CST within the Division or other stakeholders and act upon them
- Follow relevant escalation action plans
- Ensure robust dissemination and implementation of the patient move process, enforcing key aspects of timely capacity management.
- Identification of any training needs and to ensure training of updated processes.
- Ensuring adequate facilities and resources are utilised to assist with adherence to this protocol. They are also ensuring that any changes in practice are implemented.

25.10. Medical Staff

- To ensure / monitor the management of inpatients adheres to Patient Flow Bundle SAFER
- Wherever possible, it should be indicated that a delegated professional may discharge a patient once criteria are met (Criteria Led Discharge)
- To respond proactively to requests of help in resolving the hospitals capacity state
- To be responsible for recording the Expected Date of Discharge in patients notes within 14 hours of admission and updated regularly thereafter
- A clear medical discharge/management plan must be recorded in the notes and updated regularly

- Support the team to ensure appropriate medical documentation is completed prior to the medical team leaving the area
- To support the outlying process and identify suitable patients when conducting board rounds
- If discharges are planned for a future date and the drug requirements are known, the TTO's and discharge summaries are prepared in advance of that date

25.11. *Divisional Directors of Operations and Clinical Directors*

- To ensure /monitor the management of inpatients adheres to Patient Flow Bundle SAFER
- To promote 'nurse led discharges' / Criteria Led Discharges where safe and appropriate to do so
- To respond proactively to requests of help in resolving the hospitals capacity state
- To ensure a nominated deputy is known if unavailable
- To communicate and coordinate capacity escalation actions as appropriate
- Ensure that all actions are followed within the relevant escalation plans are completed in a timely manner with any issues being reported back to the Site Director
- To support the decision made by the Trust executive team to utilise escalation areas, convert SPA/admin time to DCC, and to reschedule routine activity as appropriate
- It is imperative that all Trust policies for discharge are followed and that an Expected Discharge Date (EDD) is a confirmed part of the patient journey.

25.12. *The Integrated Discharge Team (IDT)*

- On a daily basis the Integrated Discharge Team will be identifying those patients whose discharge is delayed. Daily progress assessment will be held with partners in Social Care and the Health Community where all patients with a transfer of care delay will be individually discussed, and alternatives considered.
- It is imperative that all Trust policies for discharge are followed and that an EDD is a confirmed part of the patient journey.

- A senior member of IDT will attend all Site meetings and provide feedback re community capacity and patients identified for resources
- A senior member of the IDT will carry a bleep for escalations
- The IDT team are responsible for ensuring the community transfer list is accurate and maintained in conjunction with ward staff
- They are responsible for liaising with wards and community partners re transfers and encourage ward staff to plan and enable timely transfers to community beds and discharges
- IDT staff will promote effective and timely communication with ward, departmental and own teams as well as external partners and relatives as appropriate.
- All Trust policies for discharge should be followed IDT staff will monitor and enforce this across MTW. The IDT have their own Escalation Plan/Procedure which will be followed at each Escalation status.

25.13. Therapy Responsibilities

- The therapy team contributes to the Multidisciplinary Team (MDT) discharge process using Occupational Therapists, Physiotherapists, Dieticians and Speech and Language Therapists who assess and aid: patient independence; safe mobility; timely discharge; effective nutrition and communication needs. Processes are also in place with other MDT teams in the community to aid the Trust's patient flow and enable effective discharge strategies to be implemented and delivered
- To prioritise new referrals at daily board meeting and respond within 1 working days
- Patients seen by an OT as part of wider MDT care pathway will be seen in line with agreed national and local standards, e.g. stroke patients to be seen within 72 hours from admission and for 45 minutes of rehabilitation per day.

25.14. Porter Team

- To respond proactively to requests from the CST that will enhance or enable particular patient flow pathways
- To ensure prioritisation of patient moves and actions required to expedite our patients journey

- To support the decision made by the Trust executive team to utilise escalation areas as agreed
- To communicate and coordinate capacity escalation level as appropriate and ensure actions are followed timely and fed back as appropriate

25.15. Catering Team

- To respond proactively to requests from the CST to ensure situational awareness.
- To support decisions made to escalate areas to ensure patients nutritional needs are met through timely delivery of catering services
- To communicate and coordinate levels of escalation to the wider team to ensure sustainable solutions are in place and feedback to CST concerns from local teams

Strategic Commander : Chief (Deputy) Operating Officer

- Strategic command has overall command of the Trusts resources
- Liaising with partners to develop the strategy to manage the OPEL 4 / BLACK status and work towards de-escalation.
- Delegate decisions / actions as appropriate to Tactical Commander
- Receive Tactical Commander escalations and aim to resolve at Tactical & Operational level
- Attend / lead Strategic meetings with external partner agencies
- Assist with the resolution of issues reported where ever possible to facilitate better patient flow
- Ensure business continuity at all times.



Tactical Commander : Head of CCC/ICC or Director of Operations – Patient Flow or Tactical on Call

- Responsible for directly managing the hospitals incident response and recovery
- Ensure CCC / ICC suitably resourced, functioning efficiently and commence the incident log
- Develop the plan which will achieve the objectives agreed with Strategic Commander and assist with de-escalation as soon as possible
- Lead Tactical Command / CCC / ICC meetings
- Receive Operational escalations facilitating the actions to resolve
- Be visible and available within CCC / ICC to provide leadership within the room
- Ensure business continuity at all times.



Operational Commanders : Site Director supported by DDoO's & DDNQ's

- Operational Commanders will be responsible for managing the main working elements and practices of the Trusts response
- Established in site office working closely in partnership with CCC
- Liaising closely with ED NIC & ED DrIC to support the agreed plan and convey this through to the wards and Assessment Areas resolving blockages on the way
- Escalate to the Tactical Commander any operational issues that cannot be resolved locally and need greater support (e.g. PPE shortages, Workforce, mutual aid requests, system wide resources)
- Be present and visible in ED and all affected clinical areas to support staff and patient safety decision making
- Assist with the resolution of issues reported where ever possible to facilitate better patient flow
- Ensure business continuity at all times.

27. Appendix 4 – ‘Boarding Guidelines’

BOARDING GUIDELINES

In the context of these guidelines, a boarded patient is defined as:

“A patient residing on a ward without an allocated bed space”

Purpose and rationale for these guidelines

The purpose of these guidelines is to ensure there are robust processes in place to provide assurance that patient safety is being maintained when the Trust is experiencing increased challenges managing demand and patient flow.

These new guidelines describes the process of risk sharing across the Trust when the Emergency Department (ED) has more patients than it can safely care for and supports the sites with maintaining patient safety, the provision of high quality care and a good patient experience.

Unlike many departments the ED must remain open. When all available patient care spaces are occupied, the risk of serious incidents happening not only increases with every new patient that arrives, but is concentrated in one area.

NHSI and our own MTW data shows that mortality increases for patients with avoidable long waits in ED. Allocating one extra patient (boarding) to suitable wards will share this risk across the Trust, Improve patient outcomes and reduces the risk in ED.

MTW’s Emergency Departments (ED) sees between 360 and 460 patients per day depending upon the time of week, season or weather.

At Maidstone Hospital the department has the capacity to care for 22 adult patients in trolley or bed spaces across 3 areas (majors, resuscitation, minors - excludes pediatrics).

- 9 in majors
- 2 isolation cubicle
- 4 in Resuscitation
- 7 in minors
- Pediatrics in ED have 5 care spaces
- RAP 4 spaces

At Pembury Hospital the department has the capacity to care for adult patients in 33 trolley or bed spaces across 3 areas (majors, resuscitation, minors - excludes pediatrics).

- 18 in majors
- 1 isolation cubicle
- 6 in Resuscitation
- 8 in minors.
- Pediatrics in ED have 6 care spaces
- RAP 5 spaces

When these spaces are full and ambulances are unable to offload it is recognised that there will be times when the hospital needs to operate differently.

27.1. Triggers for activating patient boarding

The Boarding of patients should be considered when a number of the following criteria are met.

- No care space in the ED
- The Trust escalation status is OPAL 3 or 4
- The ED escalation status is RED or BLACK
- More than 20 unplaced patients waiting for a bed at 8am
- Resus is full with level 2 dependency patients with incoming priority call and no immediate allocated bed space
- There are more than 3 ambulances being held for more than 45 minutes.
- Potential 12 hour ED trolley breach.

Levels of Boarding

Level one -

Boarding against identified discharges will be considered when ED has 20-25 unplaced patients with decisions to admit (DTA's), plus 2 of the triggers above

Level two -

Boarding patients on wards without identified discharges when DTA's are 25-30 and one of the above triggers.

Level three-

Boarding of patients will occur when there are 35+ patients with a decision to admit unallocated at 08:00 hrs

Note: in the first instance

Matching boarded patients to their specialty will always be considered but may be overlooked at level 4 if the number of DTA's at 08.00 hrs is plus 35

27.2. Activating patient boarding

The decision to escalate and activate patient boarding is not made by one individual alone but made together with the clinical teams, Chief Operating Officer, Operations Directors, and Divisional Directors of Nursing. OOH the decision is made by the Executive Director on call following discussion with the on call manger.

This decision should be considered seven days a week and should be taken as early in the day as possible, ideally at the 09.00 site meeting, however this decision may need to be made earlier in line with the triggers for boarding (as above). These decisions should be reviewed hourly by the Site Director.

27.3. Transfer of boarded patients to ward areas

The Site Director in conjunction with Divisional Directors of Nursing will decide, in conjunction with the Nurse in Charge of ED, Site Managers and the receiving ward, which patients are suitable to be moved to the wards. When a decision to board has

been made it is the responsibility of the NIC of ED or senior site manager to ensure that the patient and family are aware that the patients will be boarding on a ward. There should be documentation in the notes that reflects the conversation.

27.4. Criteria for transferring boarded patients to ward areas

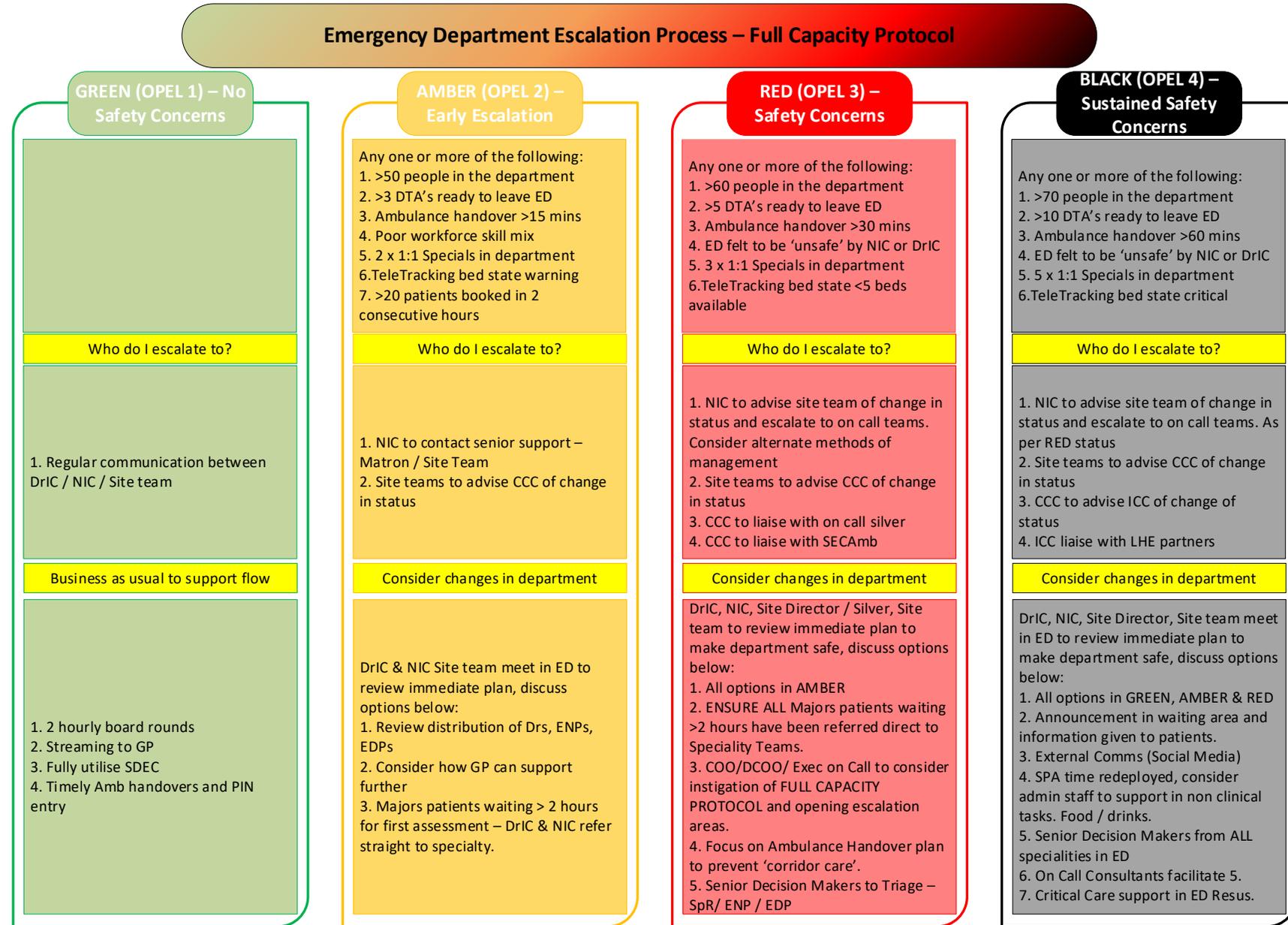
- Only patients with a decision to admit (DTA) in ED or CDU will be moved to suitable wards for boarding.
- Referred patients in ED should have a senior review and management plan documented by the on call registrar of the admitting team prior to transfer to the admitting ward.
- When transferring boarded patients it is the responsibility of ED staff to ensure that a comprehensive hand over is given to the nursing team. The patient must be escorted to the ward by a registered nurse.
- Only one patient per ward will be allocated. One ward named nurse (Registered or Support Worker dependent on the patient) must be allocated to care for the patient. In OPAL level 4 we will consider boarding a second patient
- Patients with cognitive impairment (e.g. delirium/dementia/mental health condition) should be given priority for a bed space.
- When the 'boarded' patient is bedded and the ward returns to its agreed bed base further patients can be admitted using the same criteria.
- The patient transferred from ED will be placed into the bed space and the patient awaiting discharge will be boarded outside the room. This allows treatments for the sickest patient to commence treatment without delay.
- The Infection control team should be made aware of any possible infection control risks.
- Screens should be available to maintain privacy and dignity of boarded patients.
- Patients requiring non – invasive ventilation should NOT be boarded, in this instance the patient who is mapped for discharge should be boarded to allow the patient requiring urgent intervention immediate access to a bed space.

- When boarded patients are on the wards any medications with the patient should be kept in a green pharmacy transfer medication bag and either locked in the ward drugs trolley or in a locked medicine cupboard in the clinical room.
- When boarding has been agreed, site matrons will be responsible for ensuring wards are safely staffed to receive one extra patient – this may mean moving staff from other areas.
- Tracking of boarded patients should be clearly visible in the site office and documented on the daily site reports which will be managed by site managers. An update on boarded patients will be provided at each site bed meeting so that appropriate plans can be put in place.
- Any patient boarded longer than 4 hours should be escalated to site managers and specialty matron. If there are any clinical concerns during the period of boarding these should be escalated to the site managers and matrons. An incident form should be completed when the period of boarding has exceeded 4 hours.

27.5. *Monitoring of compliance against guidance*

- The frequency of activation will be monitored by operational teams and recorded on site reports and on incident reports when boarding has exceeded 4 hours.
- Speed of transfer and the provision of the additional nursing support will be monitored by the Associate Directors of Nursing.
- Care of the additional patients on the ward will be monitored by the Senior Matron for the specialty.
- These guidelines will be reviewed at the weekly Chief Nurses Midwifery team meeting in relation to impact on provision of patient quality and safety.
- Impact on safety and care of existing patients on wards by reduced staff to patient ratios will be monitored by the Senior Matrons and reported through the Trust Clinical Governance Committee into the Quality Committee

28. Appendix 5 – Emergency Department Escalation



29. Appendix 6 – Quick Reference Action Cards	
Chief (Deputy) Operating Officer – Strategic Commander	
<i>Normal Working / Low Risk</i>	
<ul style="list-style-type: none"> Accountable for the management of beds as a Trust resource Accountable for confirming decisions on temporary bed usage Act as a resource for the Site Director in the operational management of the hospital 	
<i>Moderate Risk</i>	
<ul style="list-style-type: none"> Ensure community beds are utilised and available to MTW, challenging senior partners where appropriate Liaise with Site Director to ensure any delay are highlighted and acted upon Liaise with external partners to increase discharge opportunities Liaise with Emergency Planning Advisors to ensure current, accurate and intelligence based decision making 	
<i>High Risk – as above plus</i>	
<ul style="list-style-type: none"> Liaise with COO within SECAMB re actions to avoid queue delays Follow up actions with CoS, DDoOs & DDNQs to establish how they will be delivering the requirements Ensure staff welfare measures are in place at all levels to ensure a sustainable approach 	
<i>Very High Risk – as above plus</i>	
<ul style="list-style-type: none"> Agree OPEL 4 status with CEO Agree the responsibilities of ICC Take Strategic Command Lead for Trust 	

Director of Operations – Patient Flow & Head of Care Coordination Centre / ICC – Tactical Commander	
<i>Normal Working / Low Risk</i>	
<ul style="list-style-type: none"> Ensure a fully functioning CCC capable of stepping up to an ICC to manage a major / critical incidents and periods of heightened escalation Provide the Direction as to how the CCC / ICC will function agreeing key priorities Ensure solutions to support and enhance patient flow throughout the organisation for both elective and non-elective patients 	
<i>Moderate Risk</i>	
<ul style="list-style-type: none"> Liaise with Site Director to ensure a whole system support mechanism in place from the CCC Support the Divisional Triumvirates in the delivery of their escalation action plans Liaise with stakeholders to ensure staff safety and welfare measures are in place throughout all decision making 	
<i>High Risk – as above plus</i>	
<ul style="list-style-type: none"> Liaise with COO / DCOO to ensure that all Strategic decisions and actions are translated and actioned through the CCC Provide pragmatic solutions to Divisional problems via the CCC to support de-escalation actions Test Divisional plans to ensure a positive impact on patient flow. Challenge through the agreed structure plans not delivering improvements in flow 	
<i>Very High Risk – as above plus</i>	
<ul style="list-style-type: none"> Agree key priorities of the ICC with COO / DCOO Communicate the battle rhythm to the CCC / ICC for onward cascade Ensure robust Tactical plans in place and test these plans are impacting on flow positively Take Tactical Command Lead for the Trust 	

Site Director – Operational Commander
Normal Working / Low Risk
Moderate Risk
<ul style="list-style-type: none"> Act as point of escalation from Clinical Site Team (CST) Provide clear direction on decision making on issues above the authority or experience level of the CST Agree in advance the plan to open escalation areas out of hours as appropriate Ensure mechanisms in place for staff safety and welfare throughout decision making
High Risk – as above plus
<ul style="list-style-type: none"> Advising and signposting colleagues including external whole health and social care system partners, and other external agencies as required in order to prevent movement to OPEL 4 / Black Status Support the CST / Tactical on call Manager in making decisions on use of escalation bed capacity. Liaise with SECAMB as appropriate re risk of holding ambulances and plans to avoid or mitigate the risk Closely monitor situation to determine progress or further deterioration Liaison with On Call Directors for external partners requesting assistance and support
Very High Risk – as above plus
<ul style="list-style-type: none"> Liaise with COO/DCOO for sign off of OPEL 4 and activate plan Liaise with CCC / ICC to update on current situation and actions Take Operational Lead responsibility for Trust

Clinical Site Team & Tactical on call Manager
Normal Working / Low Risk
Moderate Risk
<ul style="list-style-type: none"> Act as point of escalation between ED / wards and Site Director Liaise with ED Consultant and ED NIC to attend 4 hourly huddles in ED 7 days a week Monitor flow acting on reduction of decision making or flow Monitor 4 hour standard closely and expedite actions to avoid delays Escalate to Directorate Triumvirate where discharge decisions are delayed Promote the use of the Discharge Lounge Monitor actions in Full Capacity Protocol if risk of delayed Ambulance handovers Ensure plans are in place to minimize and reduce escalation areas
High Risk – as above plus
<ul style="list-style-type: none"> Liaise with Directorate Triumvirates regarding staffing levels Ensure ward teams are following their action plans Escalate delays in repatriations to Site Director Liaise with SECAMB re HALO Support CCC / ICC in establishing a Command and Control structure as requested
Very High Risk – as above plus
<ul style="list-style-type: none"> Take direction from CCC / ICC / Site Director ensuring ED and ward areas are following actions plans Ensure current status is communicated to all clinical areas

Divisional Directors of Operations & Nursing, Quality
<i>Normal Working / Low Risk</i>
<ul style="list-style-type: none"> • Ensure that the Division has an up to date escalation and continuity plans • Ensure all staff understand their role in the plan • Ensure visibility of the Divisional leadership rota • Monitor and seek to improve patient flow bundle SAFER principles through internal professional standards
<i>Moderate Risk</i>
<ul style="list-style-type: none"> • Ensure all specialties have completed ward / board rounds as per SAFER principles. • Support clinical teams to unblock barriers around treatment/ transfer/ discharge • Review specific Directorate problems with GMs and Lead Matrons to resolve quickly • Respond to Site Directors requests for support in decisions affecting flow
<i>High Risk – as above plus</i>
<ul style="list-style-type: none"> • If elective clinics or theatre lists are cancelled agree how the clinical teams will be redeployed to support flow in partnership with CoS. • Agree Divisional leadership meetings to support completion of actions • Redeploy staff from areas with cancelled activity to support flow / CCC / ICC
<i>Very High Risk – as above plus</i>
<ul style="list-style-type: none"> • Ensure all elective sessions are cancelled to support flow • Nominate a Divisional lead to operate in CCC/ ICC • Ensure conversion of clinical staff training time and SPA time to direct clinical care activities support ED and Assessment areas

Chief of Service & Clinical Site Leads
<i>Normal Working / Low Risk</i>
<ul style="list-style-type: none"> • Ensure Medical workforce team understand and support the Patient Flow Bundle SAFER principles through robust internal professional standards • Ensure timely response from the Medical team to ED and Assessment areas as required • EDDs to be agreed by the admitting Consultant with 24hours of admission • Early identification of potential discharges with good criteria led discharge plans • Timely completion of the EDNs • Assist Site Director to unblock any barriers to treatment, transfer, discharge or patient flow
<i>Moderate Risk</i>
<ul style="list-style-type: none"> • Ensure Consultant body review management plans for all patients, consider alternative pathways and use of H@H • Ensure Consultant body review all outliers daily with clear plans in the notes
<i>High Risk – as above plus</i>
<ul style="list-style-type: none"> • Agree discharge and admissions thresholds with the Consultant body • Ensure additional Senior Decision Makers can support ED and Assessment Areas • Consider cancelling non-urgent elective activity • Redeploy staff from SPA
<i>Very High Risk – as above plus</i>
<ul style="list-style-type: none"> • Ensure all non-clinical activity is cancelled and medical teams are redeployed accordingly • Liaise with DDoO to cancel appropriate levels of outpatient activity to release senior staff to ED and Assessment Areas • Focus the medical team on daily / twice daily ward rounds and the use of community / alternative pathways.

Heads of Performance & General Managers
<i>Normal Working / Low Risk</i>
<ul style="list-style-type: none"> • Offer support and advice where needed to CST and Site Director regarding patient flow and activity • Ensure Directorate escalation and continuity plans are robust and current • Communicate the Trusts key messages around flow to all areas
<i>Moderate Risk</i>
<ul style="list-style-type: none"> • Take responsibility for decision making in order to enact the actions of the Site Director • Ensure timely response from all medical teams actions to support flow • Escalate quickly blockages in terms of flow to Divisional Leadership team
<i>High Risk – as above plus</i>
<ul style="list-style-type: none"> • Review Directorate specific problems with Divisional Directors to resolve quickly • Support the Site Director and CST to flex job planned activities / escalation areas • Produce a plan for cancelling non-urgent elective activity to present to Divisional Directors
<i>Very High Risk – as above plus</i>
<ul style="list-style-type: none"> • Take direction from Divisional Directors to: <ul style="list-style-type: none"> ○ Liaise with all clinical and Medical teams to ensure a Directorate wide approach to the current situation ○ Recall staff from SPA, training and admin duties to direct clinical activities ○ Liaise with all Directorate Consultants to ensure the pathways support improving flow through ED and Assessment Areas.

Lead Matrons / Matrons
<i>Normal Working / Low Risk</i>
<p>Support Matrons / Ward Managers to:</p> <ul style="list-style-type: none"> • Ensure TeleTracking is accurate and up to date in terms of bed occupancy • Ensure White Board is current • Ensure Senior review (SAFER) of new, unwell or potential discharges before 10am • Ensure accuracy of EDDs within 24 hours of admission • Ensure all patients have a clear management / discharge plan • Ensure early use of Discharge Lounge • Ensure good communication of current status • Ensure staffing levels to meet demand
<i>Moderate Risk</i>
<ul style="list-style-type: none"> • Ensure Directorate Triumvirate manage activity levels • Support changes in practice / scheduled activities to engage in discharge planning • Facilitate where required escalation space
<i>High Risk – as above plus</i>
<ul style="list-style-type: none"> • In partnership with GM ensure timely medical reviews of all patients • Liaise with DDNQ to ensure safe staffing is promoted in all areas • Supports CNSs providing in reach to ED and assessment Areas
<i>Very High Risk – as above plus</i>
<ul style="list-style-type: none"> • Directorate Triumvirate to cancel all non-clinical activities and ensure staff are focused on flow • Take direction from DDNQ to ensure Directorate teams understand the action plans

Middle Grades & Junior Doctors
<i>Normal Working / Low Risk</i>
<ul style="list-style-type: none"> • Adhere to Patient Flow Bundle SAFER principles • Ensure TTOs are completed the day before to support early discharge. • Ensure all patients have an EDD within 24 hours from admission • Ensure all outlier have a clear plan and are seen daily • Ensure all MFFD patients have a clear plan • Ensure Senior Review happens for all new, unwell and potential discharges before 10am.
<i>Moderate Risk</i>
<ul style="list-style-type: none"> • Ensure all diagnostics / treatments have been ordered / chased and then acted upon. • Escalate all patient safety / flow / delays to Consultant.
<i>High Risk – as above plus</i>
<ul style="list-style-type: none"> • Review medical management plans for ALL patients; consider community H@H and alternative pathways. Discuss with Consultant delays in plans. • Cancel non-clinical activities other than mandatory training and ensure presence on ward to support flow.
<i>Very High Risk – as above plus</i>
<ul style="list-style-type: none"> • Take direction from Consultant body with regards to supporting twice daily reviews and in reach to ED and Assessment Areas

Ward Manager & Nurse in Charge
<i>Normal Working / Low Risk</i>
<ul style="list-style-type: none"> • Ensure TeleTracking and WhiteBoard are accurate and updated in a timely manner • Ensure Senior Review happens of new, unwell and potential discharges before 10am. Escalate to Matron if this does not happen • Ensure ALL patients have an EDD 24 hours from admission • Ensure ALL patients have a robust clearly documented management plan • Promote use of the Discharge Lounge • Ensure Ward Clerk / Flow Coordinator follow escalation process
<i>Moderate Risk</i>
<ul style="list-style-type: none"> • Work with Matron / GM and Consultants to ensure the ward can manage the expected activity level • Ensure all outliers have at least a daily review
<i>High Risk – as above plus</i>
<ul style="list-style-type: none"> • Plan to accommodate off specialty patients including outliers in liaison with Matrons • Liaise with Consultant to plan for alternative care pathways, criteria led discharge and H@H.
<i>Very High Risk – as above plus</i>
<ul style="list-style-type: none"> • Focus on simple discharges and ensure ALL patients are considered for H@T

AMU & AAU Ward Clerk / Flow Co-ordinator
<i>Normal Working / Low Risk</i>
<ul style="list-style-type: none"> • All patients to be transferred within 30 minutes of bed allocation. • Ensure TeleTracking is accurate and current • Actively pull patients through from ED • Escalate patients with LOS >48 hours to Ward Manager / NIC who are not due to discharge today • Actively promote TTOs & EDNs for tomorrows discharges • Ensure all patients waiting on discharge dependent diagnostics are made aware to the CST. • Promote adherence to SAFER principles
<i>Moderate Risk</i>
<ul style="list-style-type: none"> • Work with NIC to ensure a timely review of all patients
<i>High Risk – as above plus</i>
<ul style="list-style-type: none"> • Review SDEC and Acute Assessment areas to ensure the flexible use of all space • Plan to hand patients over to off specialty wards • Recall staff on admin / study days • Support additional ward rounds
<i>Very High Risk – as above plus</i>
<ul style="list-style-type: none"> • Prepare to open additional escalation space as directed

Emergency Department – Nurse in Charge (NIC)
<i>Normal Working / Low Risk</i>
<ul style="list-style-type: none"> Attend site meeting at 0900 taking an up to date overview of the department With ED Consultant lead (DrIC) attend 4 hourly huddles in ED 7 days a week Ensure transfers out of ED within 15 minutes of bed being available from CCC Fully utilise Discharge Lounge, SDEC and Acute Assessment Areas to manage patient pathways Escalate patients without 1st assessment within 60 minutes to the DrIC or SpR Escalate patients at 3 hours without a plan to DrIC and CST Ensure agreed escalation process is followed for patients referred but not reviewed by Specialty team within 30 minutes. Escalate any intra-professional issues Liaise with ED Matron to prevent 4 hour breaches
<i>Moderate Risk</i>
<ul style="list-style-type: none"> Ensure a systematic review of all patients by Con / SpR or Specialty Dr Ensure all patients awaiting discharge dependent diagnostics are escalated to Divisional team / CST Utilise seated areas and SDEC where possible
<i>High Risk – as above plus</i>
<ul style="list-style-type: none"> Prepare staff to meet Ambulance queues Review staffing and escalate ratio concerns Ensure CCC aware of current demand Recall staff from study leave or admin time Liaise with DrIC to plan for alternative care pathways
<i>Very High Risk – as above plus</i>
<ul style="list-style-type: none"> Follow action plan from CCC / ICC to support flow

Emergency Department – Consultant in Charge (DrIC)
<i>Normal Working / Low Risk</i>
<ul style="list-style-type: none"> With ED team lead 4 hourly huddles in ED 7 days a week Prioritise patients without 1st assessment within 60 minutes to the ED medical team Prioritise patients at 3 hours without a plan to medical team requesting an urgent plan to agree Prioritise patients referred but not reviewed by Specialty team within 30 minutes. Raise any intra-professional issues with Specialty Consultant for action Liaise with ED Matron to prevent 4 hour breaches
<i>Moderate Risk</i>
<ul style="list-style-type: none"> Prioritise medical teams to provide a systematic review of all patients Ensure all patients awaiting discharge dependent diagnostics are prioritised and followed up by the requesting Dr Utilise seated areas and SDEC where possible to stream patient flow
<i>High Risk – as above plus</i>
<ul style="list-style-type: none"> Prepare medical to meet Ambulance queues Review medical staffing and escalate ratio concerns to CD / CoS Ensure CCC aware of current demand Recall medical staff from study leave or SPA time Liaise with CD / CoS to plan for alternative care pathways
<i>Very High Risk – as above plus</i>
<ul style="list-style-type: none"> Follow action plan from CCC / ICC to support flow

Critical Care General Manager / Theatre Team
<i>Normal Working / Low Risk</i>
<ul style="list-style-type: none"> Review theatre capacity for emergency and elective lists, ensure plans are in place to utilise resources effectively to avoid cancellations
<i>Moderate Risk</i>
<ul style="list-style-type: none"> Review the level of emergency cases ensuring that patients who require surgery today receive their treatment promptly Review with Divisional leads if patients can move to day case surgery Facilitate the cancellation of non-urgent elective activity with Divisional leads Surgical Specialties to agree which patients can go to theatres and liaise with relevant coordinators
<i>High Risk – as above plus</i>
<ul style="list-style-type: none"> Surgical Specialties compile a list of those patients who are ‘clinically urgent’ and must receive surgery on the day. Liaise with Matrons to ensure staff from cancelled lists are redeployed to support ED, Assessment Areas and wards Liaise with CST to ensure bed numbers are understood
<i>Very High Risk – as above plus</i>
<ul style="list-style-type: none"> Facilitate the use of theatre recovery areas as directed by the CCC / ICC

Integrated Discharge Manager / Team
<i>Normal Working / Low Risk</i>
<ul style="list-style-type: none"> Working with external partners to ensure smooth and safe discharge
<i>Moderate Risk</i>
<ul style="list-style-type: none"> Increase the pace of pulling patients from ward areas Escalate promptly delays seen at ward level preventing a patient’s timely and safe discharge. Escalate promptly failure of wards to use Discharge Lounge Proactively assess transport provisions to ensure capacity without delay Seek additional support through external partners recommending to Operational and Tactical Commanders levels of community provision required
<i>High Risk – as above plus</i>
<ul style="list-style-type: none"> IDT Lead to be present at all site meetings providing sitreps on current and upcoming discharges Focus on ‘quick wins’ supporting wards to safely discharge the less complex patients today
<i>Very High Risk – as above plus</i>
<ul style="list-style-type: none"> Follow CCC / ICC guidance to ensure IDT working across the site in areas requiring greatest focus Consider additional workforce requirements to support IDT team members to increase cover

Information Technology & Business Intelligence
<i>Normal Working / Low Risk</i>
<ul style="list-style-type: none"> • Monitor OPEL status and if escalation status is changed by Operational Commanders share this with Head of IT & BI • Support CCC / ICC with sitreps
<i>Moderate Risk</i>
<ul style="list-style-type: none"> • Monitor Divisional escalation plan requests for equipment / information to support Divisional attempts to improve flow • Consider level of support in CCC / ICC with increased pressure on Trust
<i>High Risk – as above plus</i>
<ul style="list-style-type: none"> • Prioritise requests from Divisional leads to support OPEL 3 & 4 actions • Increase workforce requirements to support CCC / ICC escalation status
<i>Very High Risk – as above plus</i>
<ul style="list-style-type: none"> • Work in partnership with CCC / ICC to support Tactical and Strategic priorities

Estates & Facilities
<i>Normal Working / Low Risk</i>
<ul style="list-style-type: none"> • Ensure Portering and domestic support present in CCC 24/7
<i>Moderate Risk</i>
<ul style="list-style-type: none"> • E & F zone supervisors present at site meetings • Liaise with E & F support staff in CCC • Be fully aware of Divisional escalation priorities
<i>High Risk – as above plus</i>
<ul style="list-style-type: none"> • Prioritise requests from Divisions that support ED and ward flow such as Portering , cleaning and transport. • Leadership team to prepare plan to extend hours and services existing workforce provide during periods of extreme pressure
<i>Very High Risk – as above plus</i>
<ul style="list-style-type: none"> • Work as directed through the CCC / ICC supporting Tactical and Strategic priorities

Ward Clerks and Receptionists
<i>Normal Working / Low Risk</i>
<ul style="list-style-type: none"> • Ensure Allscripts and TeleTracking systems are up to date with admission and discharge details • Ensure ALL patients have accurate EDDs recorded from Consultant led board rounds • Be prepared to provide up to date information to CCC as requested
<i>Moderate Risk</i>
<ul style="list-style-type: none"> • Ensure ward data is current and accurate and easily accessible through Allscripts and TeleTracking systems • Chase and escalate delays in treatment / discharge
<i>High Risk – as above plus</i>
<ul style="list-style-type: none"> • Prioritise actions from Board rounds to expedite discharges • Support ward staff in chasing and escalating treatment / discharge delays • Prioritise actions with IDT team
<i>Very High Risk – as above plus</i>
<ul style="list-style-type: none"> • Prioritise actions from CCC / ICC

Corporate
<i>Normal Working / Low Risk</i>
<i>Moderate Risk</i>
<ul style="list-style-type: none"> • All Corporate teams to monitor Trust escalation status and communicate this to the wider corporate teams
<i>High Risk – as above plus</i>
<ul style="list-style-type: none"> • Monitor and observe Trust escalation status • Clinical corporate staff to be prepared to support Clinical Operations Divisions as required • Review areas of Workforce and recruitment processes to ensure the Trust works differently to support escalation status
<i>Very High Risk – as above plus</i>
<ul style="list-style-type: none"> • Corporate / Trust meetings cancelled • Corporate staff to be available to Strategic, Tactical and Operational Commanders to support current pressure • Clinical corporate staff to work in clinical areas with clinical colleagues supporting areas of greatest pressure • Non clinical staff to support CCC / ICC and wards with liaison activities, loggists, portering, general runners and support roles

Executive Team Meeting (ETM)

Winter Wellbeing Plan / Cost of Living Crisis 2022-23

Reason/s for submission to the ETM (delete the tick for any that do not apply):

Decision	✓
Discussion	✓
Information	✓
Other – Request for funding of initiatives	✓

Link to corporate breakthrough objective/s (delete the tick for any that do not apply):

Reduce complaints re poor communication		Increase discharges by 12pm	
Reduce patient falls to 6.5 per 1000 OBD		Reduce premium workforce expenditure	✓
Achieve planned levels of new outpatient activity		Reduce staff turnover to 12%	✓

Summary of the report

Background

- Poverty in employment will be a reality for many of our staff due to the financial crisis
- Travel to / from work has become a significant concern for staff living further from their work base
- Working from home though the winter will cause financial hardship for many staff to keep warm
- The cost of living will and has placed significant pressure on some staff ability to buy food and pay rent/ mortgages

Analysis / conclusions

- Recruitment and Retention is a key focus for the Trust, supporting staff to remain in employment could make a significant difference to MTW's ability to fill shifts
- Provision of financial advice, information and signposting will support staff to mitigate some of their cost pressures

Recommendation/s

- Provision of a financial support package for the most significantly affected staff through this acute phase of financial crisis, to enable them to remain better off in employment rather than claim unemployment and other benefits

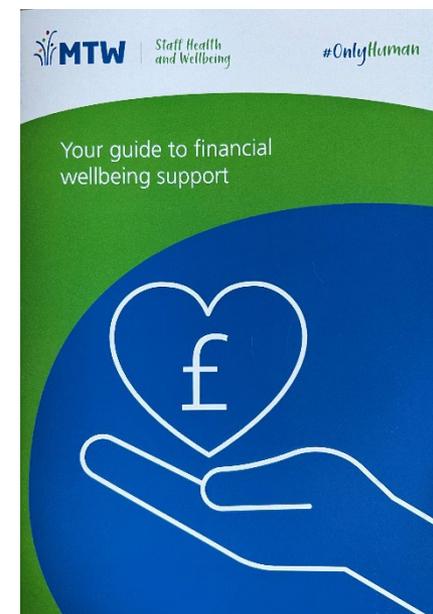
Introduction / background

The goal of the Winter Wellbeing programme is to:

- To proactively support staff to build self-awareness and self-care practice.
- Support managers and leaders to create team culture that supports wellbeing.
- Increase focus on Financial Welfare support
- Ensure staff know where and how to access support if they or others need it.
- Create and nurture a sense of community and togetherness.
- Meet the acute psychosocial health and wellbeing needs of individual staff members.
- Support the overall operational functioning of the organisation throughout the Winter.

Current Situation;

- Our Wellbeing Team are part of the networks run by NHS Futures and NHS E. This ensure MTW is up to date with new and emerging support offerings & initiatives.
- Our EAP service provides financial guidance and signposting. This aspect was almost unused until the last couple of years. There has – as yet – been no increase in uptake of the service.
- Very few staff have come forward to request foodbank vouchers through the Wellbeing Team. Significant promotion of the “banks” across the county may have supported staff to access them directly.
- Physical copies of the Financial Wellbeing booklet are now available and being distributed to staff with low levels of access to the intranet. These contain significant amount of guidance and signposting in line with current best practice; http://10.136.105.189/uploads/resources/313_Financial_Wellbeing_V7.pdf
- Trust intranet “Financial Wellbeing” page provides information and links, including NHS England pages on financial guidance and signposting



Current Support available to our People

 <p>Wellbeing Partners</p> <ul style="list-style-type: none"> -Direct support to wards -Mental Health Navigation -Financial Support navigation -Access to resources -Support for managers & teams with wellbeing practice <p>Health & Wellbeing Team</p>	 <p>In-reach & Bespoke Support</p> <ul style="list-style-type: none"> -Staffed email inbox --SIS Debriefs -Management support Mental Health First Aid Health and Wellbeing Team Psychological Team Occupational Health OD Team L&D Staff Engagement & EDI 	 <p>Wellbeing Lounges</p> <ul style="list-style-type: none"> -Recharge -Access Support -Mental Health Navigation <p>Health and Wellbeing Team</p>	 <p>Employee Assistance & NHS Staff Support</p> <ul style="list-style-type: none"> -Clear signposting for staff to access emotional support via EAP & NHS phone/ text line -Occupational Health MDT & Psychology input for treating staff with more complex needs <p>External contract</p>	 <p>Resources</p> <ul style="list-style-type: none"> -For individuals, teams & managers -NHS self management and wellbeing resources -MTW specific resources Staff Engagement & EDI L&D Libraries & Knowledge Health and Wellbeing Team 	 <p>Wellbeing Practice</p> <ul style="list-style-type: none"> -Acupuncture -Meditation -Mindfulness -Exercise -Craft activities <p>Psychological Team</p> <p>Health and Wellbeing Team</p> <p>L&D</p>	 <p>Escalation & Live Learning</p> <ul style="list-style-type: none"> -Regular feed back on staff wellbeing to relevant committee structures <p>Staff Engagement & EDI</p> <p>OD</p> <p>Health & Wellbeing Team</p> <p>FTSU</p>	 <p>Kent Wellbeing Hub</p> <ul style="list-style-type: none"> -Access to wellbeing and Psychosocial support <p>KMPT</p>	 <p>Welfare Support</p> <ul style="list-style-type: none"> -Financial support guidance internally and externally -Hardship funding for staff in need <p>Workforce Team</p> <p>Health and Wellbeing Team</p>
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Exceptional people,
 outstanding care

Cost of Living Support available now to our People

Item	Investment
Tea & Coffee	MTW Funded
Subsidised parking	MTW Funded
Wellbeing Lounges (marquees)	MTW Funded
Auricular Acupuncture training & Registration	MTW Funded
Free buss travel on direct routes to MGH & TWH including travel between sites and from Tonbridge Train station	MTW Funded
Financial Wellbeing information leaflets – including hard copy's	MTW Funded
Health Checks and MOT's – on site (Wellbeing Lounges @ TWH & MGH)	Externally Funded
Food Bank voucher allocated to staff by Wellbeing Team	Externally Funded
Wellbeing Lectures (guest speakers secured for free for various wellbeing topics as well as menopause specific)	Administrative resourcing
Financial Wellbeing Webinar & offer of 1:1 consultations (provided by Finwell at no cost to the Trust)	Administrative resourcing

Cost of Living Support coming soon to our People

Item	Investment
PC's in staff rest areas to enable access to Trust communications, financial support and signposting, wellbeing information and resources, training and development. (Trust systems such as sunrise etc. to be blocked to ensure the rest area – wellbeing PC does not become a “workstation” changing the status of the dedicated rest area)	MTW Funded
CAB (Citizens Advice Bureau) webinars & virtual sessions (possibility for on-site clinics in the future)	Administrative resource allocation

Cost of Living Support requiring funding for our People

Item	Investment
Supermarket voucher scheme – hardship support. £50 voucher, once a month for 10 months = £500 fund per person	£40,000 would fund 80 staff in significant financial crisis
Free soup and roll @ lunchtime – working with Catering to identify potential cost	Cost Pending
End of day food in canteen – sell at discounted rate, or offer for free? working with Catering to identify potential cost	Cost Pending
Parking vouchers – on site free allocation for up to 6 months set period. £10 per month = £60 fund per person	£4,800 would fund 80 staff in significant financial crisis
Lunch vouchers – canteen lunch free for set period; up to 6 months up to 5 hot lunches per week = c£684 fund per person	£54,720 would fund 80 staff in significant financial crisis
Blue Light card administration/ registration fee funded for Bands 2-5; £4.99 for 2 year subscription.	£7,485 would fund 1,500 staff
Total Investment requested (pending additional catering costs)	£107,005*

*Funding is proposed to be requested through the Charitable Trust Funds.

Cost of Living Support being investigated; no funding required

Item	Investment
<p>Salad Projects; personal loans for staff with poor or no credit rating enabling them access to reasonable rates otherwise not available to them on the open market</p> <p>(Other similar options being looked into)</p>	<p>Administrative support from H&WB Team and Workforce Team</p>
<p>Wage Stream; app linked to ESR & Health Roster enabling instant payment of shifts worked and finalised (flat rate of £1.75 per “stream” of wages advancement)</p> <p>(other similar options being looked into)</p>	<p>Administrative support from H&WB Team and Workforce Team</p>



Hospital Discharge Service: Policy and Operating Model

Published on 21 August 2020, this is a fully updated version of the document published on 19 March 2020.

Contents

1. Summary.....	3
2. Introduction	4
3. Discharge to Assess arrangements.....	6
4. What does this mean for people?.....	15
5. What are the actions for acute care organisations and staff?.....	17
6. What are the actions for providers of community health services?	20
7. What are the actions for local authorities and Adult Social Care services?	21
8. What are the actions for Clinical Commissioning Groups?.....	23
9. What are the actions for Care Providers?	24
10. Finance support and funding flows.....	27
Transition arrangements	29
Proposed finance route from CCGs for additional discharge support services	29
Reimbursement routes and cashflow	30
Monitoring of funding and overall activity	31
11. Reporting and performance management.....	33
12. Additional resources and support.....	38
Annex A: Criteria to Reside - Maintaining good decision making in acute settings.....	39
Annex B: Discharge choice leaflets	41
Annex C: Overview of decision making and escalation	46

1. Summary

- 1.1. This document sets out the Hospital Discharge Service operating model for all NHS trusts¹, community interest companies, and private care providers of NHS-commissioned acute, community beds, community health services and social care staff in England. It replaces the Hospital Discharge Service Requirements.
- 1.2. The Government has provided funding, via the NHS, to help cover the cost of post-discharge recovery and support services, rehabilitation and reablement care for up to six weeks following discharge from hospital.
- 1.3. The discharge to assess model will be fully implemented across England.
- 1.4. From 1 September 2020, the Government has decided that social care needs assessments and NHS Continuing Healthcare (CHC) assessments of eligibility will recommence.
- 1.5. We acknowledge and thank the Local Government Association, Association of Directors of Adult Social Services and the Academy of Medical Royal Colleges for their involvement and support in developing this guidance.

¹Mental Health inpatient services are not within scope for this guidance. Parallel guidance on managing demand and capacity across mental health, learning disability and autism services has been developed and should be consulted.

2. Introduction

- 2.1 Health and social care systems are expected to build upon the hospital discharge service developed during the COVID-19 response, incorporate learning from this phase, and ensure discharge to assess processes are fully embedded for all people aged 18+.
- 2.2 To support full implementation of discharge, a set of [discharge guidance action cards](#) has been developed to summarise responsibilities for key roles within the hospital discharge process.
- 2.3 Based on the criteria to reside in hospital as developed with the Academy of Medical Royal Colleges ([see Annex A](#)), acute hospitals must discharge all persons who no longer meet these criteria as soon as they are clinically safe to do so. Daily morning ward rounds to review every person and make decisions, informed by the criteria to reside, are the foundation for avoiding delay and improving outcomes for individuals. Transfer from the ward to a designated discharge area should happen promptly; for persons on Pathway 0 this should be within one hour of that decision being made, and the same day for people on all other pathways. Discharge from the discharge area should happen as soon after that as is possible and safe which will often be within two hours, or on the same day.
- 2.4 Acute and community hospitals must integrate the daily reviews into their electronic patient information systems. This will ensure a live list is available for all agencies to work from and include those suitable for discharge, the number and percentage of people on the list who have left the hospital, and reason of delay for those unable to be discharged in a timely way. This data will also form part of national data performance reporting arrangements.
- 2.5 These reporting arrangements build on situation reporting processes implemented during the COVID-19 response in March 2020, this included the suspension of Delayed Transfer of Care (DTC) data collection and submissions. NHS providers should no longer record or report DTC data, which has been superseded by the data collections outlined in this document (see [section 11](#)).
- 2.6 The Government has agreed to provide additional funding, via the NHS, alongside existing use of local authority and Clinical Commissioning Group (CCG) budgets to help cover the cost of post-discharge recovery and support services in addition to what was provided prior to admission, for up to a maximum of six weeks following discharge from hospital or any “Pathway 2” facility. This funding will apply to all those needing support for the first time.

- 2.7 The recovery and support provided post-discharge (including rehabilitation and reablement services) aims to help people return to the quality of life they had prior to their most recent admission. For some people this may require support for these additional needs for the maximum period of six weeks, although for the majority it will be suitable for them to return to usual packages of care (if applicable) in less time. The funding can also be used for urgent community response provided within 2 hours to prevent an acute admission.
- 2.8 Social care needs assessments and NHS Continuing Healthcare (NHS CHC) assessments of eligibility should be made in a community setting and not take place during the acute hospital inpatient stay. From 1 September 2020, the Government has decided these assessments will recommence where they have been suspended during the COVID-19 response. Further [guidance specific to NHS CHC arrangements on discharge from hospital can be found here](#).
- 2.9 It is essential that, under the new arrangements, there is clarity about which CCG is responsible for assessing each person's needs and paying the relevant organisation for any healthcare services provided to the individual. NHS England is publishing updated [Who Pays? rules](#) to provide this clarity.
- 2.10 The Government is making additional funding available to support the health and social care systems implement this approach during the financial year 2020/21. Local authorities and NHS bodies need to continue to work together to put this approach into practice in line with the [Community Health and care discharge and crisis care model: an investment in reablement](#)

3. Discharge to Assess arrangements

- 3.1 The [discharge to assess pathways model](#), is based on four clear pathways for discharging people, as shown below:

Discharge to Assess model – pathways²:

- Pathway 0: 50% of people – simple discharge, no formal input from health or social care needed once home.
- Pathway 1: 45% of people – support to recover at home; able to return home with support from health and/or social care.
- Pathway 2: 4% of people – rehabilitation or short-term care in a 24-hour bed-based setting.
- Pathway 3: 1% of people – require ongoing 24-hour nursing care, often in a bedded setting. Long-term care is likely to be required for these individuals.

- 3.2 Acute hospitals will continue to be the responsible organisation for discharge of all persons on pathway 0, ensuring that the 50% of people who can leave the hospital and only need minimal support, do so on time and safely.
- 3.3 People should only be discharged on this pathway if they are considered to be well enough for self-care upon discharge.
- 3.4 Upon discharge, people should receive information about who they can contact if their condition changes, ranging from re-admission to voluntary sector help for day-to-day tasks.
- 3.5 This pathway may include a limited number of arranged follow ups (for example, the removal of stitches in a clinic setting or at home). However, this pathway should not include ongoing care.
- 3.6 Voluntary sector services can also be used to support discharge and prevent further admissions to hospital.
- 3.7 Health and social care systems should have an identified executive lead to provide strategic oversight of the discharge to assess process ensuring that there are no delays to discharge and that a “home first” approach is being adopted. They should

² Adapted from John Bolton model for persons aged 65+. When used across all 18+ age groups it is expected that a greater % than detailed here will be allocated to pathways 0 and 1, and a fewer than detailed % to pathways 2 and 3.

be supported by a single coordinator who should be appointed on behalf of all system partners to secure timely discharge on the appropriate pathway. They can be employed by any partner in the system to lead the implementation and delivery of the discharge to assess model in the acute hospitals in their area. This lead role should be undertaken by the most appropriate person for the position, regardless of which organisation they are employed by. Their primary function will be the oversight of coordination of the discharge arrangements for all people from community and acute bedded units on pathways 1, 2 and 3; escalating any relevant issues to the Executive Lead. The model should operate 8am-8pm, 7 days a week.

- 3.8 Case managers will ensure all people (irrespective of their address) are discharged safely on time (from all NHS community and acute beds) and that they (or their representative or advocate if they lack capacity), have full information and advice about what is happening. This includes how their needs will be assessed, provision of follow up support as needed and if any charges will be applied to their care and support.
- 3.9 Discharge to assess pathways 1-3 require NHS organisations to work closely with adult social care and housing colleagues, the care sector and the voluntary sector. To ensure that resources are used effectively across the system, acute trusts should ensure that their staff work closely with community health services and local authorities on pathways 1-3.
- 3.10 Information essential to the continued delivery of care and support must be communicated and transferred to the relevant health and care partners on discharge. This must include, where relevant, the outcome of the last COVID-19 test.
- 3.11 Commissioners will need to determine which health and care services can best meet the needs of individuals, considering the range of health and care providers offering services in their locality.
- 3.12 Whilst most people will be discharged to their homes, a very small proportion will need and benefit from short or long term residential, nursing home or hospice care as part of pathways 2 and 3. No-one should be discharged from hospital directly to a care home without the involvement of the local authority.
- 3.13 DHSC/PHE policy is that people being discharged from hospital to care homes are tested for COVID-19 in a timely manner ahead of being discharged (as set out in the [Coronavirus: adult social care action plan](#)), regardless of whether they were residents of the care home previously or not. Where a test result is still awaited, the person will be discharged if the care home states that it is able to safely isolate the patient as outlined in [Admission and Care of Residents in a Care Home](#) guidance. If this is not possible then alternative accommodation and care for the remainder of the

required isolation period needs to be provided by the local authority, funded by the discharge funding.

- 3.14 There needs to be clear accountability and escalation mechanisms at each stage of the discharge to assess process in each locality ([Annex C](#)). Figure 1 on the following page describes the discharge to assess process that should be undertaken in acute and community hospitals, and once the person is home. Health and care systems should ensure effective information sharing, and full and carefully documented assessments of need, to ensure care providers can deliver the care and support people require.

Figure 1: Discharge to assess process (see below for plain text version)

Aim: to support people to maximise their independence and remain in their own home

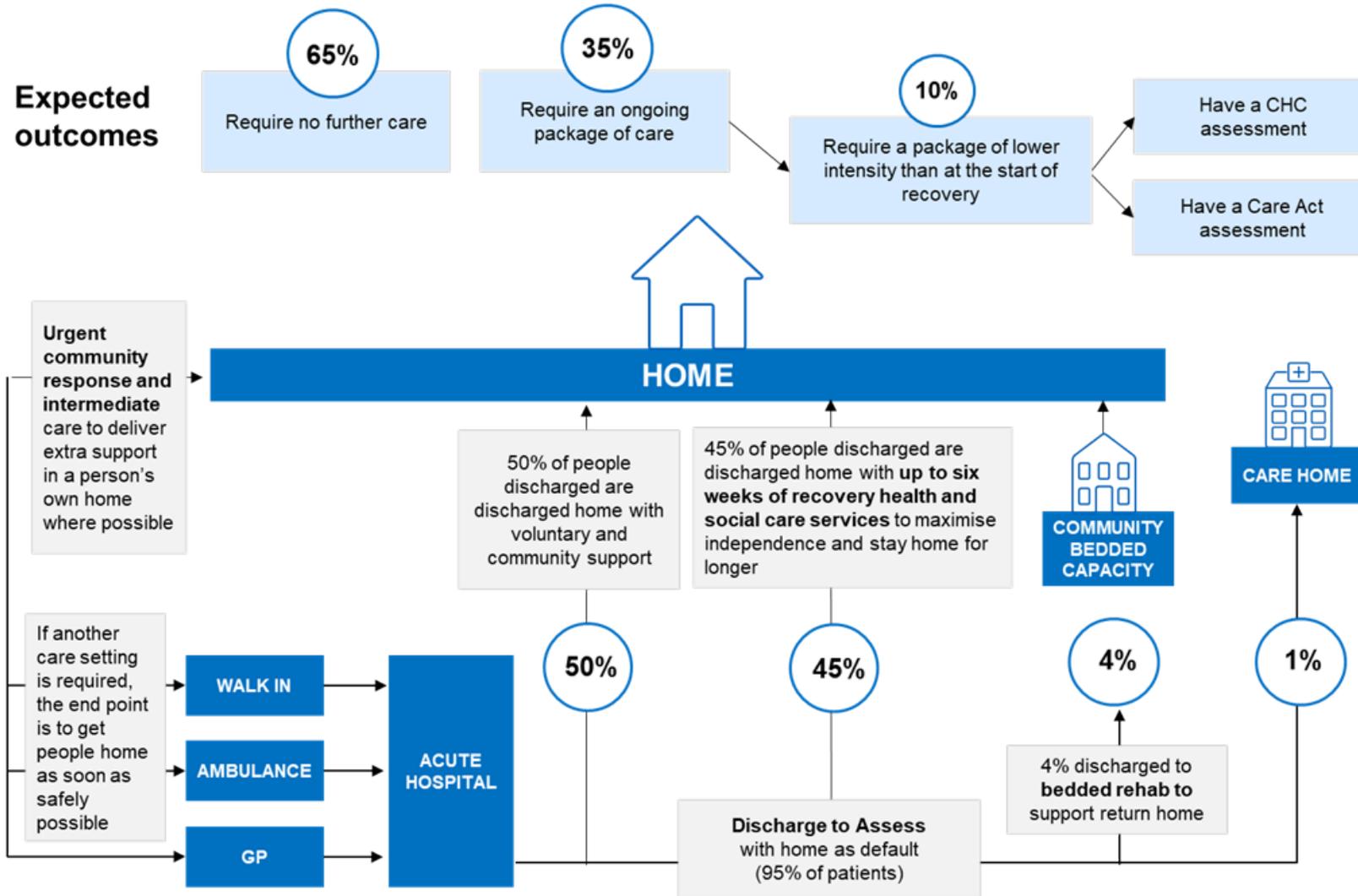


Figure 1: Discharge to assess process (plain text)

Aim: to support people to maximise their independence and remain in their own home.

Expected outcomes on discharge from hospital:

- 65% of people will require **no further care**.
- 35% of people will require an **ongoing package of care**.
 - Of those 35% of people who receive ongoing care, it is expected that 10% will require a package of lower intensity than at the start of recovery, and will have either an NHS CHC, or Care Act assessment.

Urgent community response and intermediate care to deliver **extra support** in a person's own home where possible.

If another care setting is required, the end point is to get people home as soon and as safely as possible.

- For those admitted to an acute hospital, 95% are expected to be discharged home as default. The discharge to assess model sets out 4 pathways:
 - 50% of people are expected to be discharged home with voluntary and community support.
 - 45% of people are expected to be discharged home with up to six weeks recovery support from health and social care services, to maximise their independence and stay home for longer.
 - 4% of people are expected to be discharged to bedded rehabilitation settings to support their return home.
 - 1% of people are expected to be discharged into long-term care settings, such as a care home.

There are three stages to the discharge to assess model:

Stages	Description of stage
<p>Stage one</p> <p><u>Review each individual daily and identify people for discharge to leave that day</u></p>	<ul style="list-style-type: none"> ➤ Begin discharge planning from the point of hospital admission, including the identification of immediate needs of the individual at home following discharge. ➤ Undertake daily clinically-led reviews of all people at a morning ward round. Any person not meeting the clinical criteria to reside (see Annex A) will be deemed suitable for discharge. ➤ Information about the home circumstances for people should have been collected at the point of admission. If further home assessment is required this should be undertaken in good time, coordinated between health and social care and should include equipment and reablement support. Trusted assessment arrangements should be used. ➤ All people who are suitable for discharge will be added to the discharge list. ➤ Discharge home should be the default pathway. ➤ At least twice daily review of all people in acute beds to agree who no longer needs to be in hospital and can be discharged. ➤ For people being discharged into a care home, supported housing or other temporary accommodation, a COVID-19 test must be carried out prior to admission. ➤ Senior clinical staff should be available to support staff with appropriate risk-management and clinical advice.
<p>Stage two</p> <p><u>The details of how to discharge people</u></p>	<ul style="list-style-type: none"> ➤ On decision of discharge, the person and their family or carer, and any formal supported housing workers should be informed and receive the relevant leaflet (see Annex B).

	<ul style="list-style-type: none"> ➤ Community health, social care and acute staff need to work in full synchronisation (include housing professionals where necessary) to ensure people are discharged in a safe and timely manner. ➤ For people who are going straight home with no support (pathway 0) the ward staff should arrange discharge. ➤ For those who will require reablement, rehabilitation and/or some care followed by further assessment after recovery, (pathways 1 and 2, for up to six weeks), details of their immediate needs will be given to the single point of access (SPA), a case manager will be allocated and a decision made about which pathway will be used. ➤ All people must be transferred to an allocated discharge area or lounge from their ward as soon as possible, to leave hospital the same day. ➤ Case managers will be responsible, in liaison with ward staff, for ensuring (for all those leaving hospital on pathways 1-3): <ul style="list-style-type: none"> ○ Individuals and their families are fully informed of the next steps. ○ Arrangements to transport people home from hospital are confirmed. This should be via family or carers, voluntary sector, or taxi, and only as a last resort, non-emergency patient transport (NEPTS). ○ ‘Settle in’ support is provided where needed. ○ COVID-19 test results are included in documentation that accompanies the person on discharge (where test has taken place).
<p>Stage three</p> <p><u>Assessment and care planning at home</u></p>	<ul style="list-style-type: none"> ➤ Post discharge, the case managers in conjunction with the SPA, will need to work with partners to ensure the staff and infrastructure are available to meet immediate care needs.

	<ul style="list-style-type: none"> ➤ The use of personal budgets should be discussed with the individual and their family as an option, if longer term support is needed. ➤ For all those discharged on pathways 1-3, services providing additional care to that in place pre-admission will be at no cost to the individual for a period not exceeding six weeks. It is the case manager's responsibility to ensure that there is frequent review of the support package and adjustments are made when appropriate. The case manager will liaise with the appropriate professionals to ensure timely assessments for any longer-term care provision and/or associated financial assessments (section 10) or to end support where it is no longer needed.
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Important considerations for all pathways:

- For people where new mental health concerns are considered in light of discharge, psychiatric liaison teams should be contacted by case managers in the first instance to review and assess as appropriate.
- For people with a pre-existing mental health concern who are known to mental health services, their care coordinator or relevant mental health clinician should be involved in their discharge planning to ensure their mental health needs are considered as part of this.
- Duties under the Mental Capacity Act 2005 still apply during this period. DHSC has published [emergency guidance](#) for health and social care staff in England and Wales who are caring for or treating a person who lacks the relevant mental capacity during the COVID-19 pandemic.
- If there is a reason to believe a person may lack the relevant mental capacity to make the decisions about their ongoing care and treatment, a capacity assessment should be carried out before decision about their discharge is made. Where the person is assessed to lack the relevant mental capacity and a decision needs to be made, then there should be a best interest decision made for their ongoing care in line with the usual processes. If the proposed arrangements amount to a deprivation of liberty, Deprivation of Liberty Safeguards in care homes and orders from the Court of Protection for community arrangements still apply. Further information can be found within [DHSC's guidance](#) on this specific area.

- For people identified as being in the last days or weeks of their life, the single point of access will be responsible for overseeing communication with primary care, community services and, where required, community palliative care services to coordinate and facilitate rapid discharge to home or hospice.
- All persons who are homeless or at risk of homelessness on discharge should be referred by acute hospital staff to local authority homelessness/housing options teams, under the requirements of the Homelessness Reduction Act (2017). This duty to refer ensures that services are working together effectively to prevent homelessness by ensuring that peoples' housing needs are considered when they come into contact with public authorities. Further guidance on supporting homeless persons in hospital discharge can be found in the [High Impact Change Model](#) for Managing Transfers of Care.

4. What does this mean for people?

- 4.1 People should expect to receive high quality care from acute and community hospitals, including regular and open sharing of information on the next steps for their care and treatment, as well as clarity on plans and joint decision making processes for post-discharge care. Leaflet A, describing these arrangements, is provided in [Annex B](#) and should be shared with all people on admission to hospital.
- 4.2 Hospital staff will make clear that discharge will be organised as soon as clinically appropriate and people will not be able to stay in a bed after the point where this is clinically necessary. For 95% of people leaving hospital this will mean that (where it is needed), the assessment and organising of ongoing care will take place when they are in their own home.
- 4.3 On the day a person is to be discharged, (following discussions with the person, their family, and any other professionals involved in their care using leaflets B1/B2 in [Annex B](#)), the ward should arrange to escort the person to the hospital discharge area where necessary.
- 4.4 Any ongoing care and support will have been organised, where required, by the case manager; including medication supply, transport home, any volunteer and voluntary sector support and immediate practical measures, such as shopping and turning heating on. For simple discharges (pathway 0) where minimal further support is required, people should expect to be discharged from a discharge area in around two hours. More time may be required for people with more complex care situations that need co-ordinating, though much of the support can be pre-planned during the person's hospital stay through early discharge planning (see the [High Impact Change Model](#) for further detail).
- 4.5 A lead professional or multidisciplinary team, as is suitable for the level of care and support needs, will visit people at home on the day of discharge or the day after to co-ordinate what support is needed in the home environment. If care support is needed on the day of discharge from hospital, this will have been arranged prior to the person leaving the hospital site by a case manager.
- 4.6 Additional care and support needs for all individuals on discharge from hospital (where required) will be provided free of charge for up to six weeks to allow for post-discharge recovery and support services, and any assessments of ongoing care needs and financial eligibility determinations to be made.
- 4.7 For people whose needs are too great to return to their own home (about 5% of people over 65 admitted to hospital), rehabilitation/short term care in a 24 hour bedded care facility will be arranged through the case manager. For people being discharged to a care home bed (short term or permanently) for the first time, this

provision will be provided in a care home, at rates which have been agreed locally by the health and care system and will be free to the individual for up to six weeks (see section 4.6).

- 4.8 DHSC/PHE policy is that people being discharged from hospital to care homes are tested for COVID-19 in a timely manner ahead of being discharged (as set out in the [Coronavirus: adult social care action plan](#)), regardless of whether they were residents of the care home previously or not. Where a test result is still awaited, the person will be discharged if the care home states that it is able to safely isolate the patient as outlined in [Admission and Care of Residents in a Care Home](#) guidance. If this is not possible then alternative accommodation and care for the remainder of the required isolation period needs to be provided by the local authority, funded by the discharge funding.
- 4.9 On the rare occasion that a decision is not reached within this timeframe, the parties paying for the care should continue to do so until the relevant ongoing care assessments are complete. Whatever arrangements are agreed costs from week 7 cannot be charged to the discharge support fund and must be met from existing budgets. CCGs and local authorities should agree an approach to funding of care from the seventh week.
- 4.10 Where an existing local arrangement is in place to agree who funds care while assessments are taking place, then the local authority and the CCG, if they both agree and it is affordable within existing envelopes, may choose to continue with this local funding arrangement from week seven rather than following the arrangements outlined below.
- 4.11 In the absence of an existing locally agreed approach for funding from week seven onwards, it is suggested as a default that the following approach is adopted.
- 4.12 The costs are allocated according to what point in the assessment process has been reached by the end of the six weeks of care, as follows:
- Where the NHS CHC or NHS funded-nursing care (FNC) assessments are delayed, the CCG remains responsible for paying until NHS CHC/FNC assessment is done.
 - After this, where the individual is assessed as not eligible for NHS CHC, responsibility for funding will sit with the local authority in line with existing procedures until the Care Act Assessment is completed, after which normal funding routes will apply.

5. What are the actions for acute care organisations and staff?

Acute providers need to ensure their processes and ways of working have been fully adapted to deliver the discharge to assess model.

5.1 Ward level:

- Clinically led review **of all people** at morning ward round. Discharge planning should start for any person not meeting the clinical criteria to reside in hospital.
- **At least twice daily review of all people** in acute beds to agree who is not required to be in hospital and can therefore be discharged.
- Ensure professional and clinical leadership between nursing, pharmacy, medicine and allied health professions for managing decisions and reducing delay. Use prompts in the box below:

- Does the person require the level of care that they are receiving, or can it be provided in another less intensive setting?
- What value are we adding for the person balanced against the risks of them being away from home?
- What do they need next?
- ‘Why not home, why not today’ for those who have not reached a point where long-term 24-hour care is required.
- If not home today, then when? – Expected date of discharge from an acute bed

- All people who are suitable for discharge will be added to the discharge list. The Single Point of Access (SPA) will allocate to a discharge pathway. Discharge home should be the default pathway.
- On decision of discharge, the person and their family or carer, and any formal supported housing workers should be involved/informed and receive the relevant leaflet ([see Annex B](#)).
- Transfer people off the ward into a discharge lounge where necessary.

To create a safety-net and increase confidence in discharging, consider:

- Person initiated follow up - give people the direct number of the ward discharged from to call back for advice. Do not suggest going back to their GP or coming to A&E.
- Telephone the following day after discharge to check and offer reassurance/advice.
- Call people back with results of investigations and any changes or updates to an individual's management plan.
- Bring people back under the **same team/speciality**.
- Request community nursing follow up with a specific clinical need.
- Request GPs to follow up in **some selected cases**.

5.2 Hospital Discharge teams:

- Arrange dedicated staff to support and manage all people on pathway 0. This will include:
 - Making arrangements to transport people home from hospital. This should be via family/carers, voluntary sector, or taxi and, only as a last resort, non-emergency patient transport services (NEPTS).
 - Local voluntary sector and volunteering groups helping to ensure people are supported (where needed) actively for the first 48 hours after discharge,
 - ensuring 'Settle in' support is provided where needed.
- In conjunction with local care home providers, develop trusted assessment arrangements to facilitate the prompt return of residents after a hospital stay.

5.3 Hospital clinical and managerial leadership team:

- Create safe and comfortable discharge spaces for people to be transferred to.
- Maintain timely and high-quality transfer of information to Primary Care and other relevant health and care professionals on all people discharged.
- Use change 9 within the [High Impact Change Model](#) to ensure planning and discharge for people with no home to go to, and that no-one is discharged to the street, or to a night shelter.

- Senior clinical staff to be available to support ward and discharge staff with appropriate risk-management and clinical advice arrangements.
- Ensure COVID-19 testing of all people being discharged from hospital to a care home, in advance of a timely discharge (as set out in the [Coronavirus: adult social care action plan](#)). Where a test result is still awaited, the person will be discharged if the care home states that it is able to safely isolate the patient as outlined in [Admission and Care of Residents in a Care Home](#) guidance. If this is not possible then alternative accommodation and care for the remainder of the required isolation period needs to be provided by the local authority, funded by the discharge funding.
- COVID-19 test results should be included in documentation that accompanies the person on discharge.
- Ensure all people identified as being in the last days or weeks of their life are rapidly transferred to the care of community palliative care teams, facilitating prompt discharge to home or a hospice.
- Closely monitor hospital discharge performance data to ensure discharge arrangements are operating effectively and safely across the system, and a high proportion of people on the discharge list achieve a same-day discharge to the most suitable destination for their needs.
- Ensure a live list is available for all agencies to work from and include those suitable for discharge; the number and percentage of people on the list who have left the hospital, and reason of delay for those unable to be discharged in a timely way.

6. What are the actions for providers of community health services?

6.1 Providers of community health services will work closely with other system partners to facilitate timely discharge of people, particularly for pathways 1, 2 and 3. As part of this they should:

- Have an easily accessible single point of contact who will always accept assessments from staff in the hospital and source the care requested, in conjunction with local authorities.
- Deliver enhanced occupational therapy and physiotherapy 7 days a week to reduce the length of time a person needs to remain in a hospital or care home rehabilitation bed.
- Monitor the effectiveness of reablement and rehabilitation.
- Use multi-disciplinary teams on the day a person goes home from hospital, to assess and arrange packages of support.
- Ensure provision of equipment to support discharge.
- Ensure people on pathways 1-3 are tracked and followed up to assess for long term needs at the end of the period of recovery.
- Maintain a focus on supporting timely onward transition of care for persons from community beds, including reablement and rehabilitation packages in home settings. Please refer to the [Community Health Services Standard Operating Procedure](#).
- Support the local authority to ensure that quality of provision is adequate and safe and/or that alternative provision is commissioned
- Ensure that urgent community response services to prevent unnecessary hospital admissions are recorded on the Community Services Dataset (CSDS).
- For people identified as being in the last days or weeks of their life, the single point of access will be responsible for coordinating liaison with primary care, community services and, where required, community palliative care services to coordinate and facilitate prompt discharge to home or hospice.
- Community Palliative Care teams will continue to work with commissioners in retaining the team's responsibility for coordinating and facilitating prompt discharge to home or hospice. End of life care, including palliative care, must continue to be personalised and planned in a holistic way involving the person themselves and their families, social care, community nursing, general practice, occupational therapy, and others.

7. What are the actions for local authorities and Adult Social Care services?

7.1 As part of implementing the discharge to assess model, local authorities are asked to:

- Agree a single lead local authority or point of contact arrangement for each hospital or Trust, ensuring each acute trust and single local coordinator for local discharge to assess pathways has a single point to approach when coordinating the discharge of all people, regardless of where that person lives.
- Work together and pool staffing where appropriate to ensure the best use of resources and prioritisation in relation to people being discharged, respecting appropriate local commissioning routes. Funding will be made available to people with new or additional care needs, and local authorities are enabled by the Care Act (Section 19) to meet urgent needs where they have not completed an assessment and regardless of the person's ordinary residence.
- Work with partners to coordinate activity with local and national voluntary sector organisations to provide services and support to people requiring support around discharge from hospital and subsequent recovery.
- Care packages for those discharged (including commissioning of care home beds) should be jointly commissioned; and the local authority should be the lead commissioner unless otherwise agreed between the CCG and the local authority.
- Take the lead on local care market shaping, including contracting responsibilities (e.g. expanding the capacity in domiciliary care, and reablement services in the local area).
- Work with CQC and other regulators to ensure safeguarding and quality of care, advising NHS colleagues where action is needed to make provision safe or alternatives are needed.
- Engage Local Housing Authority services to provide housing support and advice for persons requiring housing assistance on discharge from hospital.

7.2 Specific responsibilities for Adult Social Care:

- Identify an Executive Lead for the leadership and delivery of the discharge to assess model.

- Make provision for Care Act assessments of need, financial assessments and longer-term care planning if necessary.
- Review the most appropriate setting for social work staff to operate within to support people being discharged. Safeguarding activities should continue to take place in a hospital setting if necessary.
- Provide social care capacity to work alongside local community health services to provide a single point of contact for hospital staff.
- Support real time communication between the hospital and the single point of contact, not just by email.
- Provide capacity to review care provision and change if necessary, at an appropriate point in line with good practice and legal responsibilities.
- Organise any needed isolation capacity for people who do not meet the criteria to remain in hospital, in the event that they require to be discharged to a care home but are unable to be isolated in line with the [Adult Social Care Action Plan](#).
- Work closely with community health providers and local resilience fora over the provision of equipment, such as PPE.
- Support 7-day working for community social care teams (to be commissioned by local authorities).
- Deploy adult social care staff flexibly to support best outcomes for people. This can include support to avoid any immediate bottlenecks in arranging step down care and support in the community, and at the same time focus on maintaining and building capacity in local systems.
- Work with system partners - CCGs, Trusts and ICSs/STPs - to ensure appropriate data collection and that its use supports the best outcomes for individuals. Local authorities have a duty to manage local care markets and for service continuity in relation to provider failure. For the purposes of crisis intervention to avoid hospital admission and for managing hospital discharges this should involve the use of relevant databases for care at home and care homes (currently managed through CQC for domiciliary care and Capacity Tracker for care homes), augmented by systems developed in regions and local intelligence in relation to effectiveness, quality and safeguarding.

8. What are the actions for Clinical Commissioning Groups?

8.1 CCGs supported by Integrated Care Systems (ICSs) or System Transformation Partnerships (STPs) need to support the coordination of activities set out in this framework. Specifically, they must:

- Work in partnership with local authorities to plan and commission sufficient provision to meet the needs of the population based on home first discharge to assess principles.
- Work in partnership with local authorities to coordinate local financial flows for post-discharge care and support, including monitoring all local spend and coordinating local funding arrangements.
- Comply with NHS England and NHS Improvement financial controls and reporting, as set out in Section 10.
- CCGs should follow the guidance on the [Reintroduction of NHS Continuing Healthcare](#).
- Continue to build on recent learning and commissioning arrangements for community palliative care services optimising the best use of all available financial resources including those currently allotted to CHC Fast Track. Enabling community palliative care services to provide palliative and end of life care for those people transferring to, or already in, the community requiring care and support within their own home or a hospice.
- CCGs, working with partner organisations and ICSs/STPs via their capacity tracker leads, should continue to promote the use of the Capacity Tracker tool for care homes, hospices and community rehabilitation bed providers. They should ensure that the operational potential of domiciliary and residential capacity trackers is realised, by their use in health and care system wide discharge planning.

9. What are the actions for care providers?

9.1 Care home providers

- Please refer to separate specific guidance for care home providers on [Admission and care of residents in a care home during COVID-19](#).
- Accept people discharged from hospital when able to do so safely. Care providers should consider whether they are able to meet the prospective clients' needs, taking into account relevant CQC regulations and provider duties (e.g. ability to isolate, sufficient PPE, and access to staff and resident testing). Ensure isolation of residents transferred from a hospital setting in line with care home isolation and infection prevention guidance (above) and be familiar with alerting mechanisms to local Health Protection Teams in the event of positive COVID-19 test results.
- Maintain capacity and identify vacancies that can be used for hospital discharge purposes, utilising the Capacity Tracker tool to share information with partner organisations.
- Where Trusted Assessment relationships and arrangements are not in place with acute providers, rapidly work with the discharge team to implement these approaches.
- If providing reablement or rehabilitation, then monitor and share the effectiveness of that service.

9.2 Domiciliary care providers

- Identify capacity to adult social care contract leads, that can be used for hospital discharge purposes or follow on care from reablement services.
- Ensure sufficiency of PPE and COVID-19 testing, the ability to isolate and that assessment and care planning for the future are in place (for example, by ensuring all providers know who to contact to get help, and that robust workforce contingency plans ensure continuity of care).
- If providing reablement or rehabilitation, then monitor and share the effectiveness of that service.

9.3 Pathways 1, 2 and 3

- Of those people discharged to short-term reablement/rehabilitation pathways, approximately 35% are likely to require an ongoing package of care at home, or placement in a 24-hour residential or nursing setting.
- It is essential that people on these pathways are tracked and assessed through and after a period of recovery. Longer-term care (appropriate supported housing, care package or care home placement) must be made available at the right time to ensure the best outcomes for individuals, and the best use of system resources.

9.4 Community hospitals

It is vital that discharges from community hospitals are increased and delays reduced with the same approach and action taken as in acute settings. This includes:

- A daily clinical review of every person's plan, focusing on three questions:
 - Why not home?
 - What needs to be different to make this possible at home?
 - Why not today?
- The review process should explore why people require rehabilitation in a bedded setting. It is accepted that the majority of people will be medically stable in this setting.
- All people should have an expected date of discharge (EDD) and be fully involved with their discharge planning. It is essential that expectations are set at the point of transfer or admission.
- The review should specifically look at whether people can be supported at home. The default assumption will be discharge home today.
- All actions from the review should be noted and aimed to be completed by the end of the day.
- Keep the Capacity Tracker updated with live status of bed vacancies daily.
- Use and submit the daily data collection of data as described in the 'COVID-19: new EPRR data collection during COVID-19 incident for community hospital bed providers' letter, issued on 15 June 2020.

9.5 Short-term placement for people who require 24-hour care and support

- For people who need a 24-hour care setting, it is essential they are assigned a case manager (social worker, discharge team nurse or CHC co-ordinator) who will review them regularly using the same questions as for community hospitals.
- Discharge should be arranged as soon as possible to their own home and packages of support made available.

9.6 **Short term rehabilitation/reablement-at-home review**

- Using a professional supervision/case management model the case manager must review all people on their caseloads daily. The team identifies all people who have been on caseloads for an extended period.
- These people are discussed using the following questions:
 - What is our current aim of support?
 - Have we met this? If not, what is going to change to enable us to meet this aim?
 - Are we best placed to support this need? Is there an alternative?
 - Can we safely discharge this person?
- Actions from the discussion are recorded and actions followed up daily.

10. Finance support and funding flows

10.1 The Government has agreed to fund, via the NHS:

- The cost of post-discharge recovery and support services, such as rehabilitation and reablement (in addition to what was provided prior to admission) for up to a maximum of six weeks to help people return to the quality of life they had prior to their most recent admission.
- To support urgent community response services for people who would otherwise be admitted into hospital. These will typically provide urgent support within two hours and for a limited time (typically 48 hours) and, if required, transition into other ongoing care and support pathways.

10.2 The additional funding available to CCGs to support delivery of the services described in this guidance should only be used to fund activity arising from this guidance that is over and above the activity normally commissioned by CCGs and local authorities.

10.3 Eligibility funding assessments for care and health needs should not take place in acute hospital settings. NHSE/I will ensure there is sufficient funding to support CCGs and their local authority partners to commission the enhanced discharge support outlined in this guidance. CCGs are expected to ensure that an appropriate rate is paid for this support working with their local authority commissioners. This agreed rate may need to reflect the actual cost of care, particularly where some care provider capacity being utilised, would previously have been self-funded from the point of hospital discharge.

10.4 Under the provisions of this scheme, additional costs of post-discharge recovery and support services will be funded until the person's long-term care needs are assessed, or for up to the first six weeks if the assessment is not completed by that time. It is expected that an assessment for ongoing health and care needs takes place within six weeks of discharge and that a decision is made about how this care will be funded by this date. CCGs will not be able to draw down funding from the discharge support arrangements after the end of the sixth week to fund any care package beyond this date.

10.5 On the rare occasion that a decision is not reached within this timeframe the parties paying for the care should continue to do so until the relevant ongoing care assessments are complete. Whatever arrangements are agreed, costs from week seven cannot be charged to the discharge support fund and must be met from existing budgets. CCGs and local authorities should agree an approach to funding of care from the seventh week.

- 10.6 Where an existing local arrangement is in place to agree who funds care while assessments are taking place, then the local authority and the CCG, if they both agree and it is affordable within existing envelopes, may choose to continue with this local funding arrangement from week seven rather than following the arrangements in section 10.8.
- 10.7 In the absence of an existing locally agreed approach (see section 10.5–10.6) for funding from week seven onwards, it is suggested as a default that the following approach is adopted:
- 10.8 The costs are allocated according to what point in the assessment process has been reached by the end of the six weeks of care, as follows:
- Where the NHS CHC or FNC assessments are delayed, the CCG remain responsible for paying until NHS CHC/FNC assessment is done.
 - After this, the local authority should pay until the Care Act Assessment is completed, after which normal funding routes will apply.
- 10.9 For people discharged from hospital or assigned a package of short-term care to avoid admission into hospital from 1 September 2020, this funding arrangement will apply, replacing the previous arrangements introduced on 19 March 2020 as part of the COVID-19 Discharge Guidance. The approach to transition from the COVID-19 arrangements to these new arrangements is set out below.
- 10.10 Where a person was in receipt of a care package prior to admission to hospital and is discharged with a package of short term reablement, this funding will pay for those additional costs (where these are over and above the activity that is ordinarily commissioned by CCGs and local authorities). This would apply regardless of whether or not the person was still being cared for by the same care provider.
- 10.11 The additional funding will **not** pay for:
- Long term care needs following completion of a Care Act and/or NHS CHC assessment.
 - Social care or NHS CHC packages that are restarted following discharge from hospital at the same level as that already delivered prior to admission to hospital.
 - Pre-existing (planned) local authority or CCG expenditure on discharge services.

Transition arrangements

10.12 This funding support will commence from 1 September 2020 and will reimburse, via CCGs, up to six weeks of costs of out-of-hospital care and support that arise as a result of the approach outlined in this document (both new packages and enhancements to existing packages), where it is provided to people on or later than this date. Any person already receiving out-of-hospital care and support that started before 1 September 2020 will be expected to be funded through pre-existing mechanisms and sources of funding (including COVID-19 discharge funding), where the care provided continues on the same basis as prior to admission.

10.13 These new funding arrangements will apply up until 31 March 2021.

People funded through the COVID-19 Discharge Guidance funding arrangements which commenced on 19 March 2020, who enter a care package between 19 March and 31 August 2020, will continue to be funded through those arrangements. Relevant assessments should be completed for these individuals as soon as is practical to ensure transition to normal funding arrangements.

Proposed finance route from CCGs for additional discharge support services

10.14 Procurement and contracting rules continue to apply. Local commissioners should agree the most appropriate route to deliver the enhanced discharge support in their area. Additional financial support provided to CCGs and local authorities should be pooled locally using existing statutory mechanisms. Under section 75 of the NHS Act 2006 and associated regulations, CCGs and local authorities can enter into partnership agreements that allow for local government to perform health related functions where this will likely lead to an improvement in the way these functions are discharged.

10.15 Where systems decide that an enhanced supply of out-of-hospital care and support services will be commissioned via the local authority, the existing section 75 agreements can be extended or amended to include these services and functions and the local authority should commission the health and social care activity on behalf of the system. Similarly, where a CCG is already acting as a lead commissioner for integrated health and care, partners can agree that existing section 75 arrangements can be varied to allow them to commission social care services.

- 10.16 Where CCGs and local government agree, BCF section 75 agreements can be extended or varied for this purpose³. A model template was developed for the COVID-19 Discharge Service Requirements for areas to adapt locally to vary existing BCF Section 75 agreements and this document can be used as the basis for implementing these arrangements.
- 10.17 The funding provided should be separately identified within the agreement and monitored to ensure funding flows correctly. It should be pooled alongside existing local authority and CCG planned expenditure on discharge support, and this funding is intended to meet additional costs only. Support provided and agreed budgets from this funding should be recorded at individual level. CCGs should continue funding (through their existing budgets) existing intermediate care support services on discharge from hospital. Where the enhanced care services are most appropriately commissioned directly by NHS commissioners, these should be placed under existing contractual arrangements with providers but invoiced separately to ensure that enhanced discharge support funding is identifiable. This care should be paid for from the additional funding set out in this section.
- 10.18 Commissioners should work with providers of discharge services to ensure that extending existing contracts will be financially sustainable for those providers and consider mitigating actions where there is a risk that they will not be.

Reimbursement routes and cashflow

- 10.19 CCGs should ensure that both they and any local authorities commissioning on their behalf reimburse their providers in a timely fashion, reflecting differing cash-flow requirements of those providers – paying particular consideration to smaller providers. Local authority and CCG commissioners should refer to guidance on [Social care provider resilience during COVID-19](#).
- 10.20 NHSE/I expect ordinary financial controls to be maintained with respect to invoicing, raising of purchase orders and authorising payments.
- 10.21 NHSE/I will reimburse CCGs through the monthly allocation process. CCGs should, from the commencement date, maintain a record of the costs and activity associated with the enhanced discharge process so that they can submit a claim for additional payment for this from NHSE/I. This should include expenditure relating to urgent community response services to prevent unnecessary hospital admissions, where

³ The Better Care Fund Policy allocations for the [CCG minimum contribution](#) and the [improved Better Care Fund](#) have been made public.

this is over and above the level of activity for these services that would ordinarily be commissioned.

10.22 Whichever model is followed, CCGs should record the costs associated with this and should expect to be asked for monthly updates on the costs of these services.

Monitoring of funding and overall activity

10.23 For the purposes of definition, the arrangements prior to 1 September 2020 (detailed in the 19 March 2020 hospital discharge guidance) will be termed 'scheme 1' and the arrangements from 1 September 2020 will be defined as 'scheme 2'. The scheme funding arrangements will apply up until 31 March 2021.

10.24 From 1 September 2020 there will continue to be people from scheme 1 and scheme 2 receiving packages of care. People in scheme 1 will continue to receive their package of care, as defined by the 19 March 2020 hospital discharge guidance arrangements. Scheme 1 closes at midnight on 31 August 2020. Each scheme will be monitored separately.

10.25 After 1 September 2020 no-one will enter scheme 1 and as people leave this scheme having had (for instance) a means tested or CHC assessment, data will track decreasing activity and spend.

Collection and Frequency

10.26 For each scheme data will be collected for the following care settings or services:

- a) Care Home
- b) Other care accommodation
- c) Domiciliary/Home care
- d) Reablement/intermediate care
- e) Hospice
- f) Other (please specify)

10.27 It is important to differentiate and understand who is in which scheme to ensure an accurate return. Each scheme will be submitted on a separate template. Data will continue to be collected from local authorities and CCGs on a monthly basis.

Gathering more granular activity information

10.28 To further understand the pathway of people receiving the six-weeks of funded non-hospital care and support, more granular information will also be gathered. This will include understanding differences in discharge pathway spend now and pre-COVID-19. Due to the significant data burden of all systems returning information of all people and their packages of care, work will be done with a sample of systems each month.

11. Reporting and performance management

- 11.1 Current performance standards on Delayed Transfers of Care (DTOC) monthly reported delays were suspended from Thursday 19th March 2020. There are no plans to return to this reporting arrangement at present, and systems should not be counting, recording or charging local authorities under the DTOC regime.
- 11.2 In place of this, NHS providers are expected to continue to provide daily reporting through the Strategic Data Collection Service (SDCS) in the short term. These arrangements identify the numbers of people leaving hospital and where they are discharged to, and the reasons why people continue to remain in hospital.
- 11.3 This information is required to allow us to track the effectiveness of the policies described in this document. We are working on improving situation reporting and will notify providers of new requirements as and when appropriate. We are also exploring an automated system of collection of this data and, subject to further engagement with providers and other stakeholders, we hope to roll this out in 2021.
- 11.4 CCGs will be required to submit monthly financial spend to NHSE/I for reimbursement.
- 11.5 Local systems should ensure that data and intelligence about the sufficiency, suitability and sustainability of care and health services are shared, so as to maximise the effectiveness of services, outcomes for individuals and populations and the overall use of resources. This should include supporting data reporting from care providers, as outlined in the [Support for Care Homes](#) letter issued by the Government on 14 May 2020.

Data collection guidance

- 11.6 Alongside revision to this guidance, the opportunity has also been taken to update and refresh the daily acute discharge data collection, taking account of suggestions and feedback received since the original collection launched on 8 April 2020.
- 11.7 It is intended that once arrangements are made, including amending the data collection template on the SDCS portal, we will email out to data submitters to give at least one week's notice before we move to collecting data based on the revised questions.

- 11.8 Each of the revised questions for the data collection are reproduced below, with commentary beneath each one in bold. **We are seeking data for all individuals, and a number of questions (5, 6, 7 and 8) also ask about those with a length of stay of 21 days or over, and one question (9) asks about those with a length of stay of 14 days or over.**
- 11.9 It is worth noting that those with a length of stay of 14 days or over are a subset of total patients and will be counted within them, and those with a length of stay of 21 days or over are a subset of total patients and also a subset of the number of patients with a length of stay of 14 days or over.
- 11.10 Of the revised questions, below, numbers 1 to 7 should be collected daily and the data submitted on SDCS by 11.00 the following day. Questions 8 and 9 are weekly collections and should be submitted on SDCS each Friday by 11.00.
- 1) The number of people who meet the criteria to reside in total.
And the total then split by the number falling into the following reasons to reside categories:
 - a. Physiology
 - b. Treatment
 - c. Recovery
 - d. Function
 - 2) The number of people who meet the criteria to be discharged that day.
These are the people who do not meet the criteria to reside as set out in [Annex A](#). The reference to “discharged that day” refers to the period from midnight on the previous day to midnight on the current day for which the data is being collected.
 - 3) The number of people who have been or will be discharged by 17.00.
This refers to the patient numbers reported for question 2, and how many of those were actually discharged by 17.00 on the day for which data is being collected.
 - 4) Of the people who have been or will be discharged by 17.00, the number intended to be discharged to the following locations:
 - a. Home
 - b. Care Home
 - c. Hospice
 - d. Rehabilitation bed
 - e. Other

For 4d please report all discharges from acute beds to rehabilitation beds, even where the person continues to be treated by the same Trust.

- 5) Of the total number of people who have a length of stay of 21 days and over the number who:
 - a. Meet the criteria to reside in total, and split by the number falling into the following reasons to reside categories:
 - i. Physiology
 - ii. Treatment
 - iii. Recovery
 - iv. Function
 - b. Meet the criteria to be discharged

For 5a, please report the number of people with a length of stay over 21 days who meet the criteria to remain in hospital, and then split this down into categories i. to iv.

- 6) The number of people who have a length of stay of 21 days and over who have been or will be discharged by 17.00.

This refers to the patient numbers reported for question 5b, and how many of those were actually discharged by 17.00 on the day for which data is being collected.

- 7) Of the people who have a length of stay of 21 days and over who have been or will be discharged by 17.00, the number intended to be discharged to the following locations:
 - a. Home
 - b. Care Home
 - c. Hospice
 - d. Rehabilitation bed
 - e. Other

For 7d please report all discharges from acute beds to rehabilitation beds, even where the person continues to be treated by the same Trust.

Data for question 8, below, should be collected by a weekly review process that is similar to the former Discharge Patient Tracking List (DPTL) process, and be submitted weekly each Friday.

- 8) Of the total number of people who have a length of stay of **21 days or over** who have been judged to meet the criteria to be discharged but who continue to reside in hospital:

- a. The number of additional days in total they have remained in hospital since the meeting of the criteria to be discharged decision was made.
- b. A breakdown showing the number of people against each of the following reasons for why they continue to reside, despite meeting the criteria to be discharged:
 - i. Declared as not meeting the criteria to reside at morning ward round and then later in day meets the criteria to reside so discharge stopped.
 - ii. Awaiting a medical decision/intervention including writing the discharge summary.
 - iii. Awaiting therapy decision to discharge (no acute medical or nursing intervention required; therapist stating that person requires further rehabilitation in the acute hospital).
 - iv. Awaiting referral to community single point of access.
 - v. Awaiting medicines to take home.
 - vi. Awaiting transport.
 - vii. Awaiting confirmation from community hub/single point of access that referral received and actioned. The single point of access should make the decision on which pathway will best meet the needs as described by the hospital not prescribed by the hospital.
 - viii. Pathway 1: awaiting availability of resource for assessment and start of care at home.
 - ix. Pathway 2: awaiting availability of rehabilitation bed in community hospital or other bedded setting.
 - x. Pathway 3: awaiting availability of a bed in a residential or nursing home that is likely to be a permanent placement.
 - xi. Awaiting community equipment and adaptations to housing.
 - xii. Individual/family not in agreement with discharge plans.
 - xiii. Homeless/no right of recourse to public funds/no place to discharge to.
 - xiv. Safeguarding concern preventing discharge or Court of Protection.
 - xv. Repatriation/transfer to another acute trust for specialist treatment or ongoing treatment.

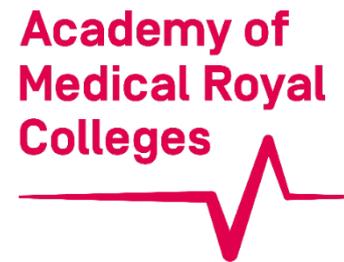
Data for question 9 should also be collected by a weekly review process that is similar to the former Discharge Patient Tracking List (DPTL) process and be submitted weekly each Friday.

- 9) Of the total number of patients who have a length of stay of **14 days or over** who have been judged to meet the criteria to be discharged but who continue to reside in hospital:
 - a. The number of additional days in total they have remained in hospital since the meeting of the criteria to be discharged decision was made.

- b. A breakdown showing the number of patients against each of the following reasons for why they continue to reside, despite meeting the criteria to be discharged:
- i. Declared as not meeting the criteria to reside at morning ward round and then later in day meets the criteria to reside so discharge stopped.
 - ii. Awaiting a medical decision/intervention including writing the discharge summary.
 - iii. Awaiting therapy decision to discharge (no acute medical or nursing intervention required; therapist stating that person requires further rehabilitation in the acute hospital).
 - iv. Awaiting referral to community single point of access.
 - v. Awaiting medicines to take home.
 - vi. Awaiting transport.
 - vii. Awaiting confirmation from community hub/single point of access that referral received and actioned. The single point of access should make the decision on which pathway will best meet the needs as described by the hospital not prescribed by the hospital.
 - viii. Pathway 1: awaiting availability of resource for assessment and start of care at home.
 - ix. Pathway 2: awaiting availability of rehabilitation/reablement/recovery bed in community hospital or other bedded setting.
 - x. Pathway 3: awaiting availability of bed in a residential or nursing home that is likely to be a permanent placement.
 - xi. Awaiting community equipment and adaptations to housing.
 - xii. Patient/family not in agreement with discharge plans.
 - xiii. Homeless/no right of recourse to public funds/no place to discharge to.
 - xiv. Safeguarding concern preventing discharge or Court of Protection.
 - xv. Repatriation/transfer to another acute trust for specialist treatment or ongoing treatment.

12. Additional resources and support

- 12.1 For queries relating to this guidance, please contact england.d2a@nhs.net
- 12.2 This document should be read alongside the 2015 [NICE guideline, transition between inpatient hospital settings and community or care home settings for adults with social care needs](#).
- 12.3 Discharge to assess also forms part of the [High Impact Change Model \(HICM\)](#) for hospital discharge.
- 12.4 For further detail on discharge to assess, please see the [D2A Quick Guide](#).
- 12.5 [Shared guidance to local authority commissioners](#) from the Association of Directors of Adult Social Services (ADASS), the Local Government Association (LGA) and the Care Provider Alliance (CPA).
- 12.6 [COVID-19 action plan for adult social care](#).
- 12.7 Newton Europe publications:
[Why Not Home, Why Not Today?](#)
[People First: Manage What Matters](#).
- 12.8 [Community Health and care discharge and crisis care model: an investment in reablement](#).



Annex A: Criteria to Reside - Maintaining good decision making in acute settings

Every person on every general ward should be reviewed on a twice daily ward round to determine the following. If the answer to each question is 'no', active consideration for discharge to a less acute setting must be made.

Requiring ITU or HDU care?
Requiring oxygen therapy/NIV?
Requiring intravenous fluids?
NEWS2 > 3? (clinical judgement required in persons with AF and/or chronic respiratory disease)
Diminished level of consciousness where recovery realistic?
Acute functional impairment in excess of home/community care provision?
Last hours of life?
Requiring intravenous medication > b.d. (including analgesia)?
Undergone lower limb surgery within 48hrs?
Undergone thorax-abdominal/pelvic surgery with 72 hrs?

Within 24hrs of an invasive procedure? (with attendant risk of acute life- threatening deterioration)

Clinical exceptions will occur but must be warranted and justified. Recording the rationale will assist meaningful, time efficient review.

Review/challenge questions for the clinical team:

- Is the person medically optimised? – (Don't use 'medically fit' or 'back to baseline').
- What management can be continued as ambulatory – e.g. heart failure treatment?
- What management can be continued outside the hospital with community/district nurses? e.g. IV antibiotics?
- Persons with low NEWS (0-4) scores – can they be discharged with suitable follow up?
 - If not scoring 3 on any one parameter – e.g. pulse rate greater than 130
 - If their oxygen needs can be met at home
 - Stable and not needing frequent observations every 4 hours or less
 - Not needing any medical/nursing care after 8pm
 - People waiting for results – can they come back, or can they be phoned through?
 - Repeat bloods – can they be done after discharge in an alternative setting?
 - People waiting for investigations – can they go home and come back as outpatients with the same waiting as inpatients?

Criteria-led discharge:

- Can a nurse or allied health care professional discharge without a further review if criteria are well written out?
- Can a junior doctor discharge without a further review if criteria are clearly documented?
- How can we contact the consultant directly if criteria are only slightly out of range and require clarification?

Annex B: Discharge choice leaflets

It is recognised that issues of individuals choice and engagement can often be significant barriers to hospital discharge where there are ongoing social care needs after discharge (particularly if moving to a residential or nursing home). The following leaflets have been produced to support the communication of this message and are [separately available for download](#). They are available in 12 languages and in Easy Read.

- Leaflet A – to be shared and explained to all persons on admission to hospital
- Leaflet B – to be shared and explained to all persons prior to discharge, this is split into leaflets:
 - Leaflet B1 for persons who are being discharged to their usual place of residence
 - Leaflet B2 for persons moving on to further non-acute bedded care

Discharge choice Leaflet A – on admission to hospital



HM Government



Hospital discharge information

Once you are better, your recovery will be faster back in your own home. It is also important that our hospitals are able to look after people that need hospital care. Due to this, once you no longer need care in hospital, as decided by the health team looking after you, you will be discharged. It is always our priority to discharge you to the best possible place to support your recovery.

In most cases this will be to your home. You might need some extra support to help your recovery or practical help, such as with shopping.

If you require more complex care, this could be in another bed in the community.

Your needs and discharge arrangements will be discussed with you and your family, if you would like them to be involved.

Prepare for discharge

- Speak to staff about your care plan after discharge.
- Include relatives and friends in the conversation – can they offer support to you once you are home?
- What extra help might you need at home?

Discharge choice Leaflet B1 – for persons who are being discharged to their usual place of residence



HM Government



Your hospital discharge: going home



This leaflet explains why you are being discharged from hospital and what you might expect after your discharge.

Why am I being discharged from hospital?

You are being discharged from hospital as your health team have agreed that you are now able to return home.

Why can't I stay in hospital?

It is important that our hospitals are able to look after people that need hospital care. Due to this, once you no longer need care in hospital, as decided by the health team looking after you, you will be discharged. It is always our priority to discharge you to the best possible place to support your recovery.

You will not be able to remain in hospital if you choose not to accept the care that is being offered to you.

What can I expect?

Your health team will discuss discharge and transport arrangements with you (and a family member, friend or carer if you wish). If you require care and support when you get home, this will be arranged.

If you need more care now than when you came into hospital, this additional care will be provided free of charge for up to six weeks to support your recovery. After this time, you may be required to contribute towards the cost of your care.

Who can I contact?

After you have been discharged, if you have any concerns or need to speak to someone about your care, you can contact **<Insert locally agreed details e.g. team name and contact number>**

www.nhs.uk

Discharge choice Leaflet B2 – for persons moving on to further non-acute bedded care



HM Government



Your hospital discharge: another place of care



This leaflet explains why you are being discharged from hospital and what you might expect after your discharge.

Why am I being discharged from hospital?

You are being discharged as your health team have agreed that you are now able to continue your recovery in another care setting, outside of hospital.

Why can't I stay in hospital?

It is important that our hospitals are able to look after people that need hospital care. Due to this, once you no longer need care in hospital, as decided by the health team looking after you, you will be discharged. It is always our priority to discharge you to the best possible place to support your recovery. You will not be able to remain in hospital if you choose not to accept the care that is being offered to you.

What can I expect?

Your discharge and transport arrangements will be discussed with you (and a family member or carer if you wish) and you will be discharged with the care and support you need to a bed in the community.

If you need more care now than when you came into hospital, this additional care will be provided free of charge for up to six weeks to support your recovery. After this time, you may be required to contribute towards the cost of your care.

It is possible that you may be moved more than once after your discharge. This is because we will be trying to find the best place for your ongoing care. Your health team are here to answer any questions you might have.

Who can I contact?

After you have been discharged, if you have any concerns or need to speak to someone about your care, you can get in touch with <Insert locally agreed details e.g. team name and contact number>

www.nhs.uk

Discharge choice Leaflet B3 – for persons' family member or person who will provide care for them in all scenarios



Looking after family or friends after they leave hospital?

This leaflet lists useful advice for family and friends of people needing ongoing care or support with day-to-day life. Support may be in the home or remotely (e.g. by phone), and might include:

- Emotional support like helping someone manage anxiety or mental health
- Housework like cooking, cleaning or other chores
- Personal support like help moving around, washing, eating or getting dressed
- Assistance with getting essential items like medicine or food, or
- Help to manage money, paid care or other services



What to consider if you are looking after someone:

1. Get help from others with caring and everyday tasks:

- Try not to do everything yourself! Speak to friends and family about what support the person needs and what others can do to help. Can they share any tasks?
- Go to the Carers UK and Carers Trust websites for information about support available. Carers UK also have an online forum where you can speak to other carers, and a free helpline, open Monday to Friday, 9am to 6pm on 0808 808 777. Carers UK website <https://www.carersuk.org/>
- If you are employed, talk to your employer about managing work whilst caring. You may be able to arrange flexible working and many employers offer other ways of making things easier.
- If you are at school, college or university, let them know you are caring for someone so they can help you manage your studies. Carers Trust has lots of helpful advice for young people looking after family members or friends. Carers Trust website <https://carers.org/>
- Check what your council or local authority can offer. Find their websites using the online postcode tool at www.gov.uk/find-local-council. Services may change during the pandemic.
- Get specialist advice about caring from condition-related organisations like Alzheimer's Society, Age UK, MIND and others. Many offer [support](#) for carers too.

2. Look after your health as well as the person you support: It's important to look after yourself to stay healthy and avoid burning out. Eat a balanced diet, get enough sleep and try to make time each day for physical activity. Taking time for yourself to exercise or take a few breathers can relieve stress and help you manage each day. Check the NHS 'Every Mind Matters' website <https://www.nhs.uk/oneyou/every-mind-matters/> for more tips. If your own health or the health of the person you support gets worse, with coronavirus or another illness, talk to your GP or call NHS 111.

3. Think ahead to make care manageable if things change: Write down what care the person needs and what others should do if you can't continue providing care for any reason. It's important that others can easily find your plan and quickly understand what needs to be done if you aren't there. Carers UK have advice on their website on how to make your plan.

4. Read the Government guidance for unpaid carers: For more detailed advice on caring for friends or family during coronavirus search for 'unpaid care coronavirus gov.uk' online.

5. Register for extra support from NHS volunteers: Carers as well as those they care for can get a range of help including with shopping and other support by calling 0808 196 3646.

Annex C: Overview of decision making and escalation

Overview of Discharge Decision Making & Escalation to ensure hospital and community beds are freed up



Key Steps	Decision Points & Responsibilities	Route of Escalation
Morning Ward Round	<p>Medical decision to discharge – discharge pathway confirmed</p> <p>(Lead: Senior Doctor in ward)</p>	Executive Director in Acute
Waiting in discharge area in hospital	<p>Case manager agreed</p> <p>(Lead: Local coordinator in acute)</p>	Executive Director in Acute
	<p>Discharge activities agreed incl. transport and medication</p> <p>(Lead: Single coordinator in acute)</p>	
Patient leaves hospital or community bed	<p>Transport to home or bedded setting</p> <p>(Lead: Single coordinator in acute)</p>	Executive Director in Acute (for acute issues) and Director of Community Services (for community health issues)

Overview of Discharge Decision Making & Escalation to ensure assessment and support is provided



Key Steps	Decision Points & Responsibilities	Route of Escalation	
<p>Assessment at home</p>	<p>Trusted assessor visit for those on pathway 1 – acute or community health care professional</p> <p>(Lead: Single coordinator in acute)</p>	<p>Executive Director in Acute (for acute issues) and Executive Director of Community Services (for community health issues) and Director of Adult Social Services (for social care issues)</p>	<p>Gold Command EPRR Team</p>
<p>Care provided as needed</p>	<p>At home support provided as needed by health and/or social care</p> <p>(Lead: Single coordinator in acute)</p>	<p>Executive Director of Community Services (for community health issues) and Executive Director of Adult Social Services (for social care issues)</p>	<p>Gold Command EPRR Team</p>
<p>Review post short team support</p>	<p>Ongoing short term support as needed by health and/or social care or discharge from all support</p> <p>(Lead: Single coordinator in acute)</p>	<p>Executive Director of Community Services (for community health issues) and Executive Director of Adult Social Services (for social care issues)</p>	<p>Gold Command EPRR Team</p>

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Maidstone and Tunbridge Wells NHS Trust

Winter Plan

Financial Summary

Continuation of Current Costs (Funded)

Directorate	Division reference number	Scheme	Comment / Extra Information	Costs in funded baseline (Y / N)	Nov	Dec	Jan	Feb	Mar	Total
Medicine		Ward 11 Escalation								£ -
Medicine		Cornwallis Escalation								£ -
Total					£ -	£ -	£ -	£ -	£ -	£ -

New Additional Costs

Elective

Directorate	Division reference number	Scheme	Comment / Extra Information	Costs in funded baseline (Y / N)	Nov	Dec	Jan	Feb	Mar	Total
General Surgery	W2223 - 1	Speciality doctor - FTC 6 months x2	To reduce bank and agency spend through winter sickness and add a spot on the rota for twilight to solely help flow in SAU leaving the other doctor to be solely CEPOD. 12pm-9am, 2 doctors required to run 7 day service	No	£ 14,000	£ 14,000	£ 14,000	£ 14,000	£ 14,000	£ 70,000
General Surgery	W2223 - 2	B3 Admin Clerk - SAU, Bank, 5 months	B3 Admin Clerk for weekend cover - currently only a 5 day service - +2 w/e shifts to assist with admin duties, Bank cost = 0.5 WTE B3	No	£ 2,849	£ 2,849	£ 2,849	£ 2,849	£ 2,849	£ 14,243
General Surgery	W2223 - 3	B3 Admin Clerk - Ward 10 & 32, Bank, 5 months	Evening admin support for the Ward to release nurses of admin duties, 4-8pm = 0.75 WTE B3, Bank cost	No	£ 5,697	£ 5,697	£ 5,697	£ 5,697	£ 5,697	£ 28,487
General Surgery	W2223 - 4	Additional ward cover - 2 x Specialist doctors each day at the weekend Saturday and Sunday 8-6 to facilitate weekend discharges maintaining flow from ED	Last year additional weekend ward cover was arranged and assisted in ensuring the higher number of post take patients were seen in a timely manner at the weekend.	No	tbc	tbc	tbc	tbc	tbc	£ -
Ophthalmology	W2223 - 5	Medical Staffing Bank to cover absences	Doctors, additional bank spend to keep Rapid Access and injection clinics running - to backfill leave over Christmas/New Year period and also to backfill any absence due to Covid isolation rules. (similar to August spend)	No		£ 4,000	£ 4,000			£ 8,000
Specialist Surgery	W2223 - 6	Foster Clark escalation	10 medical outliers on Foster Clark ward (cost transfer to Medicine needed if ward changes don't go ahead)	Yes	tbc	tbc	tbc	tbc	tbc	£ -
Specialist Surgery	W2223 - 7	Increased breast capacity for winter surge	WORST CASE SCENARIO BREAST AWARENESS WEEK IN OCTOBER 2022 :- Sat & Sun insourcing at £11k per day, weekly during Nov, Dec, Jan; apply 50% risk	No	£ 55,000	£ 44,000	£ 55,000			£ 154,000
Specialist Surgery	W2223 - 8	Increased Urology capacity for winter surge	WORST CASE SCENARIO PROSTATE AWARENESS INCREASE :- Sat & Sun insourcing at £11k per day, weekly during Nov, Dec, Jan; apply 50% risk	No	£ 55,000	£ 44,000	£ 55,000			£ 154,000
T&CC	W2223 - 9	extra Agency/bank Nursing staff ITU both sites	ITU bank and agency likely to increase to covid 2 level both sites; 2-3 per shift B6 rate; similar to wave 1 expenditure	Yes	£ 10,000	£ 10,000	£ 10,000	£ 10,000	£ 10,000	£ 50,000
T&CC	W2223 - 10	extra ITU disposables both sites		Yes	£ 3,000	£ 3,000	£ 3,000	£ 3,000	£ 3,000	£ 15,000
T&O	W2223 - 11	B4 Trauma Co-ordinator support, Bank backfill, 5 months	5 month secondment, B4 into the Trauma Co-ordinator team, to improve flow, act up internally, backfill from Bank	No	£ 3,273	£ 3,273	£ 3,273	£ 3,273	£ 3,273	£ 16,367
Total					£ 148,819	£ 130,819	£ 152,819	£ 38,819	£ 38,819	£ 510,097

Non Elective

Directorate	Division reference number	Scheme	Comment / Extra Information	Costs in funded baseline (Y / N)	Oct	Nov	Dec	Jan	Feb	Mar	Total
Medicine		Escalation of 18 beds on the old AMU and Maidstone	Do we know what this might be?								£ -
		Increase opening hours of all SDEC areas (SAU / AFU / AEC)	Is this the recent business case about extending hours?, this has been agreed so from a financial point of view should already be planend for								£ -
		CHS Funding									£ -
Total						£ -	£ -	£ -	£ -	£ -	£ -

Community Capacity

Directorate	Division reference number	Scheme	Comment / Extra Information	Costs in funded baseline (Y / N)	Oct	Nov	Dec	Jan	Feb	Mar	Total
Multiple		Double handed and hard to procure packages of care in order to be able to discharge patients and maintain flow through the winter period. Current discussions with Pulse Gome care					£ 87,517	£ 87,517	£ 87,517	£ 87,517	£ 350,068
		Hawkhurst House Additional Beds	£1,723 per week per patient - Need to provide a 'best estimate of extra rooms			Depends on number of beds					£ -
		CHS Funding	Current fundin gfrom ICB to reduce from October, if require service at current levels then this would be c£50k per month pressure	£ 50,000	£ 50,000	£ 50,000	£ 50,000	£ 50,000	£ 50,000	£ 50,000	£ 250,000
Total				£50,000	£ 50,000	£137,517	£137,517	£137,517	£137,517	£137,517	£ 600,068

Therapy

Directorate	Division reference number	Scheme	Comment / Extra Information	Costs in funded baseline (Y / N)	Oct	Nov	Dec	Jan	Feb	Mar	Total
		Urgent Care Therapy Team to increase admission avoidance	1 therapist on each site from 8am to 8pm seven days a week would require an additional 6wte.This would enable 8am to 8pm presence in ED and AFU.			£ 14,000	£ 28,000	£ 37,613	£ 33,103	£ 33,103	£ 145,819
		TADS Service Increase to Ensure Responsive Service to Reduce Length of Stay				£ 14,000	£ 21,000	£ 16,613	£ 14,358	£ 14,358	£ 80,329
Total						£ 28,000	£ 49,000	£ 54,226	£ 47,461	£ 47,461	£ 226,148

Other

Directorate	Division reference number	Scheme	Comment / Extra Information	Costs in funded baseline (Y / N)	Oct	Nov	Dec	Jan	Feb	Mar	Total
		Safer Better Sooner Corporate Project - Senior Nursing on weekend									£ -
		Cost of Living Support - Parking vouchers									£ -
Total						£ -	£ -	£ -	£ -	£ -	£ -

Grand Total (Excluding Continuation of existing escalation) £ 226,819 £317,336 £344,562 £223,797 £223,797 £1,336,313

Current Forecast

MEC Winter Plan		
Included		
Initials	Name	Role
TH	Tim Hubbard	Interim DDO
SW	Steve Williams	Head of Performance & Delivery
GV	Gemma Viner	DDNQ
KHA	Kate Hallowell	Lead Matron AMG
SK	Seeth Krishnamurthy	GM AMG
KC	Katie Cornwell	GM Med Spec
MG	Mansiri Gurung	Lead Matron Med Spec
KHO	Kate Holmes	GM ED
GS	Glenda Sonquit	Lead Matron ED
AW	Amanda Weightman	Matron AMG
LM	Laurence Maiden	Chief of Service

Number	Theme	Action	Updates	Target Dates	Assigned	Open/Closed
1	Capacity	Link with Safer Better Sooner team on frequent flyers with LOS over 14 day - see what specialist support can be offered to primary care	Hot clinics in place.		SW	
2	Capacity	Discuss potential virtual ward pathways with AAM / AAU consultants	Have specific conversation re admissions from AAU to virtual ward to ensure would work before any work put into it. Keep TH in loop (represents division at VW meetings)		KHA / SK	
3	Covid pathway	Ensure plans remain ready to be stood up should demand increase	Demand already increased, plans activated.		GV / TH	Closed
4	Elective activity	Understand impact of cath lab escalation on activity at Maidstone	KC has info from IP to look at. Any potential to go through surgery? Send out to KIMS?		KC / MG	
5	Elective activity	Confirm divisional preference re escalation into ASU footfall rather than Maidstone cath lab	Old stroke unit to be used for escalation once moved into new unit; staffing being scoped.		GV / TH	
6	Capacity	Additional capacity - accelerate virtual ward	TH to engage with this. Respiratory pathway in place. AEC patients to VW as next step. Cohort area to scope - ? Wingman tent, though rather isolated. Tentative enquiries to be made.		TH	
7	ED	Management of ambulance handover over winter	Otherwise in corridors with additional staffing as last year. GS has done walkround with IPCT re space.		KHO / GS	
8	ED	Coping with 800-900 attendances - robust surge plan to be shared with Division	Plan made, waiting for costings. To be written up to present asap		KHO / GS	
9	ED	Coping with 800-900 attendances - work up 24/7 GP UTC clinics, look into pre-business case funding via winter monies	Costings awaited		KHO / GS	
10	Capacity	Admissions avoidance / SDEC - can more be done? Protect Hilton spaces for frailty	Maidstone now running to 10pm. TWH - extension of hours / new doctors - achievable. Frailty escalation is biggest issue. Outreach info being collated, working with ECIST. Protected spaces for frailty - live on 4.10.22 - to monitor and potentially expand.		KHA / AW	
11	Capacity	Admissions avoidance / SDEC - increase into and more robust speciality in reach in ED	Improved although somewhat consultant-specific. TH to discuss further with LM		KC / KHO TH / LM	
12	Discharge planning	Robust Friday weekend plan / discharge planning meeting, consultant led / criteria led	Friday meeting of varying quality, focus needed to improve. Consultant engagement - ? SOP to be written by senior reg. Need MDT approach with IDT. To revamp and embed.		KC / SK	
13	Discharge planning	Trial two wards with senior cover at weekend to see if discharges improve	John Day being put forward to Safer Better Sooner team		KHA / MG / GV / SK / KC	
14	Teletracking	Encourage one version of truth - all Board Rounds / mop up board round decisions to be robustly recorded	TT completed effectively when flow coordinators are around. Are nursing staff deskilled? Need to be able to update after 4pm. Sally was to speak to teams re this - refresher training.		MG / KH	
15	Teletracking	Weekend meeting plan to be reflected on teletracking	See action 12 above - once revamped meeting in place can action.		KC / SK	

16	ED	Management out of hours, particularly at TWH - action plan to be brought to meeting (incorporated in surge plan)	Skills mix - ENP and B6 confidence in sending to GP and minors clinics out of hours. Senior cover out of hours trialled for a week - issues raised the same as when they leave at normal time. May bid for additional winter monies, but would have to use staff already in dept due to timescales with recruitment. Info to be included in surge plan at action 8 above asap	KHO / GS
17	Escalation	Understand impact of cath lab escalation and decide divisional escalation plan	Escalation policy being worked on - there is a plan. SK reviewing medical cover and equipment.	TH / GV / LM
18	Escalation	Explore potential nursing leadership for escalation on ASU over winter	As action 17	KHA / MG
19	Escalation	Understand medical plan	As action 17	TH / LM
20	System support	Reminder to on call managers that mutual aid support needs to be agreed at Exec level	To be reinforced to rest of system. Comms to go out via ICC	TH
21	Annual leave	Joint work with medical staffing over winter period	Comms to be sent to consultants re their team's annual leave	TH
22	Discharge	Implement 7 day respiratory ward rounds	Awaiting start date from resp lead	TH
23	Discharge	Implement 7 day Gastro ward rounds	job planning start date 31st Oct	TH
24				
25				
26				

Planned Care Winter Planning 2022/23
(this paper will be embedded into the Trust winter plan).

Version control	Changes	Date of amendments
V1	Initial Draft	David Robinson 21/09/22
V2	Activity numbers now included	11/10/2022
V3	Update following SD review	18/10/2022

1) Introduction

Like winter 2020/21, winter 2022/23 will come with additional challenges relating to possible severe weather, influenza and, at the present time, unknown effect of COVID-19. This is likely to have a significant impact on the Trusts elective care services, at a time when the backlog for patients waiting for an elective procedure, locally and nationally, is at its highest in the last decade. In addition, staff (all disciplines) are fatigued following an unprecedented 2020 and elective reset and recovery in 2021/22. Staff welfare is the Trusts and the Surgery Divisions number one priority.

The purpose of this document is to describe the arrangements put in place by the Surgery Division over the winter period (including the Christmas and New Year holidays). This plan reviews the key deliverables for the Surgery Division, including a Directorate checklist, to ensure the Trust meets the needs of the patients and staff. Lessons learnt and plans to support during this period are identified and are cost effective, sustainable over the period and helps to mitigate some of the pressures of MTW at this challenging time.

The plan is a live document and will be updated continuously, in light of any changes to capacity and demand and any potential severe weather, influenza or Covid-19 increases.

2) Key Deliverables for Surgery

- To deliver 85% of elective care as day cases and 15% as in patients and maintain this threshold throughout the winter period.
- HVLC and BADS to be incorporated into activity
- Implement national standardised protocol/template for follow up activity.
- Ensure our staff are fully supported to be able to deliver an effective 'winter' period.
- Continue to improve pathways/systems in preparation for winter to support the overall flow of the Trust, particularly during the periods of higher demand from emergency patients.

3) MTW Elective Operational Planning Submission

To support the Trust planning submission (22/23) each Surgery Directorate undertook a review of capacity and demand profiles, supported by Business Intelligence (BI). This activity is reviewed weekly at the Trust Performance meetings. The plan assumes no 104 and no 52-week breaches.

In order to maintain elective activity over the winter period the following is in place:

- 6-4-2 scheduling and Theatre performance/utilisation meetings
- Weekly Trust Performance meetings
- Exec Performance Report

Please see appendix 1 for activity vs actual to date and FOT.

ii) Independent Sector (Prime Provider West Kent)

This will be consistent with annual planning.

4) Total Elective Activity Modelling

The Trust activity modelling is based on the requirements of the national operating plan (see appendix 2). Modelling for the beds required for non-elective patients over this winter period suggests a requirement of xxx beds, peaking at xxx beds in xx 2023 (Will be added when Lightfoot/MTW internal planning is confirmed).

Total elective activity modelling (excluding Independent Sector (IS)) suggests the following:

Dec-22	Daycase	Elective	Total
Working Days	21	21	21
Plan	1,978	376	2,354
Ave Daily Attends	94	18	112

Jan-23	Daycase	Elective	Total
Working Days	21	21	21
Plan	2,078	405	2,483
Ave Daily Attends	99	19	118

5) Surgery Financial Assessment of Winter Plan and Operational Resilience

As highlighted in Section 3, a number of potential schemes to support operational resilience over the winter period have been reviewed for the Division. In addition, we were made aware my ICB system partners in August that there may be potential for further additional monies through the TIF scheme. At this current time these plans are being further prioritised and worked up into business cases to submitted to the wider system once winter funding is known/available.

*As at 19/10/22 the Trust have not had any confirmation of funding or approved schemes, however the TIF long list can be found in appendix 3.

The Divisional winter schemes can be found in workbook below.



finance winter
plan3.xlsx

8) Surgery Division Directorate Checklist

As part of the preparations for winter, a winter checklist will be completed by each Directorate within the Surgery Division. As part of this items including Christmas period annual leave and Directorate red risks will be gathered, with mitigations to support reduced risk over the period. Business Continuity Plans (BCP) have been updated and contact details for both medical and clerical staff are on Trust network with contact details. Staff aware of ongoing vaccination availability for Covid and Influenza.

Capacity and backlog monitored via PTL and weekly review of all operating lists. Members of the Directorates attend daily bed mapping meeting for both TWH and MGH. A number of WLIs in place to support reduction of backlogs. Daily huddles with booking teams and patients are being telephoned to remind them of their appointments and TCI dates.

Annual leave will be agreed by the Senior Team and Directorate teams informed no later than end of November, but teams will work to the annual leave policy.

8.1 Risk Register (as at 13th October)

Following the review, there is currently only 1 RED risk within the Division and 17 amber (scores between 8-12).

RED

- Orthoptic department vacancies (15). Mitigations in place include:
 - Recruitment and Retention premium request report being prepared
 - 3.0 WTE Posts advertised again
 - Report requested from HR to analyse any patterns in recruitment
 - Details of posts and new job pack emailed to Universities to promote to their final year students
 - Staff surveyed for preferences for working overtime / WLI, continued 1:1 meetings and team surveys

AMBER (17)

Directorate	No of Amber risks	Controls in place
Surgical Specialities	5	YES
Theatres and Critical Care	5	YES
ENT	0	YES
Orthopaedics	3	YES
General Surgery	2	YES
Ophthalmology	2	YES

Appendices

Appendix 1 - activity vs actual to date and FOT.

Appendix 2 – National Operating Model requirements

Appendix 3 – TIF Schemes

Surgery Division Action Plans

Initiative / Plan Planned care	Explanation of what it involves	Progress update for 22/23 Winter	Implementation Date	Lead
1. Achieve the national requirement for winter	15% inpatient and 85% day case activity	ongoing	Throughout winter	<ul style="list-style-type: none"> David Robinson
2. Maintain elective activity at Maidstone (MGH). Ensure elective activity continues at MGH to assist in maintaining RTT & cancer performance.	<p>All Theatre lists will run as normal in Main theatres, EEMU and MSSU.</p> <p>Maximise HVLC and day case activity (85%) to support flow out of the Trust, rather than an overnight stay.</p> <p>Review of current capacity and demand profiles</p> <p>Review of Foster Clark ward beds</p> <p>increase Ophthalmic HVLC Lists.</p>	Activity to be reviewed weekly and a six-week activity plan to be produced	December 22	<ul style="list-style-type: none"> T&O – Dan Lyons Ophthalmology – Claire Hubert ENT – Jo Woodard Gen Surg – Lucinda Hill Surgical Speciality – TBA Sharon Page
	Robust 6-4-2 model in place – process to be expanded from 28/11/22 so that theatre lists not required due to leave will be given to the speciality dependent on the overall clinical and operational need and not offered out to the same speciality.	Process currently in place and will change from 28/11/21	28/11/22	<ul style="list-style-type: none"> Joana Silva

	Available theatre slots due to leave to be monitored at the weekly 6-4-2 meeting and designated by the DOO Surgery			<ul style="list-style-type: none"> David Robinson
<p>3. Maintaining elective activity at Tunbridge Wells (TWH)</p> <p>Ensure elective activity continues at Maidstone to assist in maintaining RTT & cancer performance.</p>	<p>All Theatre lists will run as normal</p> <p>Maximise day case activity (85%) to support flow out of the Trust, rather than an overnight stay.</p> <p>Review of current capacity and demand profiles</p> <p>Review Gynae lists for use of short stay</p> <p>Accelerate the development of the enhanced care unit – this will support LOS, Nursing ratio's and potentially ring fence beds for Colorectal Surgery.</p>	As per MGH		<ul style="list-style-type: none"> T&O – Dan Lyons Ophthalmology – Claire Hubert ENT – Jo Woodard Gen Surg – Lucinda Hill Surgical Speciality – TBA
	Additional CEPOD/Trauma lists to be provided when necessary in conjunction with elective demand.	Activity to be reviewed weekly and a six-week activity plan to be produced from 28/11/21 and signed off by DOO Surgery		
	Robust 6-4-2 model in place – process to be expanded from 28/11/21 so that theatre lists not required due to leave will be given	As per MGH		<ul style="list-style-type: none"> Joana Silva

	to the speciality dependent on the overall clinical and operational need and not offered out to the same speciality.			
	Available theatre slots due to leave to be monitored at the weekly 6-4-2 meeting and designated by the DOO Surgery			<ul style="list-style-type: none"> David Robinson
<p>4. Escalation plan for TWH involving surgery</p> <p>To provide medical space without impacting surgical activity to support ED performance as part of the escalation plan.</p>	<p>SSSU to utilise beds 1-9 for NEL patient pathways</p> <p>Development of T&O SDEC</p>	SSSU 10 – 24 is a super green area so suitable surgical patients will move to SSSU to free beds in our main bed base	Complete	<ul style="list-style-type: none"> Sharon Page
<p>5. Maximising elective activity before 23rd December 2022 across both sites</p> <p>Improve RTT position and reduce waiting times before heading into winter.</p>	Ensure all existing sessions are fully utilised and pushed as much as possible to mitigate any loss of activity in Q4.	Weekly RTT monitoring in progress	Ongoing	<ul style="list-style-type: none"> Steph Parrick and GM's
<p>6.. Critical care capacity to meet peaks in demand within the Trust and within the local network.</p> <p>All escalation is dependent on a suitably trained workforce and staff are utilised flexibly across the</p>	<p>MH – ITU beds increased to 14 substantively</p> <p>TW – ITU increased to 9 substantively. A further 8 beds available on CCU.</p> <p>2 x extra beds available in Emergency recovery</p>	<p>For super surge of Covid:</p> <p>MH – Existing ITU/CPU</p> <p>ITU escalation triggers to be followed and implemented accordingly. ITU to be used</p>	Ongoing	<ul style="list-style-type: none"> Sharon Page

<p>site on a daily basis to accommodate the patients need. This may be supported by the Critical Care Outreach Service if required.</p> <p>Secure improved flow of patients into and out from the available ITU.</p>	<p>6 x 1.5 level beds available on W32</p> <p>Development of ITU flow SOP</p>	<p>for green patients and CCU for amber/red patients.</p>		
<p>7.. Implement an extra Registrar in SAU for Surgery and T&O</p>	<p>Recruit a Registrar from December –March to manage patient flow within the SAU.</p>	<p>Plans to facilitate this are currently in progress</p>	<p>30/11/20</p>	<ul style="list-style-type: none"> Greg Lawton/Danny Lawes/ James Nicholl
<p>8. Increase use of Hospital at Home</p> <p>This will assist in reducing surgical admissions and LOS.</p>	<p>Patients to be identified either on an elective or non-elective pathway that can be discharged and mindfully watched at home by KCHFT.</p> <p>Surgical beds to be freed up for non-elective activity (expectation of up to 5-25 patients at any one time)</p>	<p>Planning in progress, pathways to be agreed with clinicians.</p>	<p>Ongoing</p>	<ul style="list-style-type: none"> Sharon Page
<p>9.Escalation plan</p>	<p>Review of the escalation plan with clear triggers to be reviewed and agreed in November.</p>	<p>Confirmed escalation will be required to reflect the bed modelling demand.</p> <p>Ensure all directorates are aware of the triggers of escalation and the expectations to be set.</p>	<p>01/11/22</p> <p>End of November 22</p>	<ul style="list-style-type: none"> Sharon Page Sharon Page/Matrons/ GMs

		To be an agenda item at Divisional Board		<ul style="list-style-type: none"> Sharon Page
10. Increased management cover over holiday period	Review opportunity for greater management cover over holiday periods e.g. more business as usual	Rota for management AL	End of November 22	<ul style="list-style-type: none"> Dan Gaughan
		First two weeks of January separate rota to be implemented to ensure greater cover over a 12 hour period.		<ul style="list-style-type: none"> Dan Gaughan
11. Patient and Staff swabbing	Continue as per IPC guidance		Ongoing	<ul style="list-style-type: none"> Sharon Page
12, Covid & Flu vaccination programme	Monitor staff take up of vaccination		Ongoing	<ul style="list-style-type: none"> Sharon Page

Paediatric Directorate Winter Pressure plans 2022-2023

Initiative / Plan	Explanation of what it involves	Progress update for 2022 Winter	Implementation Date	Lead	RAG
SDEC plans in place for paediatrics	SDEC 111 and SDEC GP pathways to be put in place for paediatrics to both ambulatory units. Reducing attendances to ED and a pathway in place for review by a paediatrician	In place and being monitored – Paediatric Registrar to carry CISCO phone to triage calls and gateway to ambulatory care in place 9-5 Mon to Friday at Riverbank MH and 9-5 Mon to Sunday on Woodland Unit TWH  Paediatric SDEC111 -final.docx	Fully implemented July 2022	Jackie Tyler / Andrew Lindsey	
Paediatric POPEL plans in place to support decision making during surge activity	Paediatric surge plan updated and include actions for all areas – linked to OPEL plan and activity levels STPN dashboard to be in place to review paediatric bed capacity in sector OCC Sitrep calls in place to support movement of patients and request for mutual aid / treat and transfer pathways	Three times a week Paediatric sitrep calls in place Mon, Wed and Fri to discuss mutual aid and support across Kent and Medway STPN dashboard available to all staff in paediatrics and in paediatric ED https://stpn.beautifulinformation.org/#2 Paediatric surge plan available in all areas including paediatric ED – kept in emergency planning folder  2022 opel surge for OCC.docx Paediatric surge plans discussed and implemented with all local trusts and OCC pathway in place	Fully implemented July 2022	Jackie Tyler	

Paediatric Directorate Winter Pressure plans 2022-2023

Initiative / Plan	Explanation of what it involves	Progress update for 2022 Winter	Implementation Date	Lead	
Over recruitment of staff to support escalation beds within paediatrics	Winter Funding was not included in Budget, additional staff employed to increase staffing capacity as cost pressure to support opening of 4 extra winter pressure beds.	<ul style="list-style-type: none"> Awaiting 9 paediatric overseas nurses to start at MTW - (6 for Paediatric ED and 3 for Hedgehog) – pathway designed and in place with GOSH for OSCE training and Clinical Facilitator in post Rolling advert out for paediatric staff continues 	November 2022 Awaiting start date for overseas nurses	Jackie Tyler / Rebecca Davies	
Review of Paediatric ED opening hours on Riverbank – currently closes at 2000	Task and finish group required as Paediatric ED does not sit under paediatrics	Awaiting task and finish group to commence and business case led by ED	TBC	Timothy Hubbard and Glenda Sonquit for ED Jackie Tyler for Paeds with Dr Patankar	
Implementation of SOP for Long term Ventilation patients	SOP in place with 3 agencies and staff bank to allow the care packages for CYP to flow into the acute hospital, supporting families and allowing staff to manage more than one patient as single cubicles – these patients require 1:1	SOP in place and agreed with CCG, KCHFT, relevant agencies and Staffbank Pathways in place and working well  SOP for LTV agency provision.docx	October 2022 Awaiting finalisation of SOP at October Paediatric Directorate Meeting	Jackie Tyler	
Review of pathways to critical care	Pathways for young people aged 12 and over to be in place for ITU at MTW STPN attend surge plans with Paediatric leads and OCC three times a week to discuss issues	Guideline and pathways reviewed and in place	Implemented	Lindsay Reynolds Jackie	

Paediatric Directorate Winter Pressure plans 2022-2023

Initiative / Plan	Explanation of what it involves	Progress update for 2022 Winter	Implementation Date	Lead	
Review of equipment and training	Staff to be upskilled in High flow ventilation and CPAP / SiPAP with appropriate equipment on unit Additional suction and oxygen to be implemented in rooms that can be converted for escalation purposes	<ul style="list-style-type: none"> New cots ordered – no money in budget so cost pressure to support potential increase in infants attending New training in place for all staff via STPN – Pan London and Kent approach https://stpn.uk/ Training completed in Bronchiolitis, Vapotherm and Paediatric Basic life support mandatory training New guidelines updated and joint with STPN Additional respiratory equipment orders increased alongside pharmacy to support activity levels 	Awaiting cots on order – All actions completed August 2022	Jackie Tyler Lindsay Dilley – Clinical Educator for Paediatrics	
Support for young people with mental health disorders	Pilot to commence 10 th October for welfare checks to be implemented 48 hours for those patients who do not require admission or can be managed at home	<ul style="list-style-type: none"> QIA and SBAR approved by ICB Ready to launch 10th December 2022 	10 th October 2022	Eunice Goto / Jackie Tyler	
Reduction in agency usage for young people requiring 1:1 Enhanced care due to mental health related issues	Increase substantive staff with new role for Mental health Support Workers on Hedgehog to reduce number of RMNs required and also risk of bed closures	Business case being submitted to release funds as agreed by trust as service improvement. Training in place once agreed to go to recruitment Job description approved AFC and HR	November 2022	Nicola Cooper / Michelle Turton	

Paediatric Directorate Winter Pressure plans 2022-2023

Initiative / Plan	Explanation of what it involves	Progress update for 2022 Winter	Implementation Date	Lead	
Implementation of 2 nd isolation room on NICU	Additional isolation unit to be developed on NICU at TWH Can be used by appropriate infants <72 hours who attend for paediatrics Clear covid pathway in place with maternity	Isolation room in place Guideline for use by paediatrics in place	September 2022 Fully implemented	Lou Mair / Jackie Tyler	
Increase staffing at KCHFT (Paediatric community service provider) to support early discharge and support in the home	Meetings in place with KCHFT and ICB for increased winter pressure staffing for the community team 1. To review CYP with respiratory problems as a follow-up to facilitate early discharge 2. Sleep studies to be carried out in the home and not at MTW 3. To provide a new service of Infusion IVABs in the home	1. KCHFT have over recruited as a cost pressure to enable an increase in capacity to support winter pressure plans and are considering a 7-day service, currently 5 2. Overnight Sleep studies are now not attending MTW and can be done in the home 3. Meetings and business case underway led by KCHFT to support an increase in their infusion service for MTW and reduce attendance at MTW	November 2022 Partially implemented	Eunice Goto / Jackie Tyler	
Review of staff on Staffbank and agencies that can support paediatrics	Review underway with trust approved framework agencies to actively recruit paediatric staff New agencies to be added to staff approved list who have paediatric staff already – Unity and Emergency Personnel Communication exercise to be implemented and upskilling / training for all staff of any band on the bank to be able to work in paediatrics	<ul style="list-style-type: none"> Meetings completed with Staffbank and Deputy Chief Nurse supporting this process Two agencies going through process to be able to be accessed rather than go to Non-framework Training and competencies in place Awaiting dates for event 	November 2022	Jackie Tyler / Staff bank / Hannah Thompsett	

Paediatric Directorate Winter Pressure plans 2022-2023

Initiative / Plan	Explanation of what it involves	Progress update for 2022 Winter	Implementation Date	Lead	
Increase medical cover to support activity in line with surge plans	Medical staffing to facilitate bank/agency cover for an additional Middle grade/Reg on at nights and weekends. To support additional beds in escalation beds (4-8 additional beds).	<ul style="list-style-type: none"> • Plan in place • All medical staffing aware of plans and process. • Rota co-ordinator aware and agency's known to facilitate. 	November	Andy Lindsey/Carolyn Pitts/ Dr Rajesh Gupta	

TADS and Urgent Care Therapy Winter Capacity 2022/23

Introduction

This paper is to highlight areas which would benefit from additional therapy workforce in winter 22/23 and the associated costs and expected impact. Two areas have been reviewed to support admission avoidance and early supported discharge (UCTT and TADS).

TADS

Current Position

The TADS service provides supported discharge to all orthopaedic, medical and surgical adult patients to enable discharge to their normal place of residence as early as possible as well as supporting patients referred from A&E to avoid unnecessary hospital admissions.

Since 2019/20 there has been a 21% increase in the average number of monthly referrals to TADS. This equates to an additional 64 patients to be seen each month.

The average direct clinical care required per TADS patient is 4.8 hours including:

- 1 new visit
- An average of 3 follow up visits
- Indirect patient contacts
- Travel time
- Note writing, reports and referrals
- Screening and allocation of new referrals and daily handover

This additional demand without increasing the workforce capacity has led to a decline in TADS key performance metrics. The TADS teams have not been able to maintain the target to see 95% of patients within 24 hours of discharge home (excluding early visits declined by the patient, inability to gain access and late receipt of referrals). This is particularly important for patients referred from A&E, those discharged home with complex needs and to avoid unnecessary readmissions. The service is also unable to offer as many follow up visits increasing the numbers of patients receiving an assessment and advice only service and increasing the numbers referred on to community therapy teams for further therapy.

TADS Key Performance Indicators	2019/20	2022/23	Impact
Patients seen within 24 hours of discharge home excluding early visits declined by the patient, inability to gain access and late receipt of referrals	95.2%	81.4%	↓
Patients achieving rehabilitation goals during TADS intervention	74.0%	60.2%	↓
Patients requiring further therapy on discharge from TADS	10.8%	14.7%	↑
Patients receiving TADS Assessment and Advice only	14.60%	23.40%	↑

Proposal

To achieve the TADS key performance indicators, maintain a responsive TADS service, optimise patient recovery and reduce handovers of care to community rehabilitation teams additional staffing is required.

To deliver an average of 4.8 hours of direct clinical care to 64 additional patients a month would require an additional 312 direct clinical care hours a month. Allowing for 21% leave cover and an average of 15% SPA will require an additional 3.00wte to accommodate this increase in direct clinical care and return to the performance level in 2019/20.

In addition, the demand for TADS is expected to increase again over winter. Prior to Covid there increase was a 6% increase in the caseload between November and March. This would be an additional 23 patients, requiring 110 direct clinical hours each month. To meet this, need a further 1.00wte of capacity is required during the winter months.

To optimise efficiency of the TADS service a skill mix of experienced therapists and Band 4 Assistant Practitioners are required.

Proposal: TADS Additional Staff in Post (Phasing)

	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	
Band 7 Locum	2	3	2	1	1	
Band 7 Substantive	0	0	0	1	1	
Band 6 Substantive	0	1	1	1	1	
Band 4 Substantive	0	0	1	1	1	
Total Staff in post	2	4	4	4	4	
Cost	£14,000	£21,000	£16,613	£14,358	£14,358	
					£80,329	Total

The additional substantive posts will be part of 2023/24 business planning.

Sourcing of additional candidate required:

- 1.00wte Band 6 recruitment process initiated with a TADS therapist who left the Trust within the last year has contacted TADS requesting opportunity to return.
- 1.00wte Band 4 to include in existing Band 4 recruitment activity.
- 1.00wte Band 7 recruitment to be started.

Benefits

- Reducing length of stay for an additional 23 patients a month by at least one day. Over 5 months saving 115 bed days.
- 95% of TADS patients seen within 24 hours of discharge home excluding early visits declined by the patient, inability to gain access and late receipt of referrals.
- 75% of TADS patients achieving rehabilitation goals during TADS intervention.
- Less than 10% of TADS patients requiring further therapy on discharge from TADS.
- Improved patient experience and outcomes associated with admission advance/reduced length of stay in hospital.
- Improved staff welfare, team resilience and sustainability reducing risk of staff sickness and turnover.

- Earlier access to TADS assessment for equipment and care need review to facilitate reduction in care package requirements.

Urgent Care Therapy Team

The Urgent Care Therapy Team operate from 8am to 8pm seven days a week in ED, AFU, AMU, Ward 2 and Whatman. It is a high performing team seeing 95% of patients referred from ED and AFU within one-hour, supporting avoidance of unnecessary admissions and enabling early hospital discharges. In order to maintain this level of performance the service has run over establishment by 2.0wte.

Current Position

There are 5 members of staff per day Monday to Friday and 2 to 3 per day at weekends and bank holidays at each hospital site. This means that unplanned leave by one member of the team results in 20% of the service will not be available during the week and 50% at weekends. This impacts on patient care and flow through the hospital.

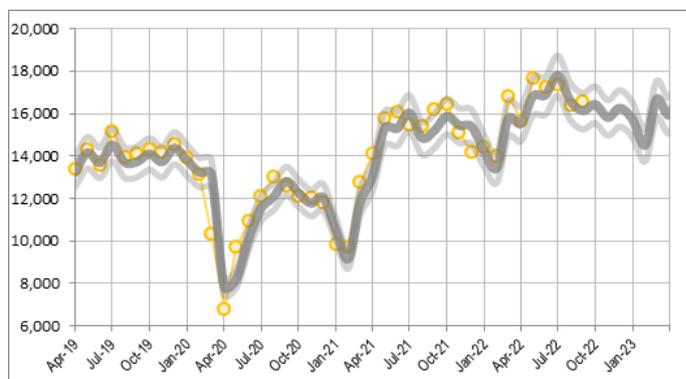
The number of patients seen by UCTT in ED has now returned to pre-Covid pandemic levels and are currently averaging 173 a month.

Despite ambition to increase activity in the Frailty Acute Assessment Unit the numbers of patients seen by therapists on this pathway from April to July this year has reduced to an average of 40 less patients a month compared to the same time period last year.

From April 2021 to March 2022 7,028 new patient assessments were completed by UCTT

Assessment Area	Source % of UCTT caseload	Number of new patients seen	Number of patients seen with admission avoidance outcome recorded
ED	18%	1,288	676 (52%)
AFU	46%	3,255	1232 (38%)
AMU, Ward 2 and Whatman	35%	2,485	-

Attendances in ED have increased from June 19 where attendances were 13,500 to June 21 17,200. (Sept 22 has slightly dipped at 16,500 but an increase is expected over winter.)



Proposal

To increase the capacity of the urgent Care therapy teams by 1 therapist on each site from 8am to 8pm seven days a week would require an additional 6wte. This would enable increased presence in ED and AFU and enable proactive identification of patients who would benefit from a therapy assessment rather than waiting for patients to be referred. This would enable 8am to 8pm presence in ED and AFU.

Proposal: Urgent Care Therapy Additional Staff in Post Phasing

	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	
Band 7 Locum	2	4	5	3	3	
Band 7 Substantive	0	0	0	2	2	
Band 4 Substantive	0	0	1	1	1	
Total Staff in post	2	4	6	6	6	
Cost	£14,000	£28,000	£37,613	£33,103	£33,103	
					£145,819	Total

The additional substantive posts will be part of 2023/24 business planning.

Sourcing of additional candidate required:

- 2.00wte Band 7 recruitment process underway with interviews planned for 7/10/22.
- 1.00wte Band 4 to include in existing Band 4 recruitment activity.

Benefits

- Promote earlier discharge for AMU Ward 2 and Whatman.
- Capacity to see 700 additional patients from November 2022 to March 2023.
- Avoid admission or reduce length of stay for 50% of the additional patients seen saving 350 bed days from November to March.
- Improved staff welfare, team resilience and sustainability reducing risk of staff sickness and turnover.

Contributors

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6 October 2022

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- To:
- ICB chief executives
 - All NHS Foundation Trust and Trust:
 - Chief executives
 - Medical directors
 - Chief nursing officers
 - Chief people officers and HR directors
 - All GP practices
 - PCN Clinical Directors

NHS England
Wellington House
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18 October 2022

- cc.
- ICB chairs
 - NHS Foundation Trust and Trust Chairs
 - All local authority chief executives
 - NHS regional directors

Dear colleagues,

In August we set out [a number of steps to boost capacity and resilience](#), with funding ahead of winter, including providing extra bed capacity and better support for staff. Thank you to you and your teams for the incredible hard work that is ongoing to make progress and deliver these focused actions, which remain crucial.

More than eight million people have already had their autumn booster COVID-19 vaccination in just over a month. However, we continue to be in a Level 3 incident, and services are under continued, significant pressure, with challenges including timely discharge of patients impacting on patient flow within hospitals, alongside ongoing pressures in mental health services.

Over the past few weeks this has been exacerbated by an increase in the number of COVID-19 inpatients and related staff absences. We continue to prepare for the possibility of high prevalence of flu, based on the evidence from other countries and advice from public health experts.

We therefore all need to be prepared for things to get even tougher over the coming weeks and months. We will support you in doing your best under these very difficult circumstances, including as you work with and support clinical leaders to ensure risk is managed appropriately across local systems. We are working with the relevant regulators to support this.

This clinical risk management is especially important to support the ongoing work to improve ambulance handovers and response times. Many of you already have access to the data platforms that you will need to drive performance or will be getting access in the coming weeks. These data platforms will inform national, regional, and local oversight, including the NHS Oversight Framework.

Going further on our winter resilience plans

In August we set out key actions to improve operational resilience, built in partnership with you. Following further engagement with systems over recent weeks we are now setting out a necessary expansion of these plans. These actions have been co-created with systems and clinical leaders and build on best practice that you have shared with us. They have been selected based on this evidence showing that they will make the biggest additional impact. In particular we want to work with you to ensure the NHS can:

- **Better support people in the community** – reducing pressures on general practice and social care, and reducing admissions to hospital by:
 - Putting in place a community-based falls response service in all systems for people who have fallen at home including care homes
 - Maximising the use of virtual wards, and actively considering establishing an Acute Respiratory Infection (ARI) hub to support same day assessment
 - Providing additional support for care homes through reducing unwarranted variation in ambulance conveyance rates

- **Deliver on our ambitions to maximise bed capacity and support ambulance services** – bed occupancy continues to be at all-time highs, and we need to take all opportunities to make maximum use of physical and virtual ward capacity to increase resilience and reduce delays elsewhere in the system. This includes:
 - Supporting delivery of additional beds including previously moth-balled beds
 - All systems setting up a 24/7 System Control Centre to support system oversight and decision making based on demand and capacity across sites and settings
 - Ensuring all ambulance services deploy 24/7 mental health professionals in emergency operation centres and on-scene

- **Ensure timely discharge and support people to leave hospital when clinically appropriate** – more than 10,000 people a day are clinically ready to leave hospital but can't be discharged, and this causes significant and fundamental issues for patient flow. In addition to maintaining focus on the high impact actions from the 100 day challenge, the Government recently announced £500m to support social care to speed up discharge across mental and physical health pathways. More details about distribution of this fund will be shared with you when available.

Winter Improvement Collaborative

In August we committed to launching new improvement initiatives to support ambulance handover and response times, in addition to the focussed work that we are continuing to do with the 10 most challenged systems and providers.

Providers, systems, and regions have done a significant amount of work on these issues, but we have heard that we need to work with you on a faster way of identifying good practice and helping you to spread it at scale. We will therefore establish a new national Winter Improvement Collaborative by the end of October. We will review the effectiveness of this programme after 10 weeks and are committed to learning and iterating the approach to ensure it has maximum benefit. This will focus on the root causes of delay in each area. It will support teams to identify, evaluate, quantify, and scale innovation and best practice in improving handover delays and response times and reducing unwarranted variation at pace, supported by a single set of metrics.

We wish to learn from providers and systems who are tackling these issues successfully and are asking all systems to participate. The collaborative will be clinically-led, and we will work in partnership with staff using an Adapt and Adopt approach.

Continuing to support elective activity

We have proved we can deliver the ambitions set out in the elective recovery delivery plan with the virtual elimination of 2 year waits in July. Now we are in the second phase of the elective recovery plan, we need to continue to have a strong operational grip across both overall long waits and care for patients with suspected cancer. It is essential that all elective procedures go ahead unless there are clear patient safety reasons for postponing activity. If you are considering cancelling significant levels of elective care you should continue to escalate to your Regional Director for support and mobilisation of mutual aid where possible. We will be writing shortly on the next steps in recovery of elective and cancer services for our most challenged providers.

We are asking every Trust providing elective and cancer services to have their Board review the relevant performance data and delivery plans for the coming months. The Board should reflect on whether the assurance mechanisms are effective and in line with your elective recovery plan. Delivery should be managed in line with the plans and trajectories that have been agreed with NHS England regional teams. These plans should also be shared with your ICB.

On cancer, the key drivers of the cancer 62-day backlog are clear. The hard work of GPs and their teams has meant that the proportion of cancers diagnosed at Stage 1 and 2 has now fully recovered and is higher than pre-pandemic. Urgent cancer referrals are at 118% of pre-pandemic levels, while cancer treatment and diagnostic activity levels are nearer 100% of pre-pandemic levels. Three pathways (Lower GI, Skin and Urology) make up two-thirds of long waiting patients and have seen the largest increases.

Given this context, there are priority actions we are asking you to implement:

1. Faecal Immunochemical Testing (FIT) in the Lower GI pathway including for patients on Endoscopy waiting lists
2. Best Practice Timed Pathway for prostate cancer including the use of mpMRI
3. Tele-dermatology in the suspected skin cancer pathway
4. Greater prioritisation of diagnostic and surgical capacity for suspected cancer.

Infection prevention and control (IPC) measures and testing

Existing [UKHSA guidance on the management of COVID-19 patients](#) remains in place, along with the appropriate IPC measures detailed in the [IPC Manual](#). Ahead of winter, providers should self-assess their compliance with this guidance using the [IPC board assurance framework](#).

This guidance will continue to be reviewed based on advice from UKHSA, in line with the latest scientific evidence including the impact of COVID-19 and other respiratory diseases in the coming months. Local healthcare organisations, with clinically appropriate advice, may also continue to exercise local discretion to test specific individuals or cohorts in line with broader IPC measures.

Symptomatic testing is continuing for patients and staff, based on the current list of symptoms. Symptomatic staff should test themselves using LFDs at the earliest opportunity. Staff testing positive should follow UKHSA's [return to work guidance](#).

Staff vaccination

It is important that health and social care workers receive both the COVID-19 and flu vaccines to protect themselves and their patients; the viruses can be life-threatening and getting both flu and COVID-19 increases the risk of serious illness. The vaccines offer the best protection for staff to better support patients and the people we care for.

All frontline healthcare workers should be offered both vaccines by their employer. Employers will confirm where both vaccines can be received, either at place of work, or, at a neighbouring provider. Health and Social Care workers can also book on the National Booking System by visiting www.nhs.uk/get-vaccination or calling 119.

Systems should continue to look at sections of their community where vaccine uptake is lower and focus significant efforts with partners to ensure community-based support is provided, building on approaches that have proved successful in the past. Trusts should also ensure that those attending for other reasons are signposted or offered vaccination.

Oversight and incident management arrangements

We will work with ICBs to ensure that oversight arrangements and associated support are appropriately focused on winter resilience and the delivery of elective recovery, including cancer, as set out above. This includes updating the NHS Oversight Framework metrics to reflect those set out in the Board Assurance Framework.

The NHS continues to operate at Level 3 Incident Response. Local systems will have their own response arrangements in place, and it is important that these continue, with robust escalation processes. There will be an opportunity to test these arrangements with a desktop exercise on winter pressures and escalation planned for November. This will be led by Regions working with ICBs, though participation will be open to all local partners. Seven day reporting against the UEC sitrep will start from Monday 31 October. Arrangements for the COVID-19 sitrep remain unchanged.

Thank you again to you and your teams for your continued hard work, and the leading role ICBs are playing in strong partnership working across the system. Since we published the winter plan in August, you have shared excellent examples of best practice

taking place across the country, and this good work has been used to inform the actions set out in this letter. The coming weeks and months will be difficult, but we will continue to support you in these challenging circumstances to ensure that we collectively deliver for patients and support our staff.



Amanda Pritchard
NHS Chief Executive
NHS England



Julian Kelly
Chief Financial Officer
NHS England



David Sloman
Chief Operating Officer
NHS England

Appendix A – Further Actions Ahead of Winter

Relevant service specifications for the actions outline in the letter can be found [here](#).

New variants of COVID-19 and respiratory challenges

- *Systems should actively consider establishing Acute Respiratory Infection (ARI) hubs as part of preparing for managing increased ARI in the community.*

Demand and capacity

We will work with local systems to:

- *Support delivery of additional beds available to admit patients to across England to reduce the number of patients waiting in ED for a suitable bed, ambulance handover delays, and ambulance response times.*
- *Deliver their agreed contribution to the winter planning ambition of delivering an additional 2,500 Virtual Ward (VW) beds. VW capacity must be included within overall bed capacity plans and monitoring and all local VW providers must submit timely, high-quality data through the national sitrep by 24 October 2022. Systems should ensure that virtual wards are effectively utilised both in terms of addressing the right patient cohort and optimising referrals.*
- *Ensure all systems establish 24/7 System Control Centres (SCCs). SCCs will balance the risk across acute sector, community, mental health, and social care services with an aim of ensuring that clinical risk is appropriately dispersed across the whole ICS during periods of surge. SCCs will need to be supported by senior operational and clinical decision-makers to proactively manage clinical risk across the country in a 24/7 format for 365 days per year. The expectation is that systems will develop the operating model for approval via the BAF and that all systems will have an operational SCC by 1 December 2022.*
- *Improve the accuracy of information provided in the capacity tracker. The accuracy of information submitted to the capacity tracker will be key to ensuring that we can effectively manage demand and capacity at a system, regional and national level. We will work with regional teams to ensure that all providers have plans in place to submit accurate data to the capacity tracker, and that updates are submitted in line with the collection timetable.*
- *Continue to invest into acute-workforce training in managing mental health need (including paediatric acute) and embed the integration framework with associated resources for systems to support children and young people with mental health needs within acute paediatric settings.*

Discharge

- *We know that discharge challenges are causing significant issues for flow and are impacting emergency care for patients. The 100-day challenge work will continue, as local systems continue to embed the 10 best practice interventions. We will work with regions to understand the specific actions where national support is*

required to go further, and a similar programme will be extended to community and mental health trusts. Intensive discharge support will also continue for a small number of our most challenged systems and Trusts. A national data focus, beginning with a drive to improve data quality, will support real-time operational decisions.

- *We are working with cross-government colleagues through the National Discharge Taskforce to explore further options to reduce delays to discharge. This includes supporting the £500m fund to recruit and retain more care workers and speed up discharge. Looking ahead to next year, with colleagues in DHSC and DLUHC we are selecting a number of discharge Frontrunners to identify radical, effective and scalable measures for improving discharge processes and joint working between and adult social care.*
- *Mental health remains a challenge for UEC activity and delayed discharge. It is important that systems continue to invest in mental health as planned in crisis alternatives, community transformation, primary care, and liaison services in acute hospitals, and that 12 hour delays are avoided.*

Ambulance service performance

We will work with local systems to:

- *Ensure all ambulance services deploy 24/7 mental health professionals in emergency operation centres and on-scene and implement new models of improving flow out of emergency departments. Staff may be employed on a rotational or joint basis with mental health trusts. This additional capacity will prevent unnecessary mental health related ambulance trips to A&E and enable more people in mental health crisis to access the right support in their community. Further guidance will be shared shortly.*

Preventing avoidable admissions

All local systems should:

- *Have a community-based falls response service in place between 8am and 8pm for people who have fallen at home including care homes. The service should be in place by 31 December 2022 and be available as a minimum 8am-8pm 7 days per week.*
- *Address unwarranted variation in ambulance conveyance rates in care homes working collaboratively with care homes to identify and access alternative interventions and sources of support.*
- *Consider targeted, proactive support for people who have high probability of emergency admission, sometimes called High Frequency Users. For example, work in one area identified that 1% of people (~600 people) accounted for 1,925 ED attendances and 54,000 GP encounters over a 12 month period.*

Workforce

In [July we wrote to you](#) asking you to prioritise five high impact actions to maximise the retention and experience of nursing and midwifery staff. Significant progress has already been made and we are asking you to continue working across key areas, including:

1. **Nursing and midwifery retention [self-assessment tool](#)** – completed self-assessment tool and retention improvement plans should be shared with your ICS retention lead or equivalent.
2. **[National Preceptorship Framework](#)** went live on 10 October. The framework includes a core set of standards and a gold standard for organisations wanting to further develop their preceptorship programmes.
3. **Flexible working** – Your staff should be made aware and encouraged to explore flexible working options. Information and tools are available on the [NHS Futures site](#).

We are now extending our workforce support by:

- *Re-launching the National NHS reserve campaign to bolster local surge capacity.*
- *Launching a staff offers hub to support spread of local good practice over winter.*
- *Providing a full list of recommended workforce solutions for Integrated Care Boards.*
- *Providing targeted support teams to any region or system that falls into difficulty.*

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

2021/22 Annual Infection Prevention and Control Report and 2022/23 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 2021/22 and the broad plan of work for 2022/23 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 statutory 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 commissioners, 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 2021/22. 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 NHSE&I, Commissioning CCGs, UK Health Security Agency (formerly Public Health England) and Regional Specialist Laboratories.

There are national contractual reduction objectives for *Clostridioides difficile* infections and there are five other infections for which mandatory reporting to UKHSA is in place.

Clostridioides difficile infections

Meticillin Resistant *Staphylococcus aureus* (MRSA) bloodstream infections

Meticillin Sensitive *Staphylococcus aureus* (MSSA) bloodstream infections

Escherichia coli (E. coli) bloodstream infections

Klebsiella spp blood stream infections

Pseudomonas aeruginosa blood stream infections

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 again dominated the infection prevention work across the Trust for 2021/22 however all other activity has continued albeit in a modified way in some instances.

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

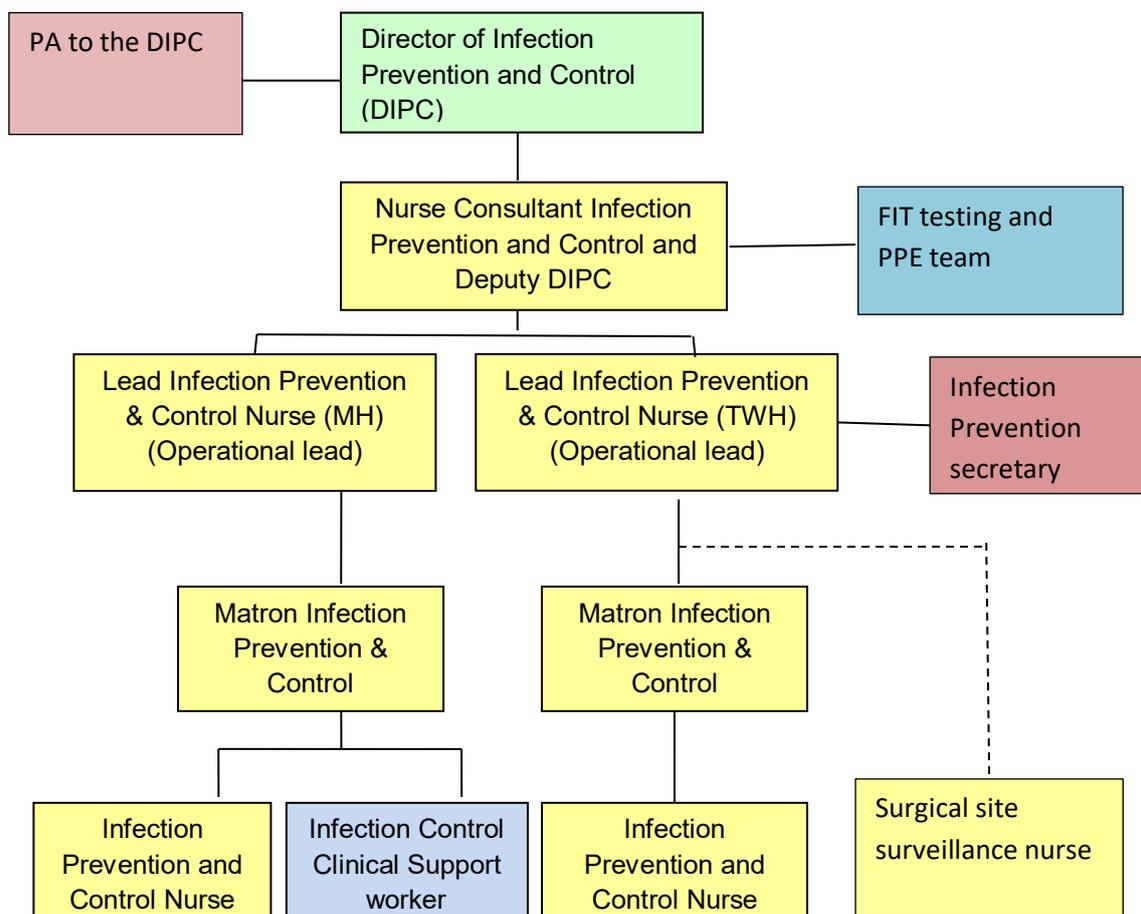
The Director of Infection Prevention and Control (DIPC) is a consultant microbiologist with specific training and experience in infection prevention and control and reports directly to the Chief Executive Officer.

The DIPC is supported by the Deputy DIPC (Nurse Consultant in Infection Prevention and Control) and the IPCT (Fig 1). Lesley Smith, Nurse Consultant returned to the Trust in March 2022 following a 16-month secondment to Public Health England. Joanne Green took on the roles of interim Nurse consultant and Deputy DIPC during this time and remains with the team in another role.

Following a successful business case, the IPCT has expanded to include the Fit testing and PPE team and additional 8b and B6 nursing posts together with a data analyst role. The

surgical site surveillance nurse is now full time in the IPCT and an additional 0.5WTE post has been agreed to support the role

Fig 1: Structure of the Infection Prevention and Control Team 2021-2022



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 or more latterly at times of change due to updated guidance.

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 were MTW's main commissioning organisation during 2021/22. IPC is a key element of quality commissioning and forms part of the joint commissioning quality schedule. The MTW DIPC took on an additional role of SRO for IPC in Kent and Medway in September 2021.

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. During the last year, the panels have been adapted into table top reviews by the senior IPCT due to the operational pressures of the pandemic response. 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

Hospital associated COVID-19 infections resulting in the death of the patient were investigated as serious incidents following initial case review.

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 Kent and Medway CCG and UKHSA. The Chief Nurse is the Executive Director member of the committee

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

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

The objectives of the IPCC include:

- To advise and support the Infection Prevention and Control Team.
- To provide assurance to the Quality Committee with respect to infection prevention and control structure, processes and outcomes and compliance with CQC requirements as set out in the 'Hygiene Code' (The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance).
- To inform the Quality Committee in a timely manner of any serious problems or hazards relating to infection control.
- To receive reports from the Infection Prevention and Control Team.
- To monitor Healthcare Associated Infection against key performance indicators including receiving reports on compliance data from Directorate representatives.
- To discuss and approve Infection Prevention and Control policies.
- To review the annual infection control programme and audit programme.
- To ensure the implementation of national guidance, and action plans arising from Patient Safety alerts relating to Infection control
- To monitor progress against CQUIN targets related to infection control

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

1.3 Surveillance

The IPCT undertakes continuous surveillance of target organisms and alert conditions. Patients with pathogenic organisms or specific infections (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	<i>Salmonella</i> spp	Group A <i>Streptococcus</i>	<i>Aspergillus</i>
<i>Clostridioides difficile</i> infection (CDI)		Glycopeptide-resistant <i>Enterococci</i>	<i>Influenza</i>
<i>Campylobacter</i> spp	<i>Mycobacterium tuberculosis</i>	<i>Neisseria meningitidis</i>	<i>Norovirus</i>
Multi-resistant gram-negative bacilli e.g. extended spectrum beta-lactamase (ESBL)producers			
Carbapenem resistant and Carbapenemase-producing Enterobacteriaceae (CRE/CPE)			
Hepatitis A	Hepatitis B	Hepatitis C	

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

The national HCAI objectives for MTW for 2021/22 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 UKHSA 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

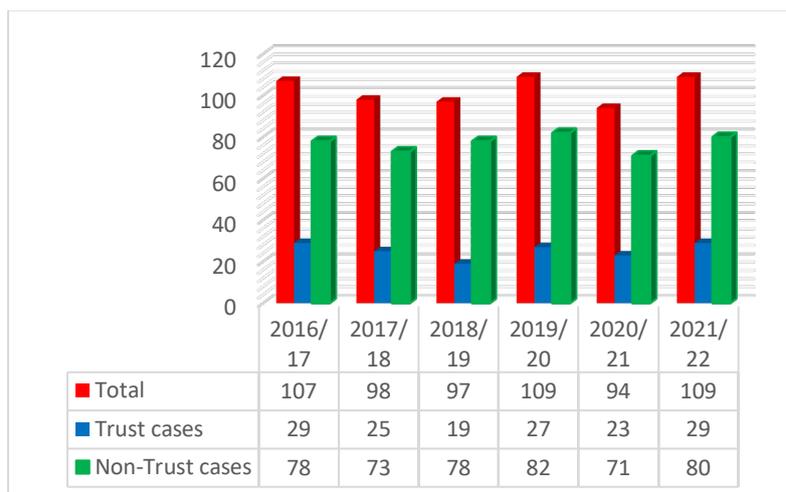
1.4.1 MSSA

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.

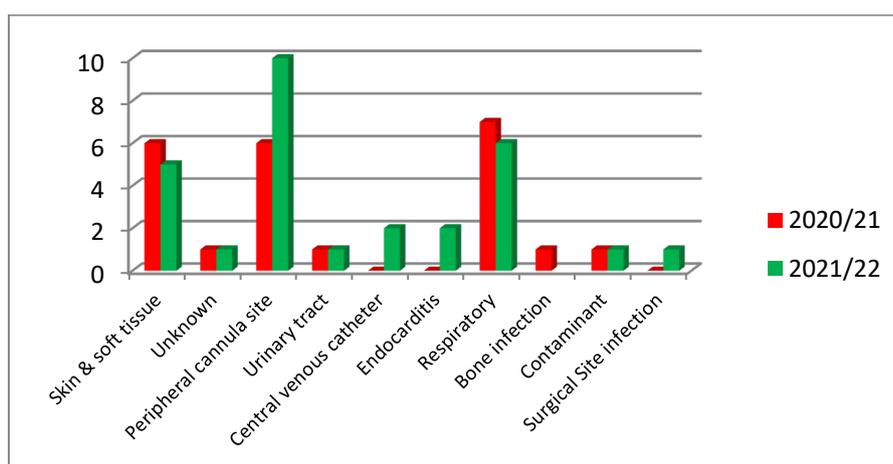
During COVID waves the process was changed; a table top review of cases was carried out by the senior IPCT to determine root cause, feeding back learning to ward teams and matrons. During times of high COVID incidence and difficulties with staffing levels, the IPCT also carried out the data collection for bacteraemia patients

Fig 2: MSSA bacteraemia cases



The numbers of hospital attributable cases seen rose to 29 over the year, a rate of 12.2 per 100 000 bed days compared with an England benchmark rate of 11.3. The most marked rise was in peripheral vascular access site infections. Of the 29 cases, 7 were avoidable.

Figure 3: MSSA bacteraemia root cause 2020/21 – 2021/22



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 2021/22. 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. A Post Infection Review (PIR) is carried out on all cases and 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 two non-Trust apportioned cases and one Trust apportioned case for 2021/22.

The Trust case was declared as a Serious Incident and further investigated through the SI process. The root cause was found to be failure to actively manage the patient's chest drain and over-reliance on chest drain management advice from a tertiary centre.

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 and Social Care policy. The policy is reviewed when new guidance is published. Further guidance was published in December 2021: *Joint Healthcare Infection Society (HIS) and Infection Prevention Society (IPS) guidelines for the prevention and control of meticillin-resistant Staphylococcus aureus (MRSA) in healthcare facilities* which clarified earlier guidance but did not require any material changes to be made to the MTW policy.

Rates of MRSA infection and colonisation amongst elective patients have remained relatively low and a protocol is in place for decolonisation prior to admission and surgery.

Non-elective patients who are colonised are usually identified from screening swabs within 24 hours of admission. Some colonised patients are also identified as a result of clinical samples. Early detection 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 2015-22

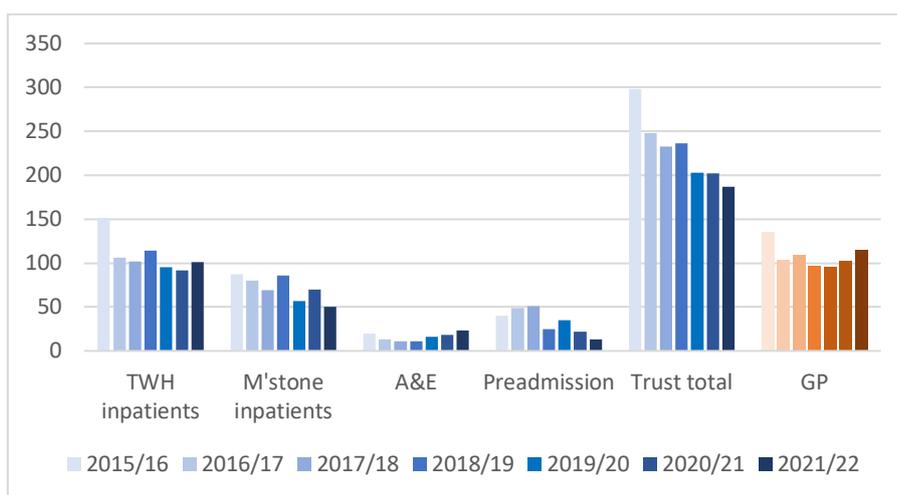
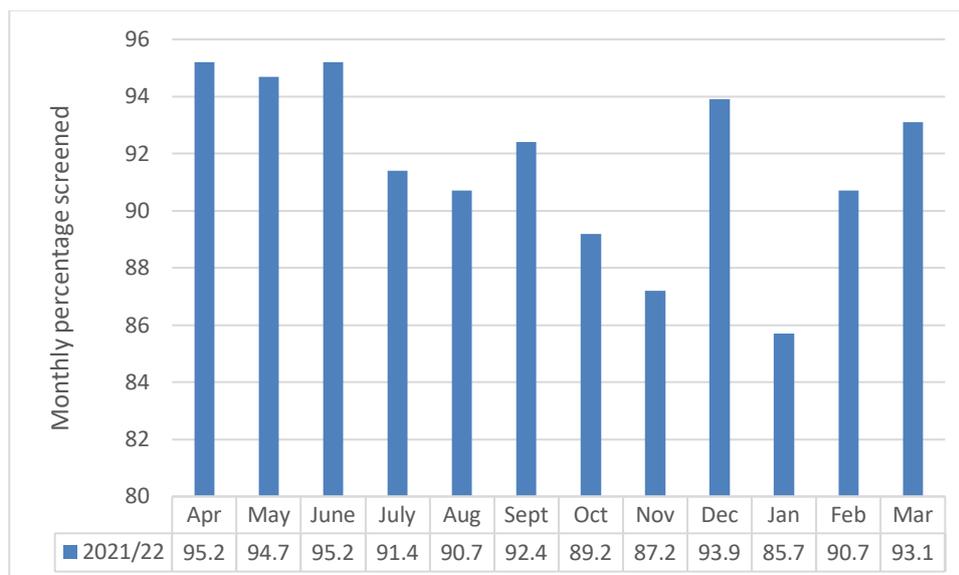


Fig 5: MRSA screening 2021/22



The number of patients who may have acquired MRSA colonisation in hospital is also monitored and investigated. For 2021/22, 11 such cases were identified at Maidstone Hospital and 17 cases at TWH. There were several investigations into possible cross infection but none were proven.

1.4.5 Periods of Increased Incidence

Where two or more new (post 48 hour) acquisitions (whether related or not) of MRSA colonisation are identified by screening on the same ward within 28 days, 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 NHS standard contract objective for MTW for 2021/22 was to have 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)

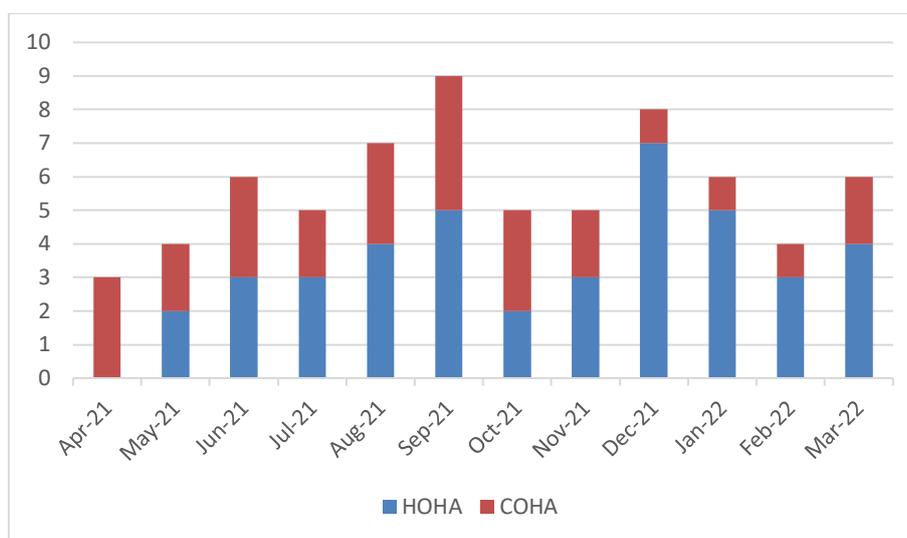
Community-onset healthcare-associated (COHA) - Date of onset is < 2 days after admission and the patient was admitted to the trust in the 4 weeks prior to the current episode

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.

In 2021/22 a total of 68 Trust attributable cases were seen, 37 HOHA cases and 30 COHA cases, a rate of 17.3 HOHA cases per 100 000 bed days (compared with 18.1 for the previous year).

Figure 6: C. difficile HOHA and COHA cases

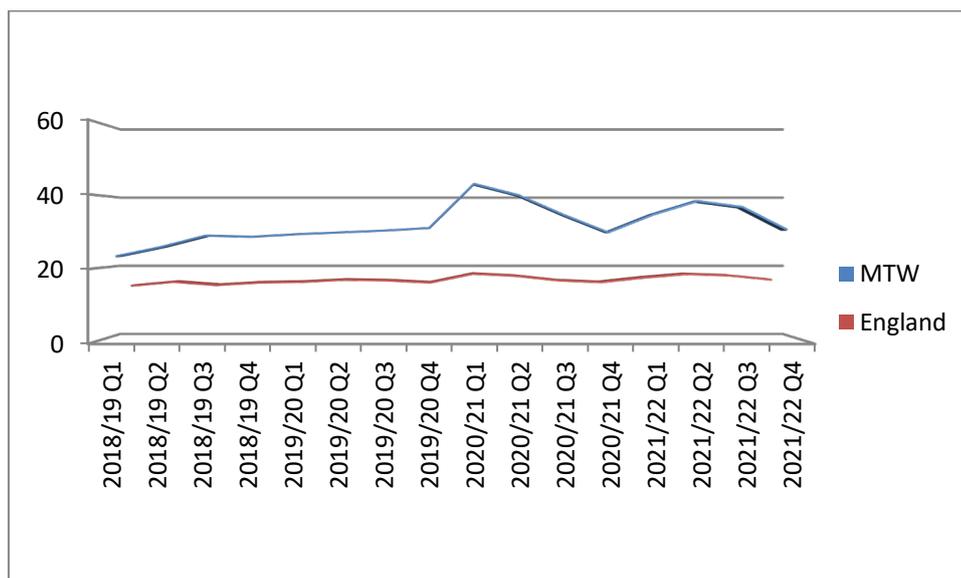


In Q4 there was a national rise in the number of cases of *C. difficile* both healthcare associated and community onset. Compared with Q4 2018/19 immediately prior to the COVID pandemic there was a 25.5% increase in incidence nationally of all reported cases with an increase in incidence rate from 18.8 to 23.2 per 100 000 population. This rise has persisted into 2022/23.

1.5.1 Laboratory Diagnosis

C. difficile tests are processed on diarrhoea samples according to national guidelines. During 2021/22, the microbiology laboratory processed 8461 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 2021/22



199 patients were newly identified as carriers of toxigenic *C. difficile* (133 in 2020/21). 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 a further review by the DIPC and senior members of the IPCT.

The outcomes of root cause analysis shown in the table overleaf.

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

Cross infection	Inappropriate antibiotics	Appropriate antibiotics	Relapse	Community antibiotics	Underlying GI disease
1	12	48	3	2	1

Thirteen 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 and the main areas for learning are:

- Delay in sending stool specimen
- Referral to microbiologist for prescribing advice
- 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'.

At MTW a PII is declared for the ward area whenever a new case of *C. difficile* is diagnosed.

In response to the PII declaration, several actions have to be taken including structured IPC audits, antimicrobial prescribing audits, additional cleaning and support and education from the IPCT

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.

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 2021/22, thirty-seven PIIs were declared for *C. difficile*, twenty at Maidstone and seventeen at TWH. Four PIIs were re-declared due to standards not being maintained after initial closure. Five wards had two PIIs during the year, one ward had three and two wards had four. The PIIs lasted an average of three weeks with the longest period being seven weeks.

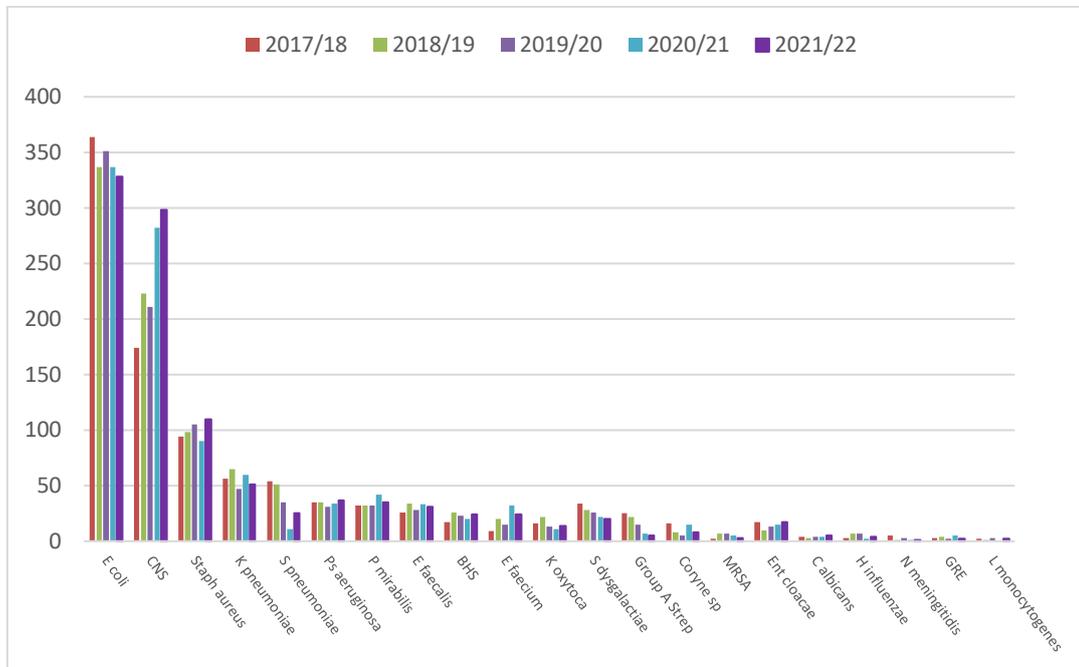
1.5.4 Non-Trust attributed CDI cases

There was an increase in the number of patients with non-Trust attributable CDI from 56 cases in 2020/21 to 65 cases in 2021/2022

1.6 Blood stream infections

A total of 1116 patients had positive blood cultures during 2021/22, an increase (79 patients) on the previous year. *E. coli* is the commonest organism causing blood stream infection in the Trust accounting for around 24% 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*

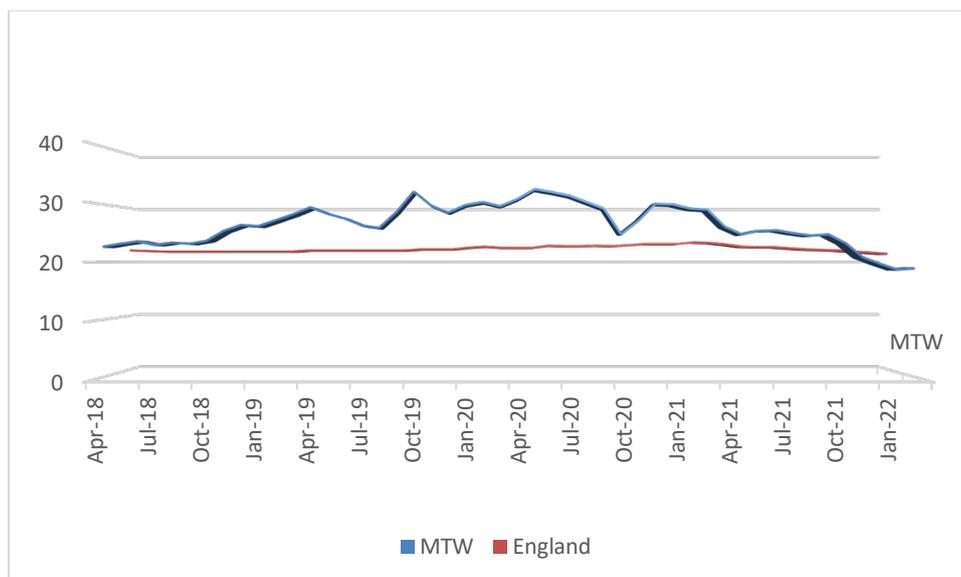
The Trust has been submitting *E. coli* surveillance data to PHE for many years and from April 2017 *Klebsiella species* and *Pseudomonas aeruginosa* data was also required

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 2021/22 was 18.9/100 000 bed days compared with an England rate of 23.7/100 000 bed days, a significant reduction from the rate in 2020/21 of 28.9/100 000 bed days.

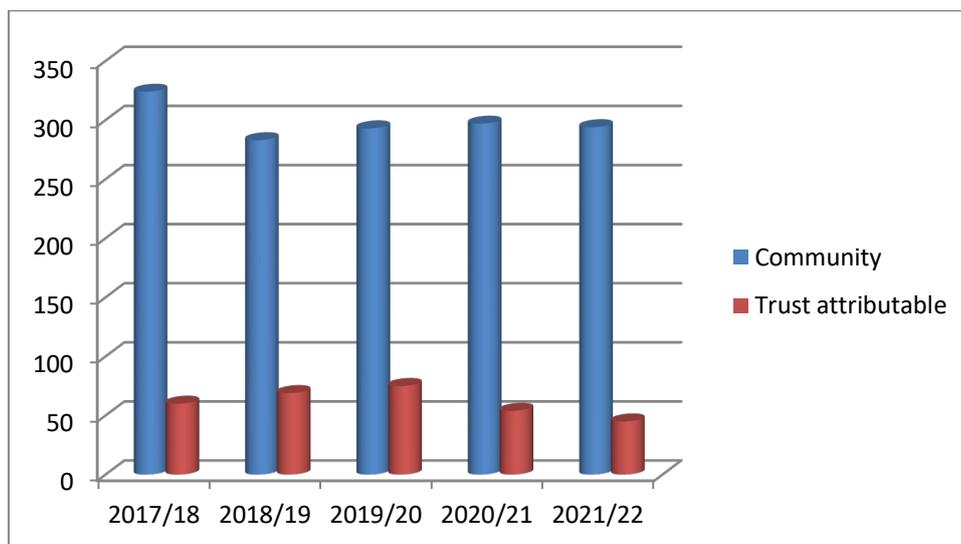
E. coli is the commonest cause of bacteraemia (all sources) seen in MTW

Figure 9: Hospital onset rates of *E.coli* bacteraemia (12 month rolling rate)



The rate of *E. coli* bacteraemia in hospital and in the community has decreased following interventions such as improvements in urinary catheter management.

Figure 10: Cases of *E. coli* bacteraemia 2016-2022



Previous actions taken to reduce the rate of *E. coli* bacteraemia have been continued in 2021/22. However, the associated quality improvement work has been curtailed by the COVID pandemic and the pressure on clinical staff

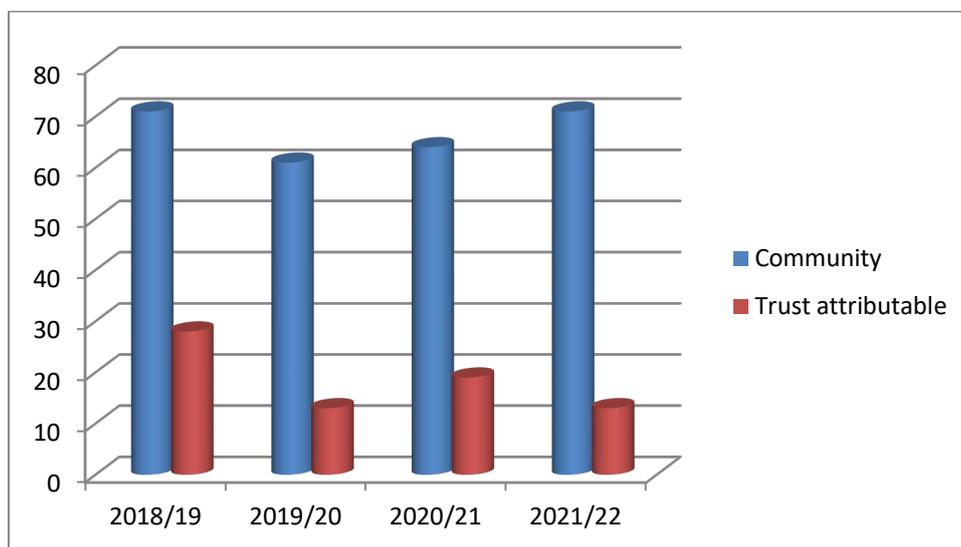
Further measures are outlined in the HCAI reduction plan for 2021/22.

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. Whilst the number of infections has continued to rise in the community, there has been a fall in numbers in the hospital setting. This may be related to changes made as a result of the national concern around ventilator associated pneumonia thought to be due to staff wearing long sleeved gowns during COVID and therefore unable to be bare below the elbows.

Figure 11: *Klebsiella* bacteraemia cases 2018-22



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.

In a healthcare setting *pseudomonas* can contaminate devices that remain moist such as respiratory equipment and catheters but also ice-making machines and equipment with a water reservoir. It also causes outbreaks in neonatal units. Cases remain low with 38 cases seen in total, with 11 healthcare associated cases.

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 in this group from April 2021 – March 2022. Identification of carriers enables antibiotic regimens to be tailored to individual patients depending on their carrier status, improving patient safety. Knowledge of the carriage rate is also helpful in recognising any increase of concern and planning action to prevent the organism becoming endemic in our hospitals.

Although the incidence of GRE infection has always been very low at MTW, with just two healthcare associated blood stream infections recorded in 2021/22, 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 12: New ESBL cases 2011 - 2022

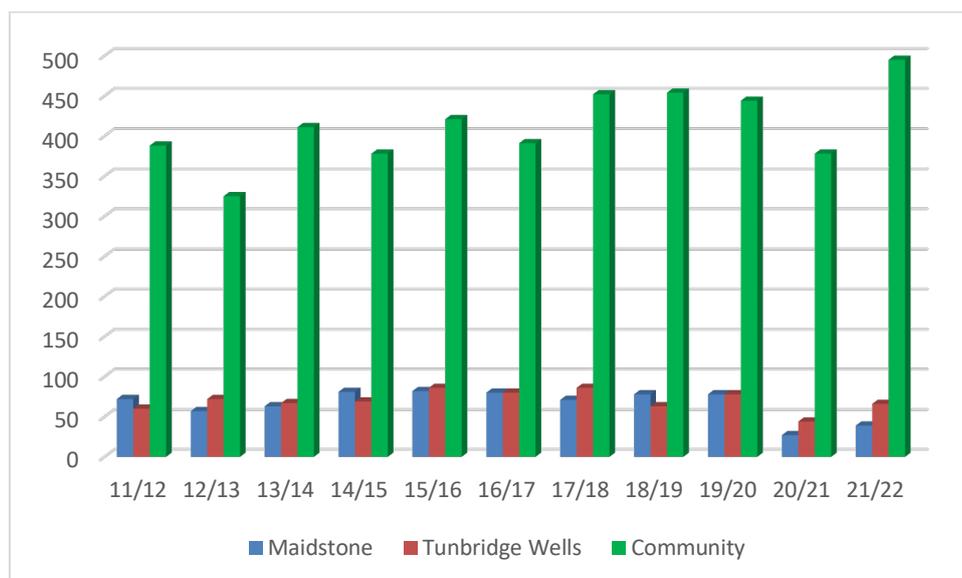
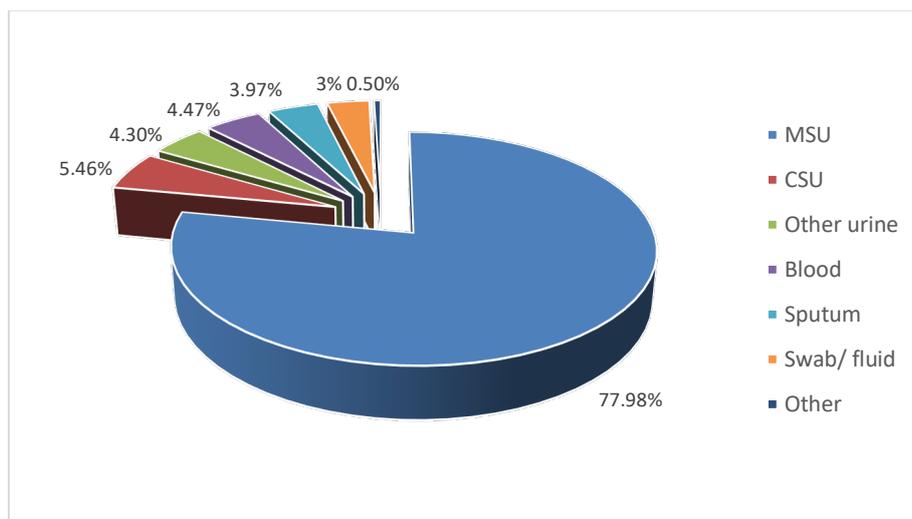


Figure 13: New ESBL isolates by specimen type 2021-22



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 2021/22, 1435 CRE/CPE screening swabs were processed, slightly fewer than the previous year.

Updated guidance has been implemented which reduced the number of screens for an individual patient from three to a single swab. So, despite the increase in bed occupancy during 2021/22 and some increases in international travel, the overall number of screening swabs remains lower than pre-pandemic numbers.

Nine adult patients and two children were identified as carriers on screening, nine had recently been inpatients in London 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 2021 to March 2022, eight patients with Influenza were admitted to the Trust. This is compared to none the previous year.

In addition to the admitted patients, a further 32 patients were diagnosed as having Influenza following an attendance in A&E but did not require admission. Unusually only sporadic cases were seen prior to March but the number of positive cases seen in ED rose to a peak in April, then continued into May and June, with the last case seen on 1 July 2022.

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 was one case of norovirus infection in an inpatient identified from April 2021 to March 2022.

1.12 SARS-CoV-2 (COVID-19)

COVID again dominated the work of the infection prevention and control team for 2021-22. Wave 3 proved challenging with relatively low numbers of patients admitted but high numbers of transmissions resulting in outbreaks

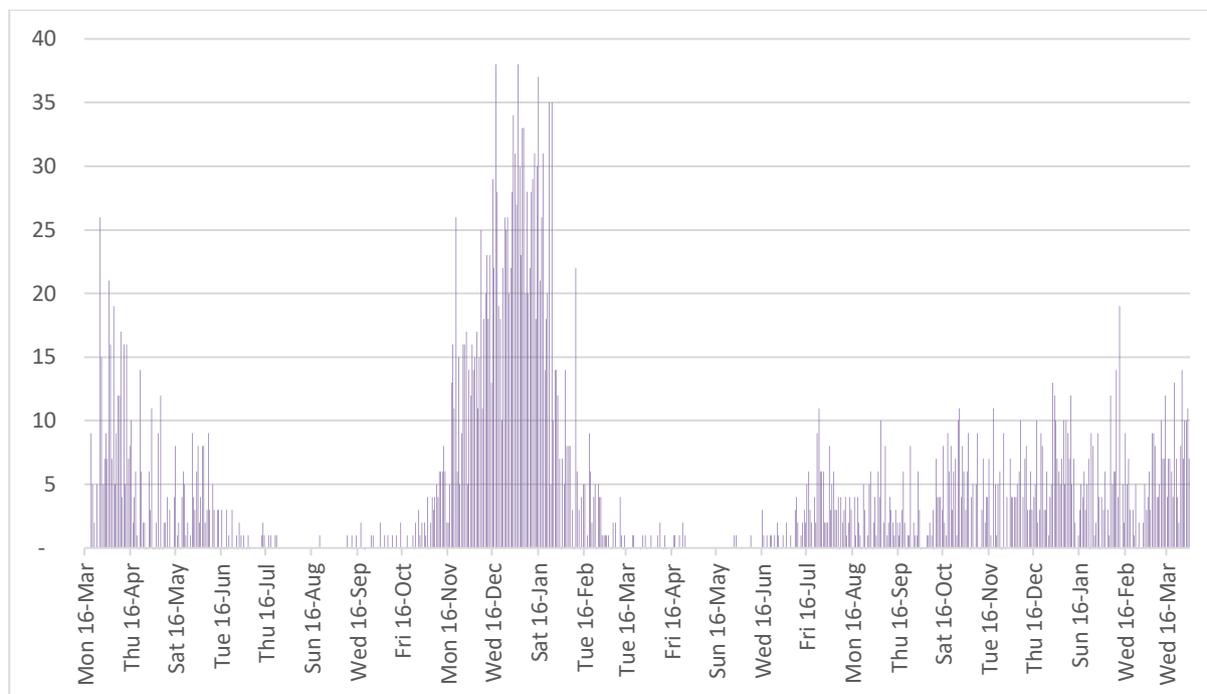
The Infection Prevention and Control team had three main priorities; to ensure patient and staff safety, to advise and educate staff in new ways of working and to work with colleagues across the Trust to ensure that IPC was considered and included in all plans and changes, especially designing new patient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

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 14: COVID positive admissions by week March 2020 – March 2022



Wave 3 of the pandemic continued to place pressure on the organisation and brought further challenges for IPC. Due to the increased infectivity of the new variants, outbreaks were seen

on many wards and processes were put in place to contain outbreaks rapidly and reduce patient to patient spread.

Although the numbers of inpatients with COVID was much lower than in wave 2, and for many COVID was not their primary diagnosis, the measures required to control the spread of infection continued to be required.

On 27 January 2022 the 2022 *The Health Protection (Coronavirus, Wearing of Face Coverings) (England) Regulations 2021* expired. This meant that there was no longer a requirement by law to wear a face covering anywhere however in the healthcare setting there was an ongoing risk of infection and mask wearing in clinical and public areas was maintained throughout 2021/22

In February 2022 (updated May 2022) the government set out its *Living with COVID strategy*, outlining the next stage of the pandemic to “*enable the country to manage COVID-19 like other respiratory virus while minimising mortality and retaining the ability to respond if a new variant emerges with more dangerous properties than the Omicron variant, or during periods of waning immunity, that could again threaten to place the NHS under unsustainable pressure.*”

This removed the legal requirement to self-isolate following a positive test and for non-vaccinated contacts. NHS staff were exempt for much of this guidance and policies were put in place to ensure that staff and patient safety was maintained

Untoward Incidents and Outbreaks

1.13.1 SARS-CoV-2 (COVID-19)

Outbreaks of COVID are difficult to prevent because of the highly transmissible nature of the virus. 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-six ward-based outbreaks of COVID have been identified from April 2021 to March 2022. All the other outbreaks occurred during the third wave from July to March and affected a total of 273 patients and 64 staff. The number of staff affected was much lower than in previous waves as would be expected in a highly vaccinated group.

The investigation approach to outbreaks changed during wave 3 and the Kent and Medway system agreed, following national guidance, to declare a serious incident for any deaths where the patient died as a result of healthcare associated COVID infection (but not where they died

of an underlying condition). Duty of candour was completed with the families of 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 June 2021 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

1.13 Orthopaedic surgery

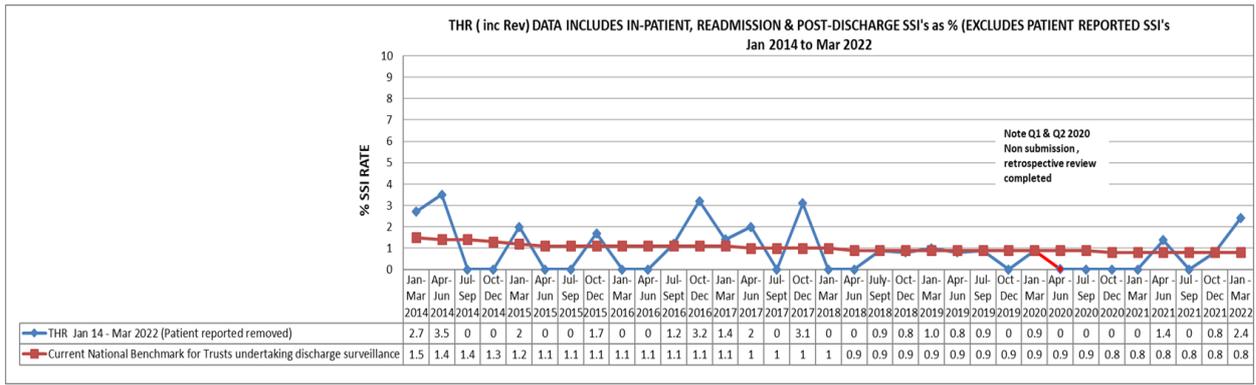
Orthopaedic surgical site infection (SSI) has been included in the mandatory healthcare associated infection surveillance system from April 2004. All NHS Trusts or facilities undertaking orthopaedic surgery must do surveillance in one or more of the orthopaedic categories - total hip replacement, hip 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 UK Health Security Agency (UKHSA) in Colindale.

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

The overall numbers of orthopaedic operations increased in 2021-22 compared with the previous year which was affected by the pandemic

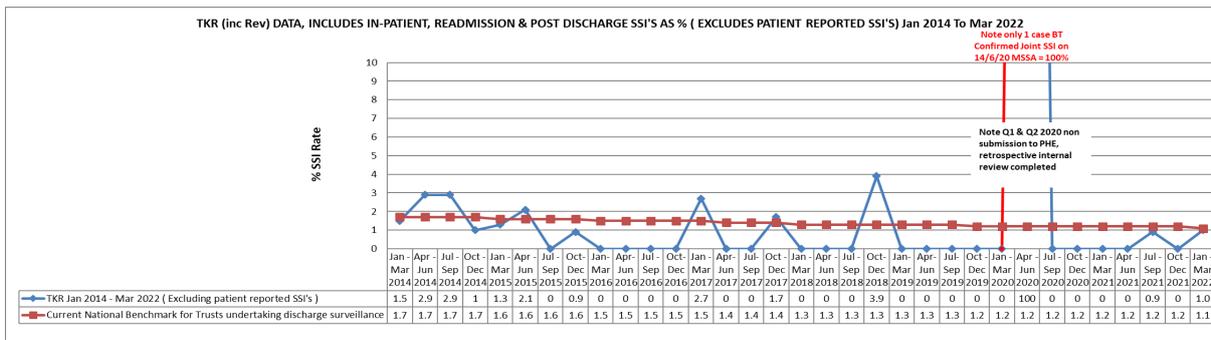
Fig 15: Results for elective hips



An uptick in the rate of infection was seen in Q4 however the overall infection rate for 2021/22 is 1.1% with 6 confirmed surgical site infections out of a total of 531 total hip replacements.

All surgical site infections are subject to case review at the orthopaedic clinical governance meeting to identify learning and actions.

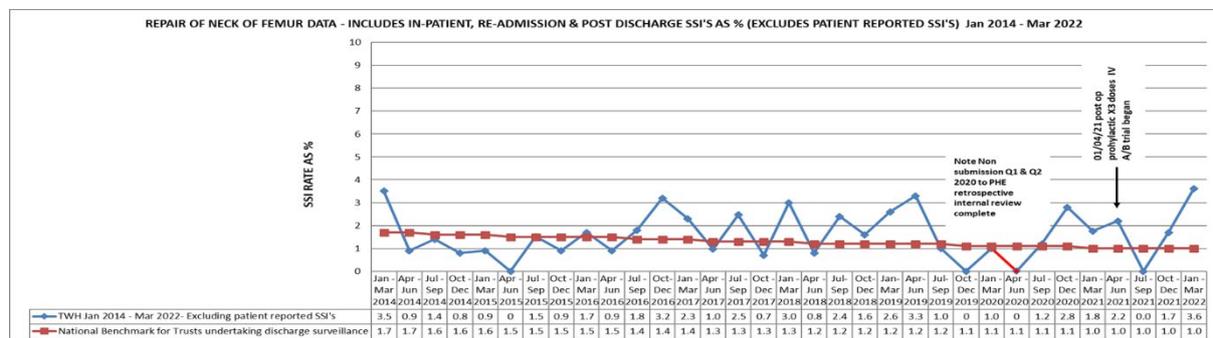
Fig 16: Results for elective knees



The overall infection rate for 2021/22 is 0.4% with 2 infections out of 450 total knee replacements.

The national average SSI rate in this group reduced to 1.1% in Q4 2021/22.

Figure 17: Results for repair of fractured neck of femur



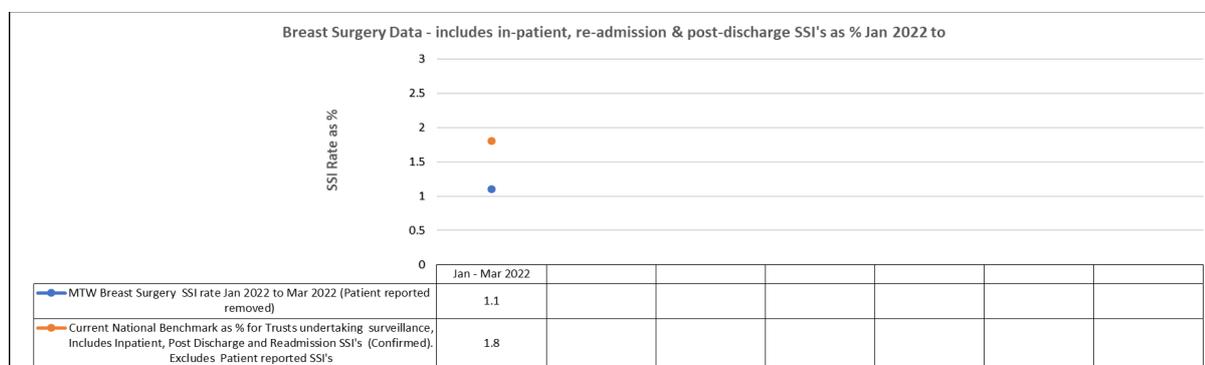
The overall infection rate for 2021/22 is 1.95% with 8 confirmed infections from 413 repairs of fractured neck of femur. Work to address the high rate of infections continues and all cases are reviewed by a consultant surgeon and a multi-disciplinary team.

1.14 Breast surgery

The UKHSA web-based data capture system also collates data from a number of other categories of surgery which Trusts can complete on a voluntary basis.

MTW started to collect data on breast surgery in January 2021

Fig 18: Results for breast surgery



Two infections were seen from a total of 188 procedures giving a Q4 rate of 1.1% against a national average of 1.8%.

Surveillance will continue to build up accurate data over a period of time

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 paediatric ED, additional outpatient area in oncology, the barn theatre 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 maintained all requirements for both HTM 01-06 and the joint Advisory Group (JAG).

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 (until November 2021), processing a total of over 7 million items per year. There are also a number of smaller community contracts. Annual audits are undertaken.

Cleaning arrangements

2.3.1 Monitoring

The National Standards of Healthcare Cleanliness 2021 were introduced from April 2021 to replace the *National Specifications for Cleanliness in the NHS 2007*. The revised mandatory standards seek to drive improvements towards high quality and safe cleaning services contributing to the overall patient experience and care. The categories of risk have been expanded, requiring an improved and more robust auditing process to be put in place to ensure the healthcare environment is kept clean to the levels required and expected.

MyAudit is a new digital compliance system to support cleanliness auditing, based on the functional risk of an area and covering the 50 elements guidance. The new standards will continue to see regular audits taking place, with public facing cleanliness star ratings now required to be displayed.

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

NHSE&I suspended the PLACE inspection programme for a second year in 2021 but encouraged PLACE-lite whenever possible and without patient assessors.

25 PLACE-Lite assessments have been undertaken every month since May 2021 (apart from December 21) following a programme to incorporate both Maidstone and Tunbridge Wells sites. Stakeholders assisting with the inspections include representation from IPCT, Domestic Managers and Estates/Mitie.

Any environment cleaning findings are reported and actioned by the respective Domestic management team with any maintenance issues logged and raised with Estates/Mitie for prioritised action to resolve. The Ward Manager/NIC are also advised of any immediate rectifications that may be considered or require action by their ward team to improve their care environment for patients.

2.3.2 Cleaning levels

Since the onset of the pandemic, enhanced cleaning has been in place in all areas including public areas and was stepped down following wave 3 except for COVID 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 2021-22

Tunbridge Wells

	Level 2 Discharge Cleans	Level 3 - Steams	Level 3 – UV's	Level 4 - FOGs
2020/21	23144	894	4113	562
2021/22	43697	1434	3951	644

Maidstone

	Level 2 Discharge Cleans	Level 3 - Steams	Level 3 – UV's	Level 4 - FOGs
2020/21	20317	2163	555	205
2021/22	25719	713	1342	236

There is a significant difference in the numbers of cleans at the two sites and compared with the previous year representing the increased activity following the first year of COVID. At Maidstone there is a large increase in level 2 cleans which are routine for COVID discharge from a bay.

2.3.3 Deep Cleaning

The rolling deep cleaning programme has been interrupted by COVID and the very high bed occupancy on both sites as deep cleaning relies on having a decant ward to facilitate the process. Every UVC and HPV clean contributes towards the deep clean process but areas such as clean and dirty utility rooms have not been cleaned and this will need to be addressed in 2022/23

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 this will require a rolling programme of works over around 18 months with clinical areas prioritised. Works on this scale will inevitably disturb the water system and in order to ensure there is no increased risk to patients and staff, point of use filters are to be applied to all outlets in clinical areas and staff showers whilst the work is progressing. The work is due to start in the autumn of 2022.

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).

Page 26 of 57

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 KM ICB antimicrobial pharmacist and invites other clinicians to join to discuss specialist guidelines. The group reports to the Drugs, Therapeutics and Medicines Management committee (DTMMC) and provides reports to the IPCC.

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

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

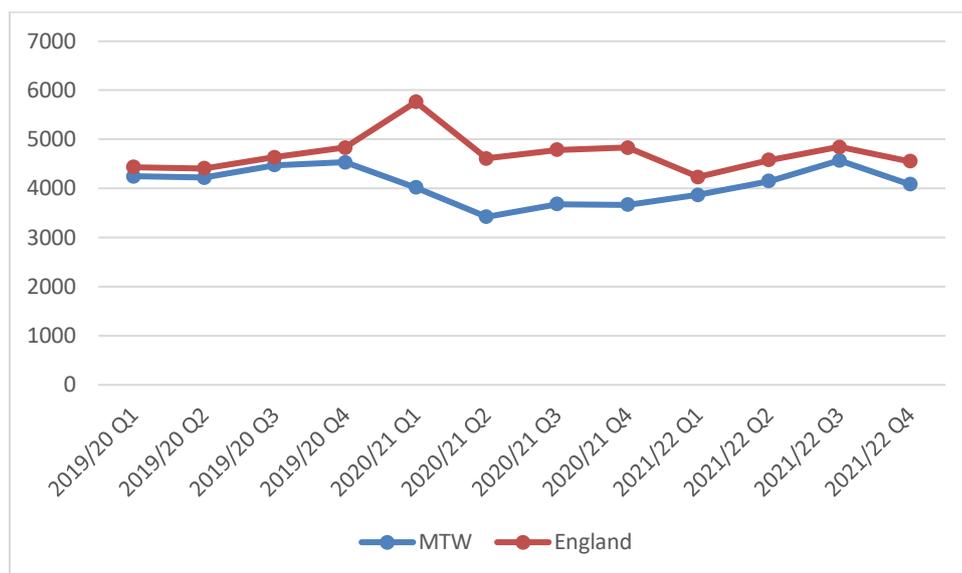
3.1 Antimicrobial Usage

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.

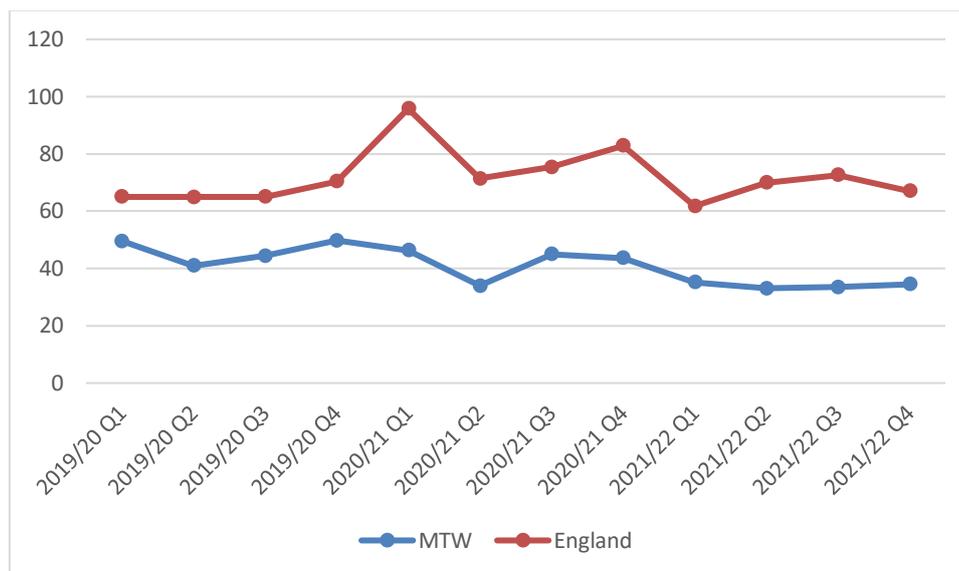
Usage has not varied significantly despite the increase in bed occupancy and acuity seen during the year.

Fig 19: Total antibiotic prescribing DDDs per 1000 admissions by quarter



MTW remains below the national average for antimicrobial prescribing.

Fig 20: Carbapenem usage in DDDs/1000 admissions



MTW prescribing of carbapenems is significantly below the England rate.

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.

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 including the COVID pages on the Trust intranet.

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
- COVID information is available for patients and visitors on the Trust internet site and advice is included within appointment and admission letters

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.

The daily executive strategic command call is attended by the DIPC and deputy DIPC or Lead IPC nurse to share relevant IP&C information in real time.

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 IPCT performs risk assessments for any potential infectious disease incident in the Trust. Contact tracing for both staff and patients is facilitated by the IPCT 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 and COVID as appropriate (see Criterion 1).

An outbreak policy is in place and colleagues in UKHSA are available to assist with outbreak control if required.

Guidelines are available on the intranet for COVID sickness, isolation and return to work and are updated with publication of national guidance.

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 have been 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.

Some face to face training was reinstated during 2021/22 including induction training for junior doctors

The frequency of training depends on individual's role; annual update for frontline clinical staff including domestics and porters, two yearly updates for clinical but non-patient facing staff and three yearly updates for non-clinical staff.

Compliance with training is above target for all groups: 88.6% for annual, 93.6% for two yearly and 94.5% 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 2021 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.

Over the last two years there has been increasing collaboration between Kent and Medway infection control teams from all providers. This has been facilitated by weekly teleconferences to share learning and experience through the COVID pandemic. An IPC Leadership forum for DIPCs and their deputies has also met monthly and is chaired by the MTW DIPC as SRO for IPC for the system. The group is developing the system-wide IPC strategy and is developing educational opportunities for both established and aspiring IPC professionals, with the first training conference held in April 2021.

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 241 deaths 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 although there are current challenges associated with the national rise in rates.

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.

The IPCT continues to be involved in the preparations for CQC. A hygiene code gap analysis was undertaken for 2021/22

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 overleaf;

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.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • Range of information leaflets for patients and relatives • Regular communication with ICB HCAI lead • EDN includes MRSA status • Switchboard messages on norovirus

		<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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, COVID as appropriate • Diarrhoea policy • Reporting mechanism for notifiable disease to UKHSA in place • Temperature and symptom check at front doors (stepped down June 22). • Triage for COVID-19 at the front door of emergency departments • Separation of flow into respiratory and non-respiratory pathways to ensure the streams do not mix • Introduction of rapid COVID testing in ED to identify cases early and prevent 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.	<ul style="list-style-type: none"> • Mandatory training for all staff and volunteers • Information provided to contractors • Handbooks and competency for temporary staff • 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 • Infection control responsibility included in all job descriptions • Facing to face ward-based training for new nurses • Additional training for international nurses
7	Provide or secure adequate isolation facilities.	<ul style="list-style-type: none"> • Isolation policy

		<ul style="list-style-type: none"> • 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 designate 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	<ul style="list-style-type: none"> • 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 including rapid testing in both Emergency Departments.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	<ul style="list-style-type: none"> • 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. • UKHSA guidance followed
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	<ul style="list-style-type: none"> • 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 staff through rapid route if required. Advice provided on lateral flow tests • COVID spike antibody testing available as needed

		<ul style="list-style-type: none"> • COVID vaccination provided for staff within national guidelines
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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. During the COVID pandemic the IPC Board Assurance Framework has been discussed at Board meetings regularly.

C. difficile and MRSA and gram-negative bacteraemia numbers and rates are on the Board level dashboard together with MRSA screening rates.

The IPCC reports to the Quality Committee which is a sub-committee of the Board.

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 15-30% between 2020 and 2024 varying depending on animal type
- Be able to report on the percentage of prescriptions supported by a diagnostic test or decision support tool by 2024

COVID-19 and Seasonal Respiratory Viruses

The national COVID-19 pandemic is having a major impact on the way healthcare is provided in the UK. In addition, there is concern that an influenza epidemic may place the system o additional pressure during the winter period. Pathways have been redesigned to accommodate respiratory and non-respiratory patient flows with plans in place for placement of affected

patients. Rapid testing for COVID, influenza A & B and RSV has been implemented in both Emergency Departments.

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

Microbiology laboratory services are based at Maidstone Hospital. The laboratory has ISO 15189 accreditation.

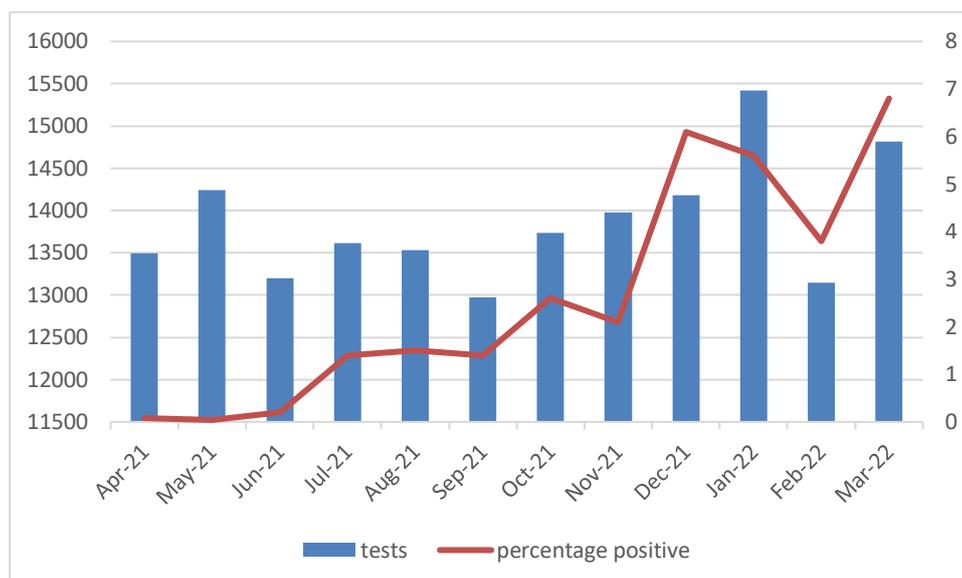
The laboratory is open 7 days a week and provides a 24-hour service with on call facilities from 6pm to 8am.

Reference laboratory support is available at all times from both the UKHSA reference laboratories and other commercial laboratories which provide additional rapid diagnostics.

The COVID testing workload changes significantly with changing national guidance. The microbiology laboratory also manages the Point of Care testing service in ED for COVID and other respiratory viruses.

During 2021/22, the laboratory processed 166 328 COVID tests with a positivity rate of 2.7% overall.

Fig 20: Number of COVID tests by month and positivity rate



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 compliance with the documentation of the MRSA care bundle and decolonisation therapy
- Commode audit
- Re audit of compliance with screening for Carbapenemase producing enterobacteriaceae (CPE).
- Audit of non-elective MRSA screening
- Patient experience audit
- ENT Outpatient Clinic environmental assessment

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.

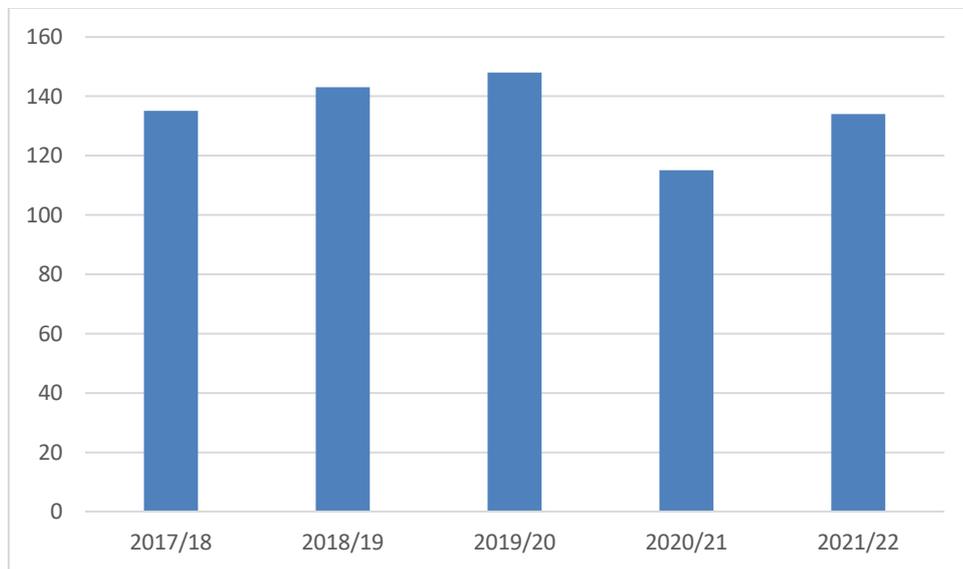
Occupational Health

The Occupational Health service provides pre-employment health assessments and assessment of immunity and provides vaccinations for new staff.

10.1 Sharps/Splash Injuries

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 2017-2022

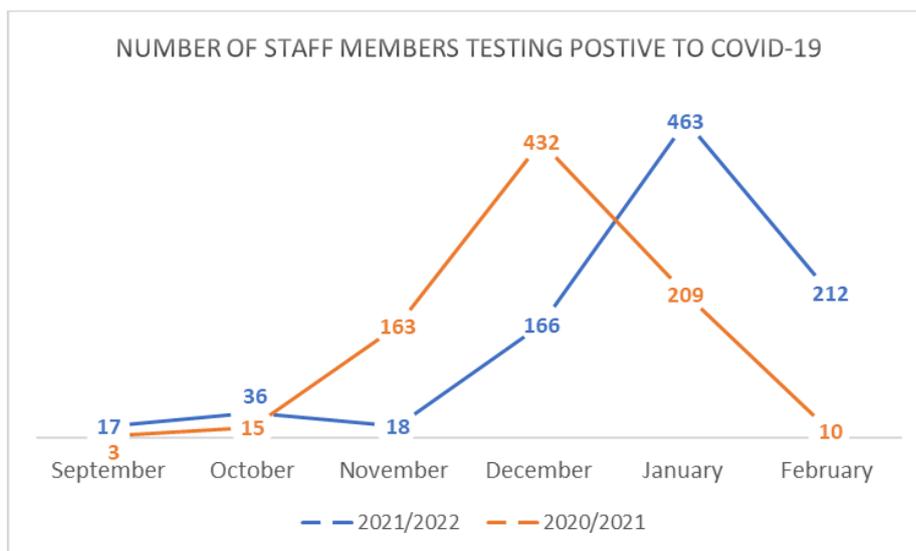


The split between types of injury has remained constant at around 75% sharps to 25% splash injuries

10.2 COVID-19

From March 2020 – March 2022, 2005 staff tested positive to COVID-19 with 264 cases seen in the first wave, 829 in the second wave and 912 in the third wave to February 2022. Numbers may be higher due to under-reporting of lateral flow test results.

Fig 23: Staff COVID Infections wave 2 & 3



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.

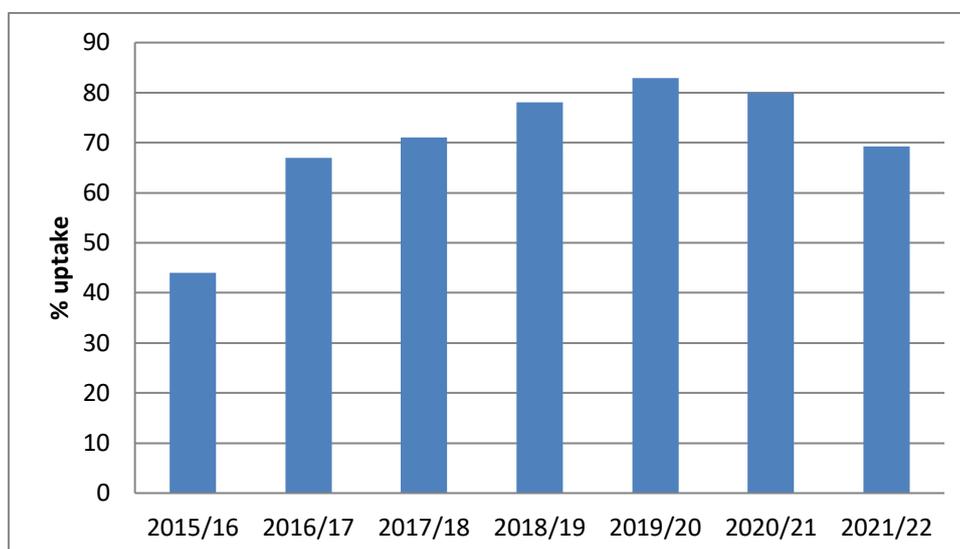
10.2.1 COVID-19 vaccination

Vaccination against COVID has been offered to all staff. By March 2022, 94.7% of staff had received two doses of vaccine (compared with the England average for NHS staff of 90.7%*) and 91.3% of those who were eligible had received a booster dose. For the year 2021/22, the COVID team delivered 12 298 doses of vaccine.

10.3 Influenza vaccination

The Occupational Health department leads the seasonal flu vaccination campaign. For 2021/22 there was lower uptake than usual for the vaccine with the Trust achieving 69.16% coverage, a total of 4693 staff. The campaign was launched in September and used a peer vaccination programme to outreach into clinical areas as well as combining with the COVID vaccination autumn booster programme.

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 2021/22 (appendix 1)

* January 2022 data

INFECTION PREVENTION AND CONTROL WORK PLAN 22/23



RAG RATING DEFINITION

R	ACTIONS APPEARS UNACHIEVABLE NEEDS RE-BASELING / REASSESSING
A	SUCCESSFUL DELIVERY OF PROJECT TIME AND THERE ARE NO THREATS TO DELIVERY
G	COMPLETED AND CLOSED NO FURTHER ACTIONS REQUIRED

Acti on No	Date Identif ied	Sour ce	Output (What are we trying to achieve)	Action (How are we going to do it)	By wh en	Work plan Quar ter	Owner	Current Progress (How are we doing)	RAG Rati ng
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CULTURE AND ENGAGEMENT

CE-001	Apr-22	APW	Improved attendance and engagement to the IPC Link workers programme and meetings	1) Monthly link worker meetings to be held by Microsoft teams - length of meeting to be agreed with ward managers and links to help improve attendance 2) Link worker attendance to be monitored, fed back to divisions and monitored through IPCC 3) Summary report to be presented to IPCC with action plan to improve attendance and engagement such as, re-introduction of link of the year.	Mar-23	Q4	Claire Taylor (Infection Prevention Nurse)	Summary report to be presented to July IPCC	
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CE-002	Apr-22	APW	Monitor and improve compliance with IPC practice and procedures	<p>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</p> <p>2) findings from PII investigations are fed back, followed up and monitored</p> <p>3) Audit/ QI programme developed and available on the Q drive. Also see Audit and Surveillance section of this work plan</p>	Mar-23	Q4	Lesley Smith (DDIPC)		
CE-003	Apr-22	APW	All medical devices and equipment to meet IPC requirements for use	<p>1) IPC team to work with procurement to provide IPC advice on new products being considered</p> <p>2) Attend the Medical devices meeting</p> <p>3) IPC approval of products via pre-purchase questionnaire (PPQ)</p>	Mar-23	Q4	Danny Moore (Infection Prevention Nurse)		

CE-004	Apr-22	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-23	Q4	Lesley Smith (DDIPC)	IPC team to support World Hand Hygiene Day https://www.who.int/campaigns/world-hand-hygiene-day/2022 5th May 2022 Glove awareness week 2nd 6th May https://www.rcn.org.uk/Get-Involved/Campaign-with-us/Glove-awareness/resources?fbclid=IwAR3mvp2w0dIWharvYhNYAm6qkIrh-nlzMmnYYXrkax38l_nlZB77eXlXIG4	
CE-005	Apr-22	KLOE	IPC patient feedback survey	1) 21/22 survey to be collated and report written up and fed back to IPCC 2) Review finding for areas for improvement for action 2) Explore utilising existing patient feedback systems such as F&F to gain this information	Aug-23	Q3	Danny Moore (Infection Prevention Nurse)	21/22 finding to be fed back to IPCC July	
CE-006	Apr-22	APW	Living with COVID-19 - reset and recovery	1) IPC leads to visit all wards and departments to promote good IPC practice. Reverting back to standard IPC precautions, promoting ventilation, hand hygiene and pre-pandemic practices, 2) Work with staff, departments and wards to review new / alternative ways of working 3) Interpretation and implementation of national IPC	Jul-22	Q2	Lesley Smith (DDIPC)		

				recommendations and guidance					
SCE-001	Apr-22	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) <i>Pseudomonas</i> risk assessment reviewed and updated yearly 4) Water safety workstream to be supported by consultant microbiologist	Mar-23	Q4	Joanne Green (Lead Nurse IPC)		
SCE-002	Apr-22	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-23	Q4	Joanne Green (Lead Nurse IPC)		
SCE-003	Apr-22	KLOEs (S1)	Full review of isolation risk assessment to be undertaken.	1) Full review to be undertaken 2) Finding to be discussed at IPC team meeting / IPCC, to agree further actions required	Dec-22	Q3	Jacqui Griffin (Lead Nurse IPC)		

			Process to be revised and re-implemented					
SCE-004	Apr-22	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-23	Q4	Danny Moore (Infection Prevention Control)	
SCE-005	Apr-22	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-23	Q4	Joanne Green (Lead Nurse IPC)	
SURVEILLANCE & AUDIT								

SA-001	Apr-22	APW	Programme of audit / QIP to be developed and completed for 22/23	1) Audit / QI programme to be developed and agreed at IPCC 2) IQVIA / Uylsess / Electronic audit systems to be reviewed and considered for audit use 3) Ward /Dept environmental audits 4) PII audits of MRSA and CDI	Mar-23	Q4	Jo Green (Lead Nurse IPC)		
SA-002	Apr-22	KLOE (S2)	Improved compliance with the documentation of MRSA decolonisation	1) MRSA decolonisation documentation on sunrise to be reviewed to see if any processes (hard stops) can be put in place to improve compliance 2) Alternative process to be evaluated and implemented	Dec-22	Q4	Jacqui Griffin (Lead Nurse IPC)		
SA-003	Apr-22	APW	Mandatory reporting of surgical site surveillance	1) SSIS to be reported 6 monthly to IPCC 2) Quarterly reports to UKHSA 3) Feedback of findings to orthopaedic directorate 4) Recruitment into vacant SSIS post 5) Increase scope for SSIS to include breast and laparotomys	Mar-23	Q4	Linda Baker (surgical site surveillance Nurse) & Jacqui Griffin (Lead Nurse IPC)		
SA-004	Apr-22	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	Mar-23	Q4	Lesley Smith (DDIPC)		

				3) Trends and lessons learnt to be shared within the Trust wide 4) Panel outcomes to be shared with IPCC					
SA-005	Apr-22	APW	Reduce rates of MSSA by 26% nearer to 18/19 rates when we had 19 cases Rates for 21/22 = 27 Rates for 20/21 = 24	1) Continue to promote good IPC practice 2) Act on lessons learnt from RCAs and disseminate for shared learning - focus on cannula care	Mar-23	Q4	Lesley Smith (DDIPC)		
SA-005	Apr-22	APW & KLO E	50% reduction in gram negative blood stream infections by 2024/25 5% reduction during 12 month timeframe ending November 2021 which equates to	1) Patient indwelling catheter cards to be provided to patients going home with indwelling catheters (E1.5) 2) Preventing CAUTI cards which promote Houdini (E1.5) 3) Laminated 'tea cup posters to be provided to ward to promote the hydration of patients (E1.5) 4) Continue to promote catheter passport 5) Report all > 48hr & <48 hr E.coli, Klebsiella and Pseudomonas aeruginosa bacteraemia on the National Data Capture System	Mar-23	Q4	Jo Green (Lead Nurse IPC)		

			E. coli 82 P.aeruginos a 16 Klebsiella spp 23	6) RCAs to be completed on all gram negative bacteraemia which are considered avoidable and / or identify areas for learning 7) Volunteers to support additional drinks rounds to assist in promoting hydration. 8) Monitor trends against the national UKHSA fingertip data 9) Gram negative reduction meetings to be held 10) utilisation of GNBSI reduction plan tools and plan available at: https://improvement.nhs.uk/resources/gram-negative-bloodstream-infection-reduction-plan-and-tools/					
SA-006	Apr-22	APW	<i>Clostridium difficile</i> Trust attributable infections to be within the Trust Limit of 62 This represents 1 less C. diff than the total count during the 12 month period	1) Monitor trends from the RCA & PIs 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-23	Q4	Lesley Smith (DDIPC)		

			ending November 2021 20/21, we had 50 cases against a limit of 55 YTD 21/22, we had 68 against a limit of 55 YTD					
SA-007	Apr-22	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 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-23	Q4	Sara Mumford (DIPC) Lesley Smith (DDIPC) Lucy Head & Hilary Baldwin (PPE Lead)	
SA-008	Apr-22	APW	Implementation 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	Aug-22	Q4	Jacqui Griffin (Lead Nurse IPC)	

SA-009	Apr-22	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-23	Q4	Jo Green (Lead Nurse IPC)		
SA-010	Apr-22	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 teletracking 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	Mar-23	Q4	Jo Green (Lead Nurse IPC)		
TRAINING & EDUCATION									
TE-001	Apr-22	BAF	All training to be updated to include latest best practice guidance and COVID	1) Online training package 2) Face to Face training 3) Hand hygiene practical sessions 4) Doctors training	Mar-23	Q4	Jacqui Griffin (Lead Nurse IPC)		

			19 requirements						
NATIONAL & LOCAL STANDARDS									
NLS-001	Apr-22	APW	Delivery of the local Antimicrobial Resistance Strategy	1) ASG to report to the IPCC 6 monthly 2) AMR CQUIN Appropriate antibiotic prescribing for UTI in adults aged 16+	Mar-23	Q4	Helen Burns (Deputy Chief Pharmacist) & Grace Sluga (Consultant Microbiologist)		
NLS-002	Apr-22	APW / KLOE / EPOC	Demonstrate Shared learning from lessons 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-23	Q4	Lesley Smith (DDIPC)		

NLS-003	Apr-22	APW	Support the Implementation of the Annual Flu plan	<ul style="list-style-type: none"> 1) Plan for vaccinators to support the 90% of frontline staff vaccination to be agreed 2) Fit testing of front-line staff (PPE fit testing team) 3) Support 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-23	Q4	Jacqui Griffin (Lead Nurse IPC)		
NLS-004	Apr-22	APW	<p>Develop a Policy review programme to spread across the next 3 years to avoid Policies expiring at the same time</p> <p>Ensure Policies are reviewed in accordance with new national recommendations</p> <p>Review</p>	<ul style="list-style-type: none"> 1) Candida auris (New) (In progress) SM 2) Notification of Infection (New) (In progress) SM 3) Animal visitor policy June 2024 4) Scabies policy - February 2024 5) TSE policy- November 2024 6) Norovirus - Oct 2024 7) Isolation - Dec 2023 8) Control of resistant organisms Oct 2024 9) Blood borne viruses - Oct 2022 10) Environmental disinfection - October 2024 11) Laundry- Reviewed and extended to 2024 12) CPE - February 2025 13) Decontamination of Mattresses - 2025 14) Single use medical devices 	Mar-23	Q4	Jacqui Griffin (Lead Nurse IPC) IPT	MRSA policy approved at IPCC in March 2021 awaiting ratification	

			format of policies to consider similar format to the HR's people's policy	<p>- October 2024 15) Infection Prevention and Control policies and procedures November 2024 16) TB - October 2024 17) VZV - October 2024 18) Outbreak of communicable disease -2024 19) Ward closure - October 2024 20) Hand hygiene - October 2024 21) Single case of GAS (flow chart) April 2023 22) MRSA July 22</p> <p>Policies to be formatted into similar format as Trusts people's policy</p>					
NLS-005	Apr-22	CCG	Deliver ICS KPIs	<p>1) KPIs to be agreed 2) Agreed KPIs to be monitored through the IPCC meeting</p>	Mar-23	Q4	Lesley Smith (Consultant Nurse IPC)		
NLS-006	Apr-22	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-23	Q4	Lesley Smith (Consultant Nurse IPC)		

NLS -007	Apr-22	APW	Revise all IPC leaflets due for update during 20/21	All leaflets that require updating for 21/22 to be reviewed 1) Hand hygiene information for staff - August 20 2) CPE - information for patients (Standard and Large print) - April 20 3) <i>C.difficile</i> - 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 -23	Qu4	Jacqui Griffin (Lead Nurse IPC)		
NLS -008	Apr-22	APW	Seek opportunities to publise 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 -23	Qu 4	Lesley Smith (DDIPC)		

NLS-009	Apr-22	APW	Participate in developing a safe environment for staff and patients (based on the latest evidence) move towards living with COVID-19	1) Support the 100% of frontline staff vaccination 2) Adequate stock PPE 3) Ongoing fit testing programme for front-line staff 4) Surveillance of COVID-19 cases 5) Review respiratory / red pathways 6) Support patient placement for patients with known or suspected COVID-19 7) Ensure national guidance is interpreted and implemented with Trust approval 8) Early identification and management of COVID-19 related outbreaks	Mar-23	Qu 4	Lesley Smith (DDIPC)		
NLS-010	Apr-22	APW	Public COVID-19 enquiry	1) Provide all relevant information to support the Public COVID-19 enquiry	Mar-23	Qu4	Lesley Smith (DDIPC)		
			Key						
			APW	Annual Programme of Work					
			KLOE	Key Lines of Enquiry					
			BAF	Board assurance Framework					
			EPOC	Exceptional people outstanding care					

Findings of the national inpatient survey 2021

Chief Nurse

The report enclosed highlights the key findings of the NHS Adult Inpatient Survey 2021 Benchmark Report.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 18/10/22

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

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

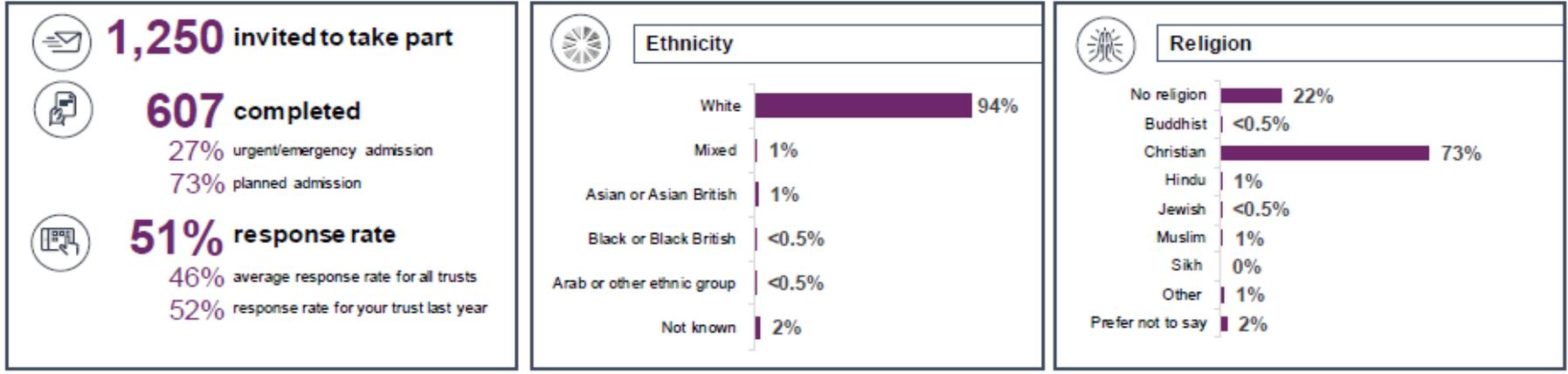
Executive Summary

- The NHS Patient Survey Programme (NPSP) collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services.
- The NPSP is commissioned by the Care Quality Commission (CQC).
- CQC will use results from the survey to build an understanding of the risk and quality of services and those who organise care across an area.
- A total of 166,318 patients were invited to participate in the survey across 134 acute and specialist NHS trusts.
- Patients were eligible to participate in the survey if they were aged 16 years or over, had spent at least one night in hospital, and were not admitted to maternity or psychiatric units.
- Between January and May 2022, 1,250 people at each participating NHS trusts were invited to take part in the survey. Responses were received from 514 people at Maidstone and Tunbridge Wells NHS Trust (43% response rate).
- Questions included in the survey follow people's journeys from admission to hospital, treatment and discharge.

Who took part in the survey- Comparison between 2020 and 2021

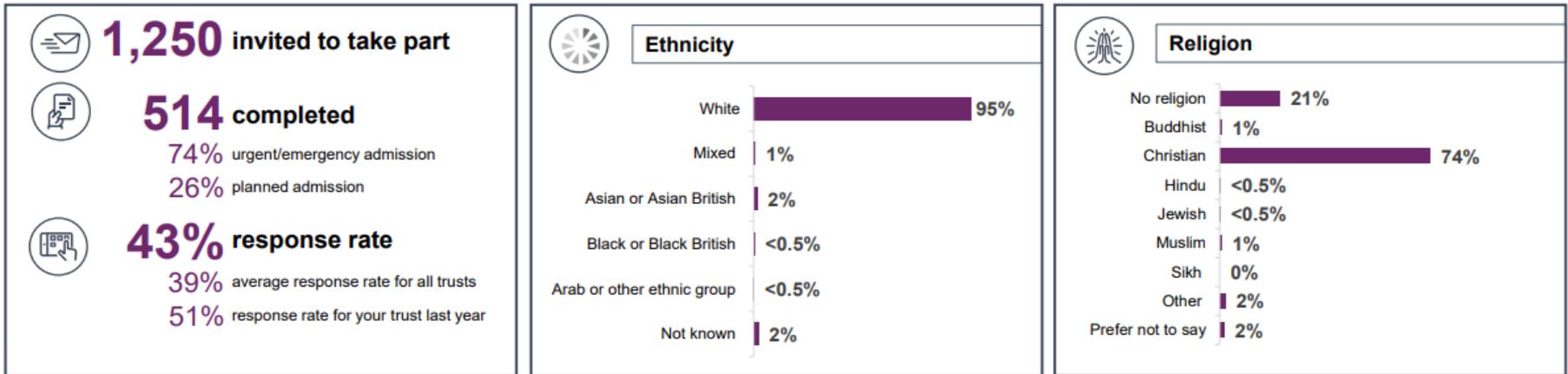
• 2020

This slide is included to help you interpret responses and to provide information about the population of patients who took part in the survey.



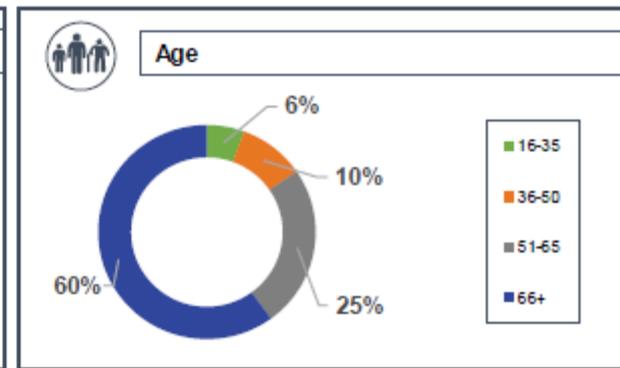
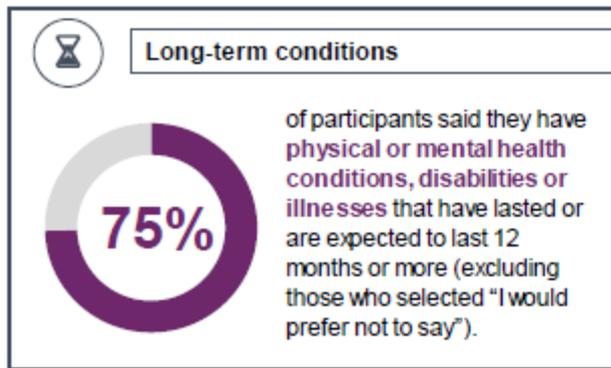
• 2021

This slide is included to help you interpret responses and to provide information about the population of patients who took part in the survey.



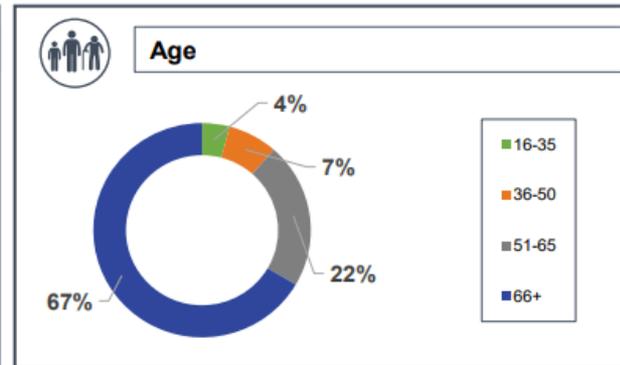
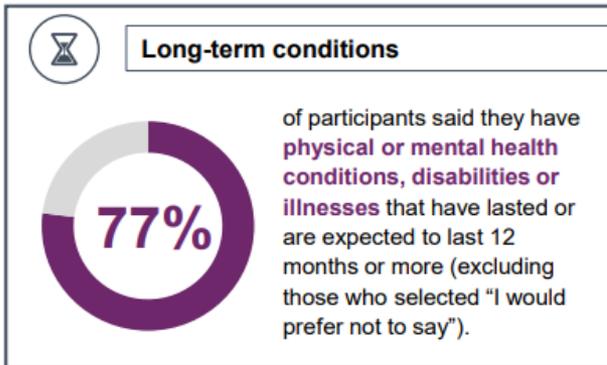
Who took part in the survey- Comparison between 2020 and 2021

- 2020



8 Adult Inpatient Survey 2020 | RWF | Maidstone and Tunbridge Wells NHS Trust

- 2021



8 Adult Inpatient Survey 2021 | RWF | Maidstone and Tunbridge Wells NHS Trust

Summary findings

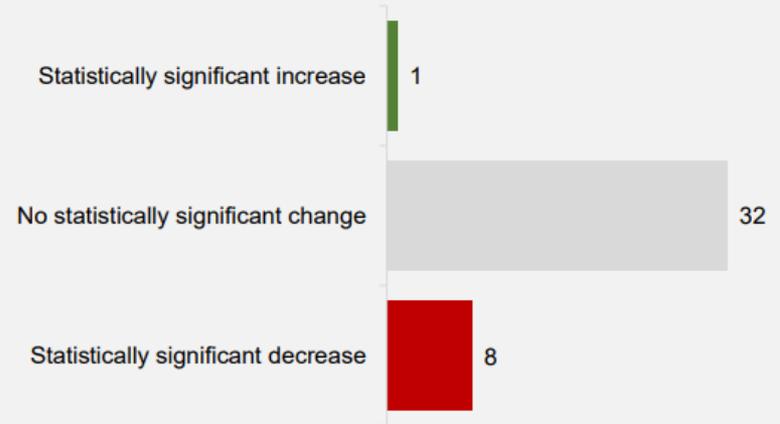
Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.



Comparison with last year's results

The **number of questions** in this report where your trust showed a statistically significant increase, decrease, or no change in scores compared to 2020 results.



Summary findings- Trusts within MTW that were used for comparison.

Queen Victoria
Hospital NHS
Foundation Trust

East Sussex
Healthcare NHS Trust

Oxford University
Hospitals NHS
Foundation Trust

University Hospital
Southampton NHS
Foundation Trust

Royal Surrey NHS
Foundation Trust

East Kent Hospitals
University NHS
Foundation Trust

Dartford and
Gravesham NHS Trust

University Hospitals
Sussex NHS
Foundation Trust

Isle of Wight NHS
Trust

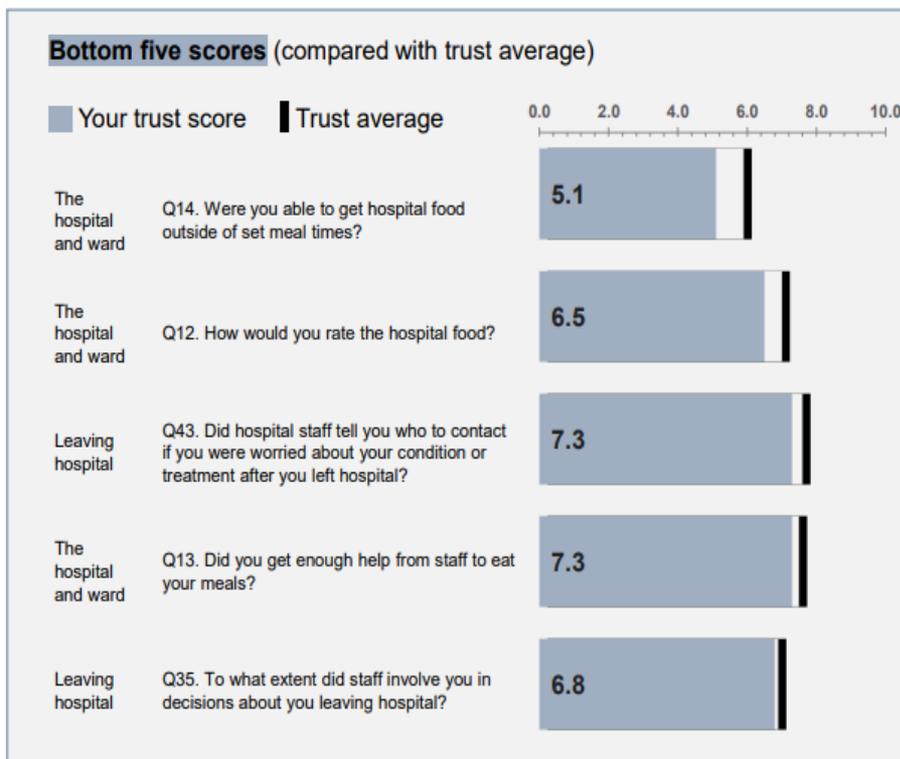
Buckinghamshire
Healthcare NHS Trust

Summary findings

Best and worst performance relative to the trust average

These five questions are calculated by comparing your trust's results to the trust average (the average trust score across England).

- **Top five scores:** These are the five results for your trust that are highest compared with the trust average. If none of the results for your trust are above the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's best performance may be worse than the trust average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the trust average. If none of the results for your trust are below the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's worst performance may be better than the trust average.



Summary findings: Key areas surveyed

✓ Admission to hospital	Patient Response ⓘ 7.2 / 10	Compared with other trusts ⓘ About the same
✓ The hospital and ward	Patient Response ⓘ 7.7 / 10	Compared with other trusts ⓘ About the same
✓ Doctors	Patient Response ⓘ 8.8 / 10	Compared with other trusts ⓘ About the same
✓ Nurses	Patient Response ⓘ 8.3 / 10	Compared with other trusts ⓘ About the same
✓ Care and treatment	Patient Response ⓘ 8.1 / 10	Compared with other trusts ⓘ About the same

Summary findings: Key areas surveyed

<p>▼ Operations and procedures</p>	<p>Patient Response ⓘ 8.3 / 10</p>	<p>Compared with other trusts ⓘ About the same</p>
<p>▼ Leaving hospital</p>	<p>Patient Response ⓘ 7.2 / 10</p>	<p>Compared with other trusts ⓘ About the same</p>
<p>▼ Feedback on care</p>	<p>Patient Response ⓘ 1.3 / 10</p>	<p>Compared with other trusts ⓘ About the same</p>
<p>▼ Respect and dignity</p>	<p>Patient Response ⓘ 9.1 / 10</p>	<p>Compared with other trusts ⓘ About the same</p>
<p>▼ Overall experience</p>	<p>Patient Response ⓘ 8.1 / 10</p>	<p>Compared with other trusts ⓘ About the same</p>

Summary findings

Comparison to 2020 results

The questions in this report where your trust showed a statistically significant increase or decrease compared to 2020 results are listed below.

Significant Increase	Point change	Significant Decrease	Point change
Q39. Before you left hospital, were you given any information about what you should or should not do after leaving hospital?	+1.0	Q22. In your opinion, were there enough nurses on duty to care for you in hospital?	-0.8
		Q3. How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?	-0.5
		Q10. If you brought medication with you to hospital, were you able to take it when you needed to?	-0.5
		Q29. Do you think the hospital staff did everything they could to help control your pain?	-0.3
		Q21. When nurses spoke about your care in front of you, were you included in the conversation?	-0.3
		Q48. Overall, how was your experience while you were in the hospital?	-0.3
		Q8. How clean was the hospital room or ward that you were in?	-0.3
		Q28. Were you given enough privacy when being examined or treated?	-0.2

Summary findings



NHS Adult Inpatient Survey 2021

Results for Maidstone and Tunbridge Wells NHS Trust



Where patient experience **is best**

- ✓ Noise from other patients: patients not being bothered by noise at night from other patients
- ✓ Privacy for discussions: patients being able to discuss their condition or treatment with hospital staff without being overheard
- ✓ Equipment and adaptations in the home: hospital staff discussing if any equipment or home adaptations were needed when leaving hospital
- ✓ Noise from staff: patients not being bothered by noise at night from staff
- ✓ Changing wards during the night: staff explaining the reason for patients needing to change wards during the night

Where patient experience **could improve**

- Food outside set meal times: patients being able to get hospital food outside of set meal times, if needed
- Quality of food: patients describing the hospital food as good
- Contact: patients being given information about who to contact if they were worried about their condition or treatment after leaving hospital
- Help with eating: patients being given enough help from staff to eat meals, if needed
- Involvement in decisions: patients being involved in decisions about leaving hospital, if they wanted to be

These topics are calculated by comparing your trust's results to the average of all trusts. "Where patient experience is best": These are the five results for your trust that are highest compared with the average of all trusts. "Where patient experience could improve": These are the five results for your trust that are lowest compared with the average of all trusts.

This survey looked at the experiences of people who were discharged from an NHS acute hospital in November 2021. Between January 2022 and May 2022, a questionnaire was sent to 1250 inpatients at Maidstone and Tunbridge Wells NHS Trust who had attended in late 2021. Responses were received from 514 patients at this trust. If you have any questions about the survey and our results, please contact [NHS TRUST TO INSERT CONTACT DETAILS].

Adult Inpatient Survey 2021 | RWF | Maidstone and Tunbridge Wells NHS Trust

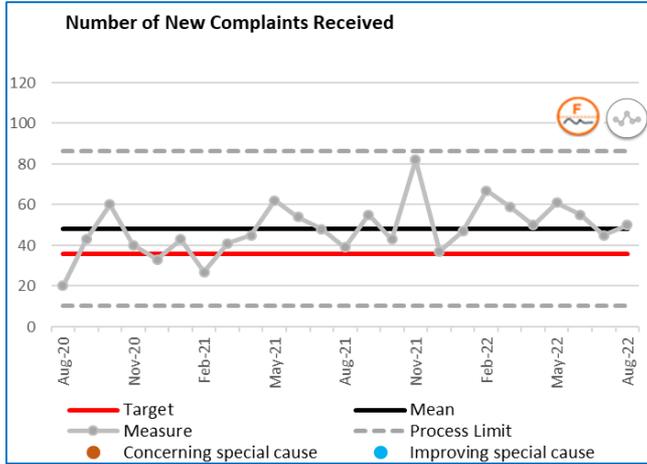


Vision Objective: Counter Measure Summary

Metric Name – To reduce the overall number of complaints or concerns each month

Owner: Joanna Haworth
Metric: Number of Complaints Received Monthly
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Aug-22
50
Variance Type
Metric is currently experiencing Common Cause Variation
Max Limit (Internal)
36
Target Achievement
Metric has failed the target for >6months

1. Historic Trend Data

Historic trend data to be available from October now methodology agreed for data collection

3. Top Contributors

A3 Thinking currently underway to understand the themes of complaints and concerns where poor communication is the main issue affecting patient experience

4. Action Plan

Action for A3	Timeline	Progress
Method to collect data from datix to be and agreed	August	Complete
Current condition being analysed	September	Complete
Audit of complaints to be completed	October	In Progress
Root Cause being identified	October	TBC

Next steps: Patient food / menu	Timeline
Paperless menu task and finish group set to review patient menu app	Ongoing
Finger foods trial	28 th October 2022
Chef's Academy Training for Trust Chefs	Planned
Food service is part of syllabus for dietitians. Dietetic students to spend time with catering in each level of placement	N/A
At TWH we continue to provide excellent cook-chill service to patients. The catering team is working with Dietetics and Nutritional leads to launch the similar service at MGH as well.	N/A
The special consideration to patients with Disabilities (audible, sight etc) is part of the project	N/A
PLACE Audit and mealtime assessments are once again scheduled for September to October 2022 to enable us to benchmark the quality standards.	September to October 2022
Use of volunteers to support patient feeding	N/A
Emergency departments on both sites to be provided with housekeeping staff and have the ability to serve a variety of hot and cold food	N/A

Next steps: Patient Experience Strategy	Timeline
Initial working group set up linking with the NHSIE patient experience leads to take part in the draft reframing of the national patient experience framework	December 2022
MTW to start the engagement process with stakeholders in drafting the new patient experience strategy	Three months November 2022 to January 2023
Patient experience team workforce review to ensure they are able to undertake the required tasks	January 2023
Review the use of volunteers and patient partners across MTW	In progress
Poor communication theme currently undergoing the A3 process as part of SDR	
Inpatient Quality Checklist pilot on InPhase took place on the 14 th October	Full roll out expected beginning of November 2023

- Monitoring of progress to be done through the patient experience committee, and the SDR process at ETM.

▪ **Appendix 1 - Adult Inpatient Survey 2021**

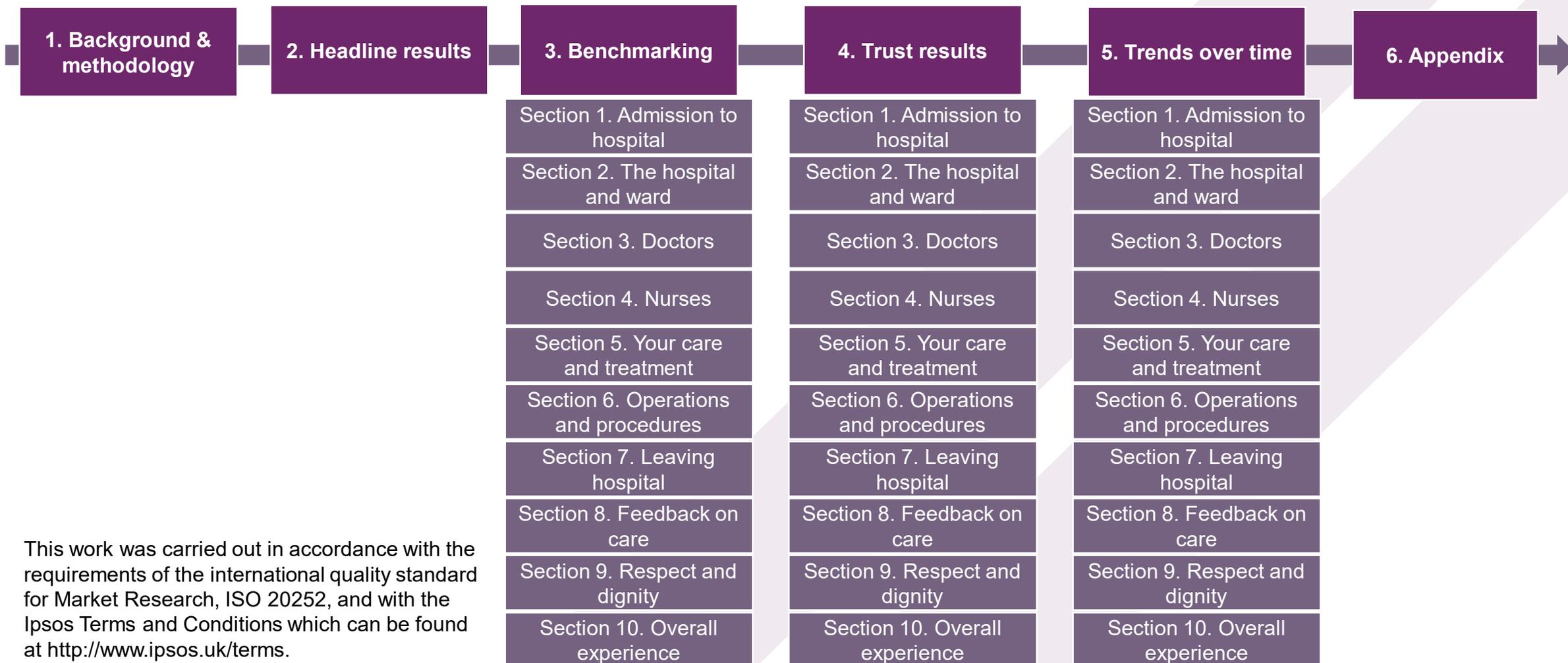


NHS Adult Inpatient Survey 2021 Benchmark Report

Maidstone and Tunbridge Wells NHS Trust



Contents



This work was carried out in accordance with the requirements of the international quality standard for Market Research, ISO 20252, and with the Ipsos Terms and Conditions which can be found at <http://www.ipsos.uk/terms>.

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Background and methodology

This section includes:

- an explanation of the NHS Patient Survey Programme
- information on the Adult Inpatient 2021 survey
- a description of key terms used in this report
- navigating the report



Background and methodology

The NHS Patient Survey Programme

The NHS Patient Survey Programme (NPSP) collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services.

The NPSP is commissioned by the Care Quality Commission (CQC); the independent regulator of health and adult social care in England.

As part of the NPSP, the Adult Inpatient Survey has been conducted annually since 2002. CQC will use results from the survey to build an understanding of the risk and quality of services and those who organise care across an area.

To find out more about the survey programme and to see the results from previous surveys, please refer to the section on further information on this page.

The Adult Inpatient Survey 2021

The survey was administered by the Coordination Centre for Mixed Methods (CCMM) at Ipsos. A total of 166,318 patients were invited to participate in the survey across 134 acute and specialist NHS trusts. Completed responses were received from 62,235 patients, an adjusted response rate of 39%.

Patients were eligible to participate in the survey if they were aged 16 years or over, had spent at least one night in hospital, and were not admitted to maternity or psychiatric units. A full list of eligibility criteria can be found in the survey [sampling instructions](#).

Trusts sampled patients who met the eligibility criteria and were discharged from hospital during November 2021. Trusts counted back from the last day of November 2021, sampling every consecutively discharged patient until they had selected 1,250 patients. Some smaller trusts, which treat fewer patients, included patients who were treated in hospital earlier than November 2021 (as far back as April 2021), to achieve a large enough sample.

Fieldwork took place between January and May 2022.

Trend data

The Adult Inpatient 2021 survey was conducted using a push-to-web methodology (offering both online and paper completion). There were minor questionnaire changes, including three new questions and changes to question wording. The 2021 results are comparable with data from the Adult Inpatient 2020 survey, unless a question has changed or there are other reasons for lack of comparability such as changes in organisation structure of a trust. Where results are comparable, a section on historical trends has been included.

Further information about the survey

- For published results for other surveys in the NPSP, and for information to help trusts implement the surveys across the NPSP, please visit the [NHS Surveys website](#).
- To learn more about CQC's survey programme, please visit the [CQC website](#).

Key terms used in this report

The 'expected range' technique

This report shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part. It uses an analysis technique called the 'expected range' to determine if your trust is performing about the same, better or worse compared with most other trusts. This is designed to help understand the performance of individual trusts and identify areas for improvement.

This report also includes site level benchmarking. This allows you to compare the results for sites within your trust with all other sites across trusts. It is important to note that the performance ratings presented here may differ from that presented in the trust level benchmarking.

More information can be found in the [Appendix](#).

Standardisation

Demographic characteristics, such as age and gender, can influence patients' experience of care and the way they report it. For example, research shows that men tend to report more positive experiences than women, and older people more so than younger people.

Since trusts have differing profiles of patients, this could make fair trust comparisons difficult. To account for this, we 'standardise' the results, which means we apply a weight to individual patient responses to account for differences in demographic profile between trusts.

For each trust, results have been standardised by the age, sex and method of admission (emergency or elective) of respondents to reflect the 'national' age, sex, and method of admission distribution (based on all respondents to the survey). This helps ensure that no trust will appear better or worse than another because of its profile of service users, and enables a fairer and more useful comparison of results across trusts. In most cases this standardisation will not have a large impact on trust results. Site level results are standardised in the same way.

Scoring

For each question in the survey, the individual (standardised) responses are converted into scores on a scale of 0 to 10. A score of 10 represents the best possible result and a score of 0 the worst. The higher the score for each question, the better the trust is performing. Only evaluative questions in the questionnaire are scored. Some questions are

descriptive (for example Q1) and others are 'routing questions', which are designed to filter out respondents to whom the following questions do not apply (for example Q6). These questions are not scored. Section scoring is computed as the arithmetic mean of question scores for the section after weighting is applied.

Trust average

The 'trust average' mentioned in this report is the arithmetic mean of all trusts' scores after weighting or standardisation is applied.

Suppressed data

If fewer than 30 respondents have answered a question, no score will be displayed for that question (or the corresponding section the question contributes to).

Further information about the methods

For further information about the statistical methods used in this report, please refer to the [survey technical document](#).

Using the survey results

Navigating this report

This report is split into six sections:

- **Background and methodology** – provides information about the survey programme, how the survey is run, and how to interpret the data.
- **Headline results** – includes key trust-level findings relating to the patients who took part in the survey, benchmarking, and top and bottom scores. This section provides an overview of results for your trust, identifying areas where your organisation performs better than the average and where you may wish to focus improvement activities.
- **Benchmarking** – shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part; using the ‘expected range’ analysis technique. This allows you to see the range of scores achieved and compare yourself with the other organisations that took part in the survey. Benchmarking can provide you with an indication of where you perform better than the average, and what you should aim for in areas where you may wish to improve. Section score slides also include a comparison with other trusts in your region. It may be helpful to compare yourself with regional trusts, so you can learn from and share learnings with trusts in your area who care for similar populations.

- **Trust results** – includes the score for your trust and breakdown of scores across sites within your trust. Internal benchmarking may be helpful so you can compare sites within your organisation, sharing best practice within the trust and identifying any sites that may need attention.
- **Trends over time** – includes your trust’s mean score for each evaluative question in the survey shown in a significance test table, comparing it to your 2020 mean score. This allows you to see if your trust has made statistically significant improvements between survey years.
- **Appendix** – includes additional data for your trust; further information on the survey methodology; interpretation of graphs in this report.

How to interpret the graphs in this report

There are several types of graphs in this report which show how the score for your trust compares to the scores achieved by all trusts that took part in the survey.

The two chart types used in the section ‘benchmarking’ use the ‘expected range’ technique to show results. For information on how to interpret these graphs, please refer to the [Appendix](#).

Other data sources

More information is available about the following topics at their respective websites, listed below:

- Full national results; link to view the results for each trust; technical document: www.cqc.org.uk/inpatientsurvey
- National and trust-level data for all trusts who took part in the Adult Inpatient 2021 survey: <https://nhssurveys.org/surveys/survey/02-adults-inpatients/year/2021/>. Full details of the methodology for the survey, instructions for trusts and contractors to carry out the survey, and the survey development report can also be found on the NHS Surveys website.
- Information on the NHS Patient Survey Programme, including results from other surveys: www.cqc.org.uk/content/surveys
- Information about how the CQC monitors hospitals: www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-nhs-acute-hospitals

Headline results

This section includes:

- information about your trust population
- an overview of benchmarking for your trust
- the top and bottom scores for your trust



Who took part in the survey?

This slide is included to help you interpret responses and to provide information about the population of patients who took part in the survey.



1,250 invited to take part



514 completed

74% urgent/emergency admission

26% planned admission



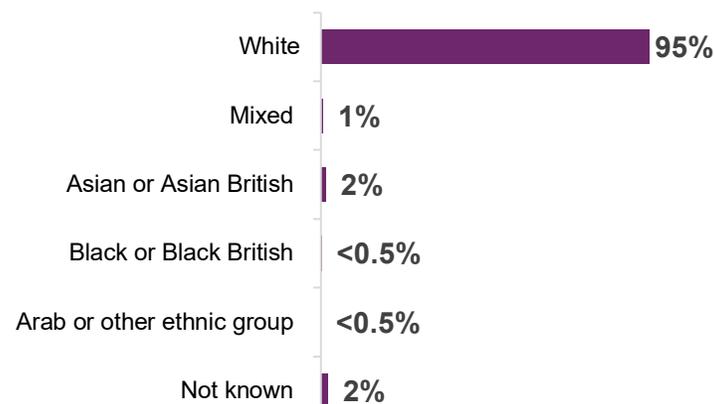
43% response rate

39% average response rate for all trusts

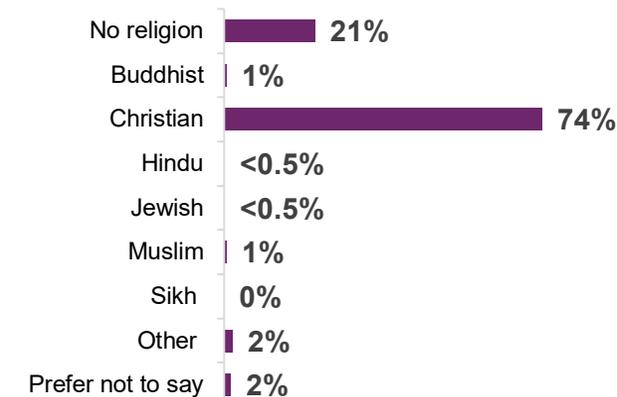
51% response rate for your trust last year



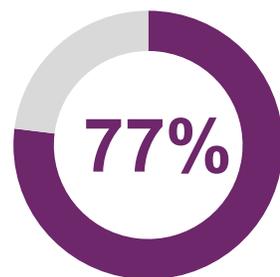
Ethnicity



Religion



Long-term conditions



of participants said they have **physical or mental health conditions, disabilities or illnesses** that have lasted or are expected to last 12 months or more (excluding those who selected "I would prefer not to say").



Sex

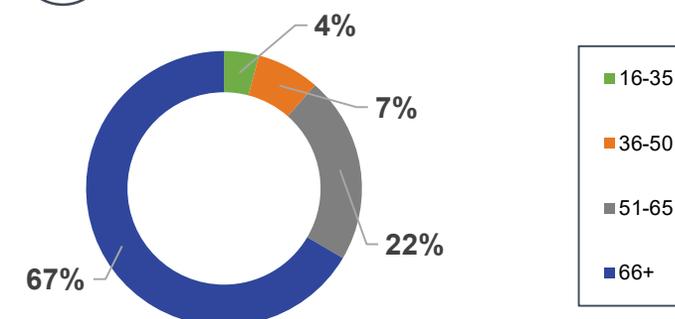
At birth were you registered as...



0% of participants said their gender is different from the sex they were registered with at birth.



Age



Summary of findings for your trust

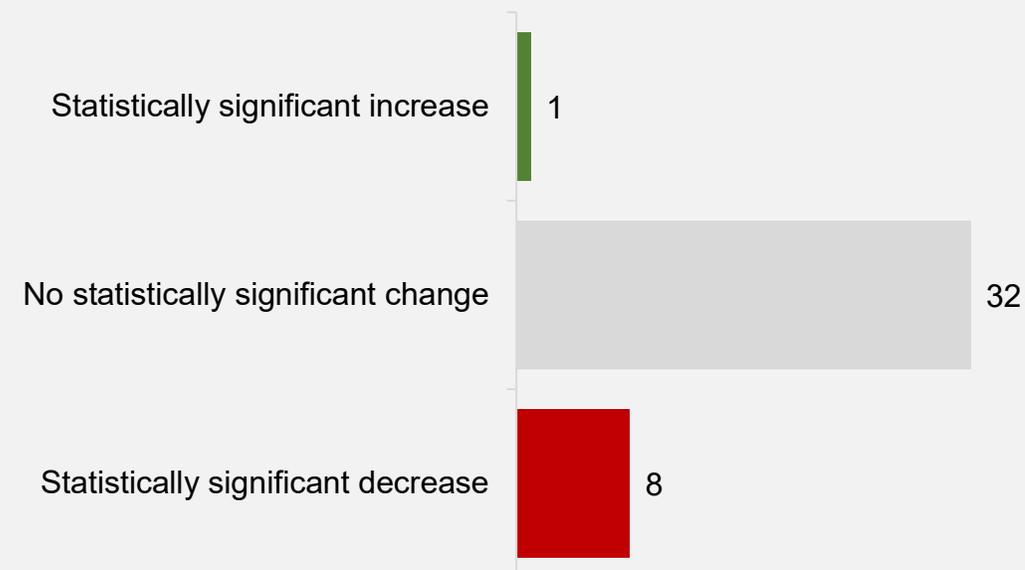
Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.



Comparison with last year's results

The **number of questions** in this report where your trust showed a statistically significant increase, decrease, or no change in scores compared to 2020 results.



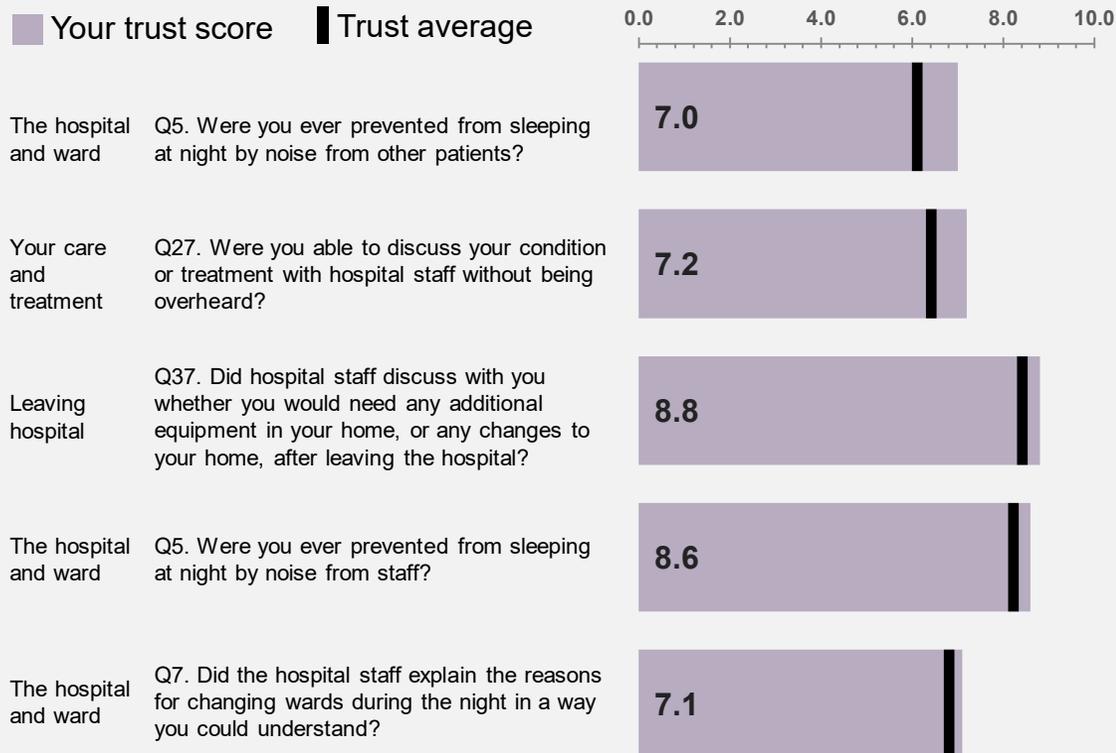
For a breakdown of the questions where your trust has performed better or worse compared with all other trusts, please refer to the appendix section [“comparison to other trusts”](#). For a breakdown of the questions where your trust showed a statistically significant increase or decrease in scores compared to 2020 results, please refer to the appendix section [“comparison to 2020 results”](#).

Best and worst performance relative to the trust average

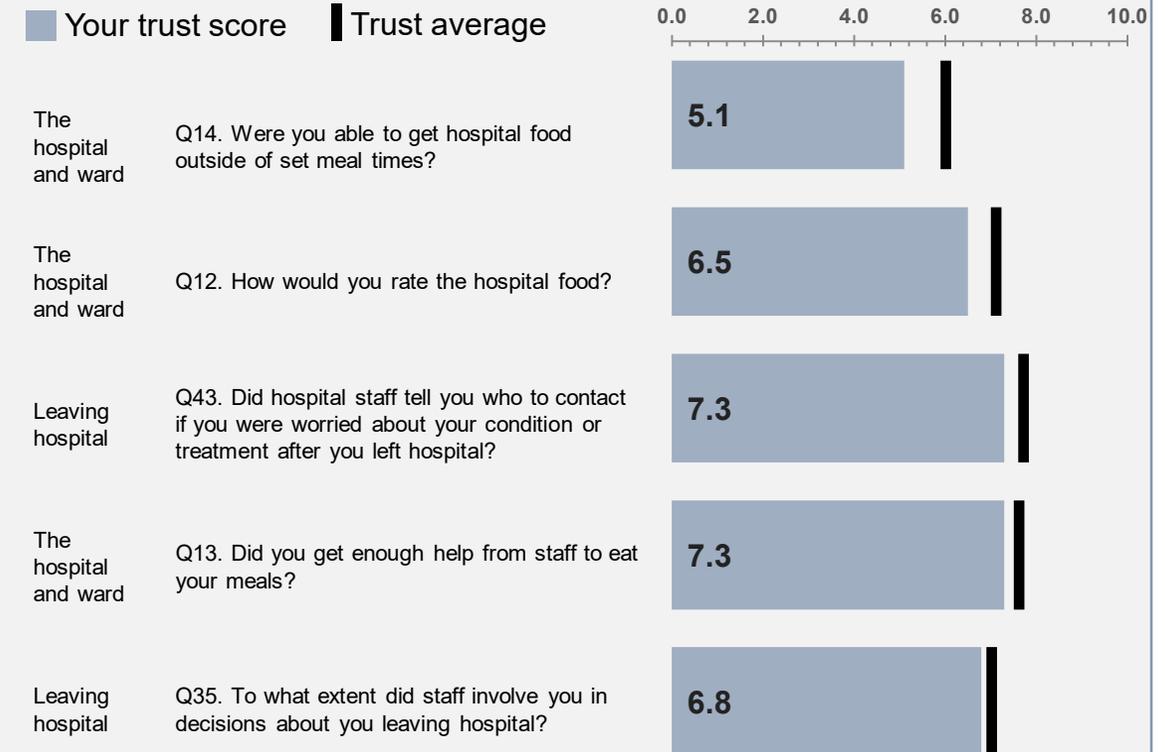
These five questions are calculated by comparing your trust's results to the trust average (the average trust score across England).

- **Top five scores:** These are the five results for your trust that are highest compared with the trust average. If none of the results for your trust are above the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's best performance may be worse than the trust average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the trust average. If none of the results for your trust are below the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's worst performance may be better than the trust average.

Top five scores (compared with trust average)



Bottom five scores (compared with trust average)



Benchmarking

This section includes:

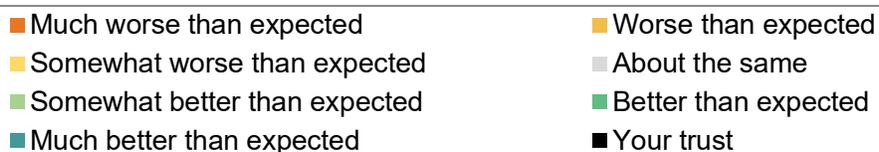
- how your trust scored for each evaluative question in the survey, compared with other trusts that took part
- an analysis technique called the 'expected range' to determine if your trust is performing about the same, better or worse compared with most other trusts
- a comparison of section scores with other trusts in your region



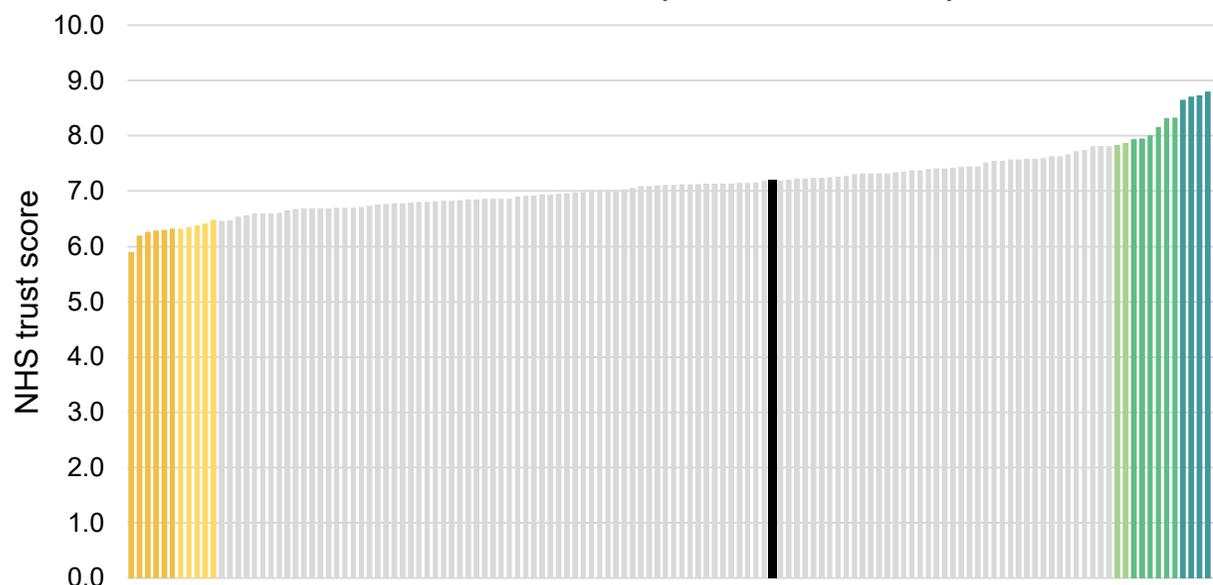
Section 1. Admission to hospital

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



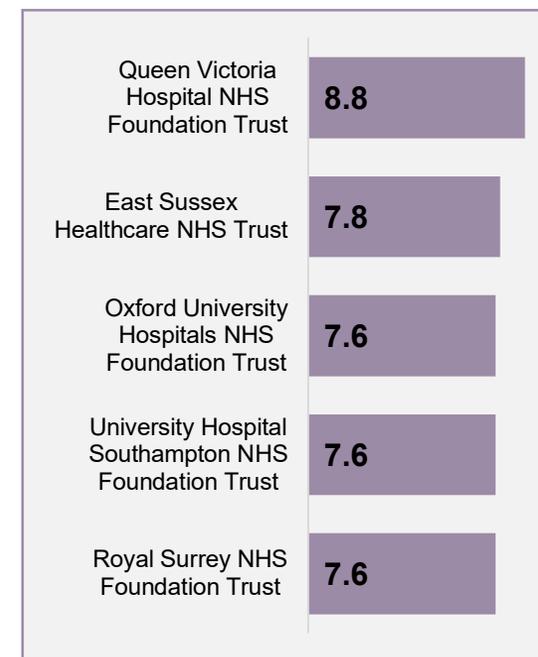
Your trust section score = 7.2 (About the same)



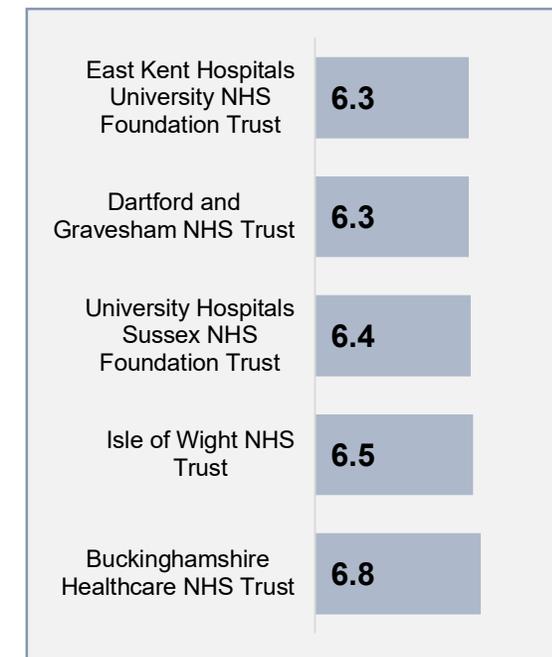
Each vertical line represents an individual NHS trust
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region

Trusts with the highest scores



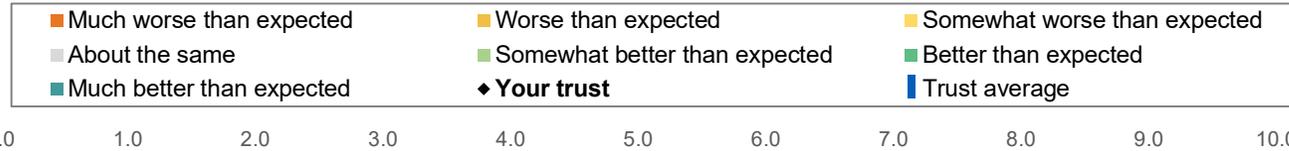
Trusts with the lowest scores



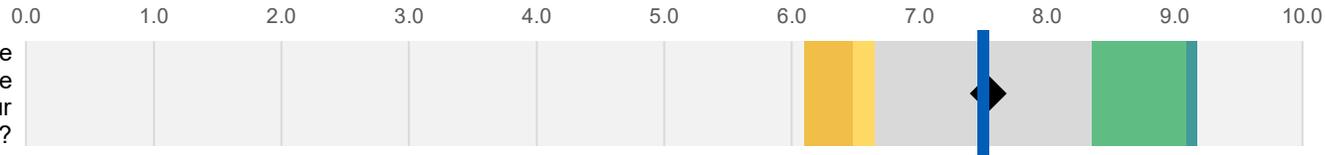
Section 1. Admission to hospital (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.



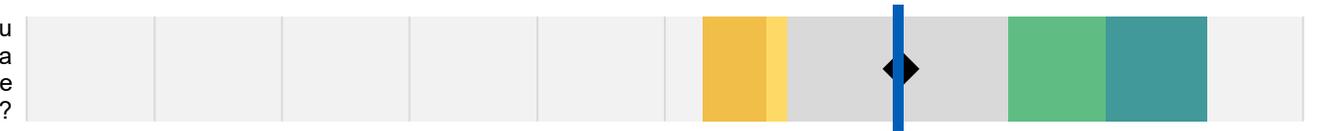
Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital?



About the same

Number of respondents (your trust)	Your trust score	All trusts in England		
		Trust average score	Lowest score	Highest score
137	7.5	7.5	6.1	9.2

Q3. How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?



About the same

490	6.8	6.8	5.3	9.2
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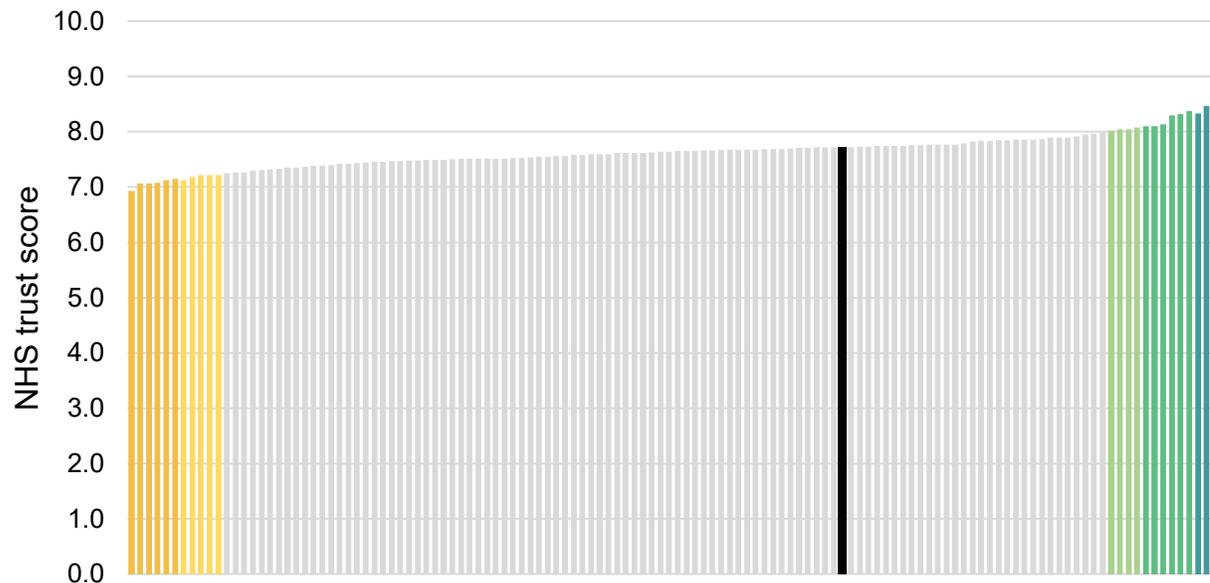
Section 2. The hospital and ward

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



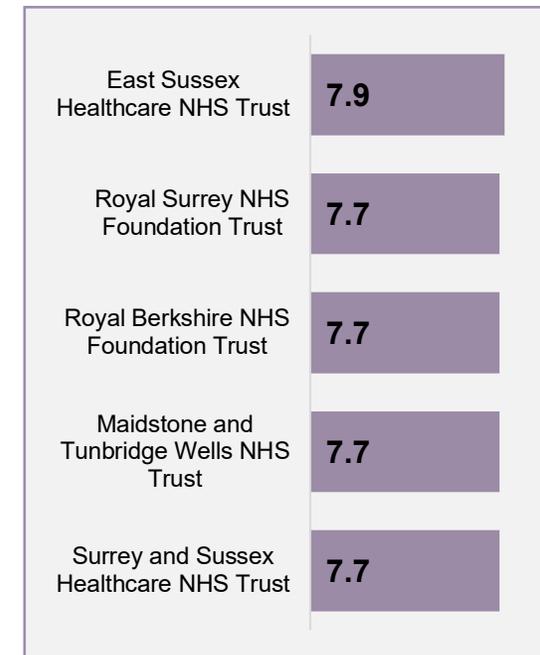
Your trust section score = 7.7 (About the same)



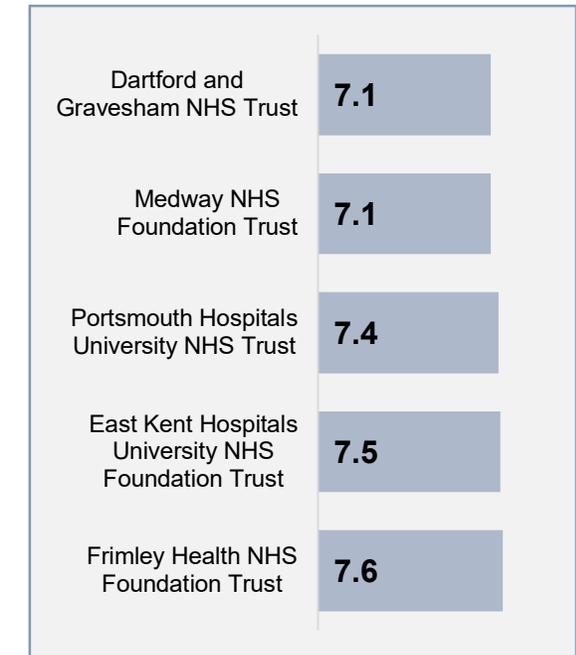
Each vertical line represents an individual NHS trust
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region

Trusts with the highest scores



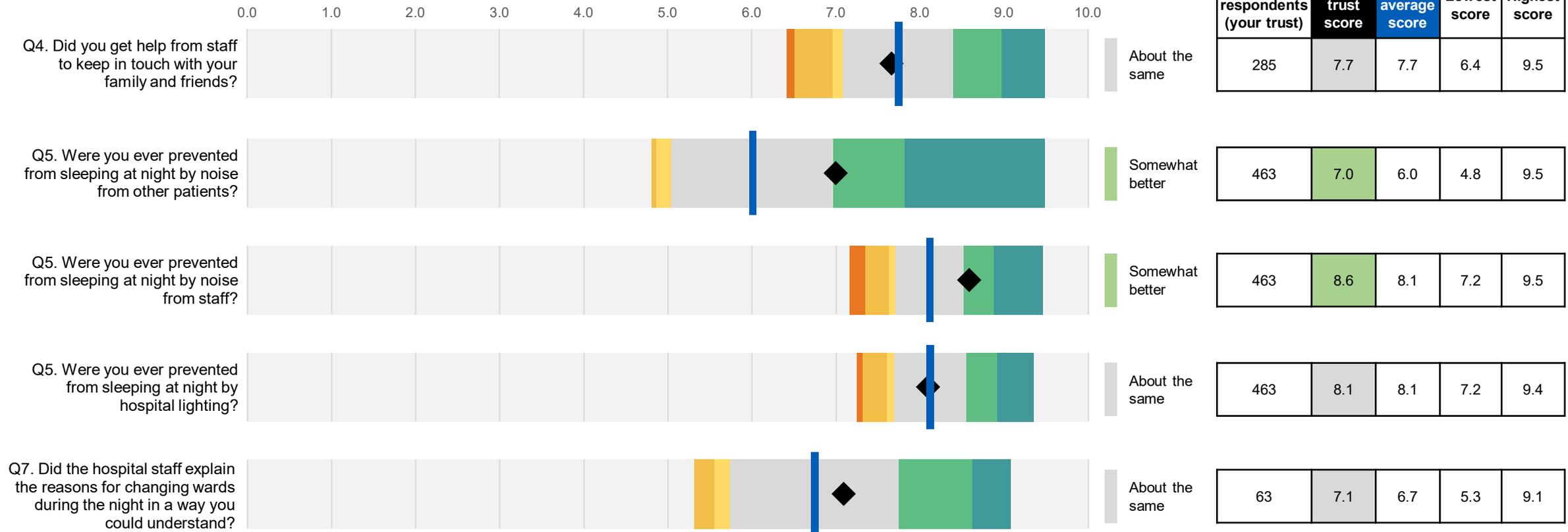
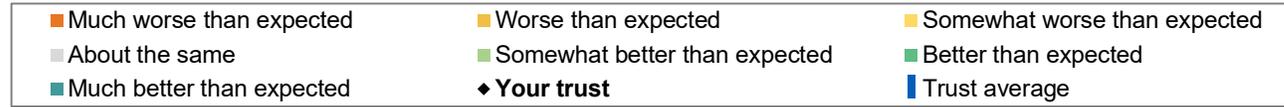
Trusts with the lowest scores



Section 2. The hospital and ward (continued)

Question scores

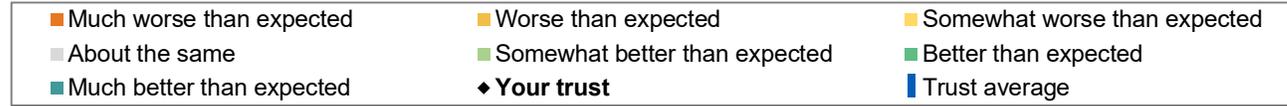
Trust score is not shown when there are fewer than 30 respondents.



Section 2. The hospital and ward (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.



0.0 1.0 2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0

Q8. How clean was the hospital room or ward that you were in?



About the same

Number of respondents (your trust)	Your trust score	All trusts in England		
		Trust average score	Lowest score	Highest score
501	9.1	9.1	8.4	9.9

Q9. Did you get enough help from staff to wash or keep yourself clean?



About the same

350	8.2	8.1	7.2	9.4
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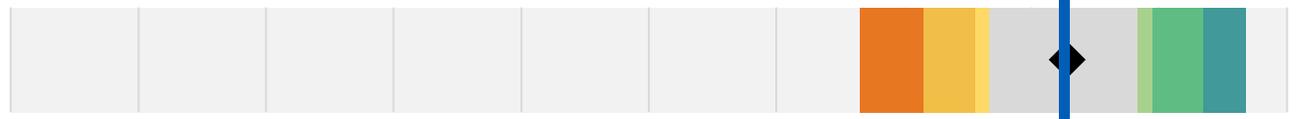
Q10. If you brought medication with you to hospital, were you able to take it when you needed to?



About the same

298	8.2	8.1	7.3	9.5
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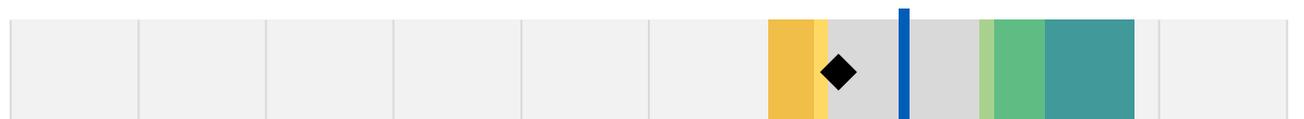
Q11. Were you offered food that met any dietary needs or requirements you had?



About the same

251	8.3	8.3	6.7	9.7
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Q12. How would you rate the hospital food?



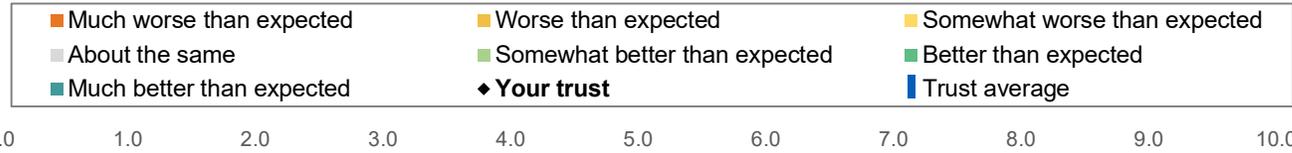
About the same

487	6.5	7.0	5.9	8.8
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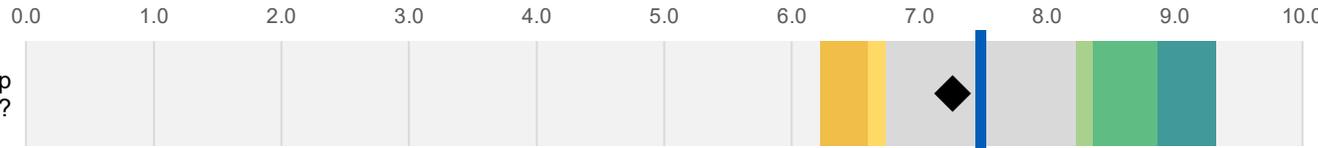
Section 2. The hospital and ward (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.



Q13. Did you get enough help from staff to eat your meals?



About the same

Number of respondents (your trust)	Your trust score	All trusts in England		
		Trust average score	Lowest score	Highest score
130	7.3	7.5	6.2	9.3

Q14. Were you able to get hospital food outside of set meal times?



About the same

210	5.1	5.9	4.3	8.6
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Q15. During your time in hospital, did you get enough to drink?



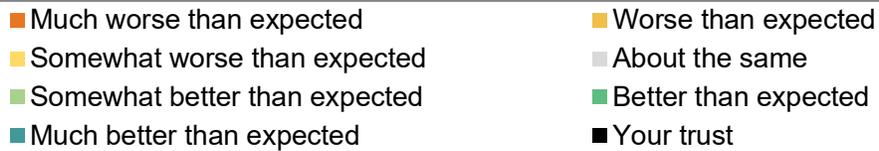
About the same

476	9.3	9.4	8.6	9.9
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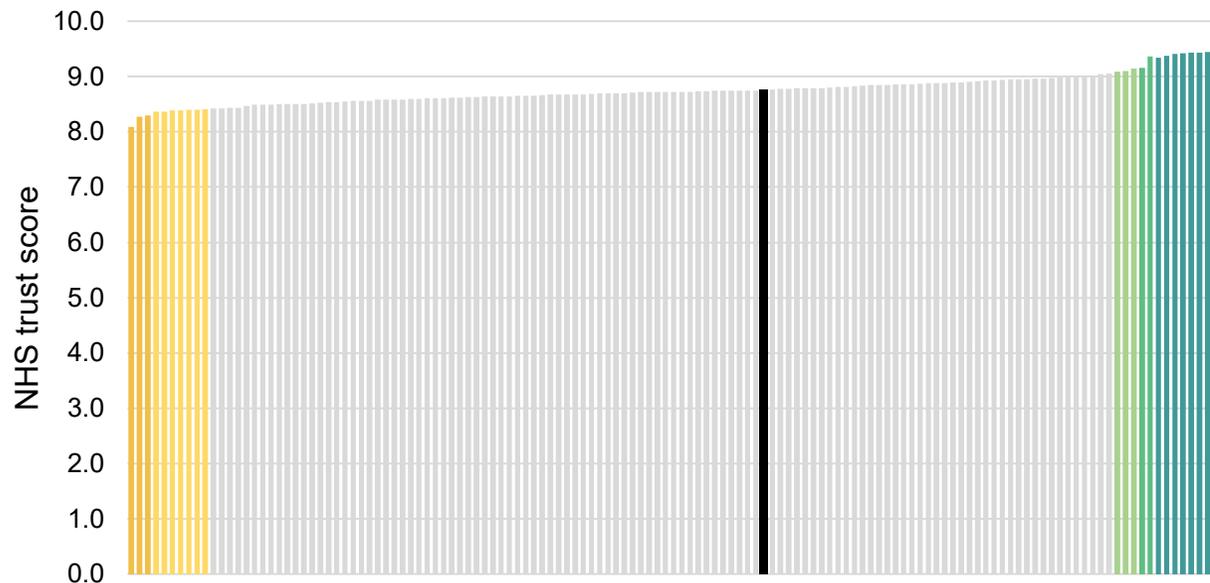
Section 3. Doctors

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



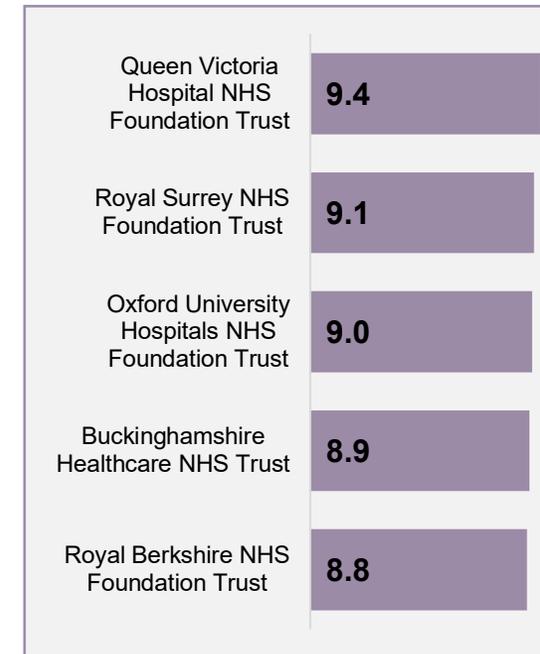
Your trust section score = 8.8 (About the same)



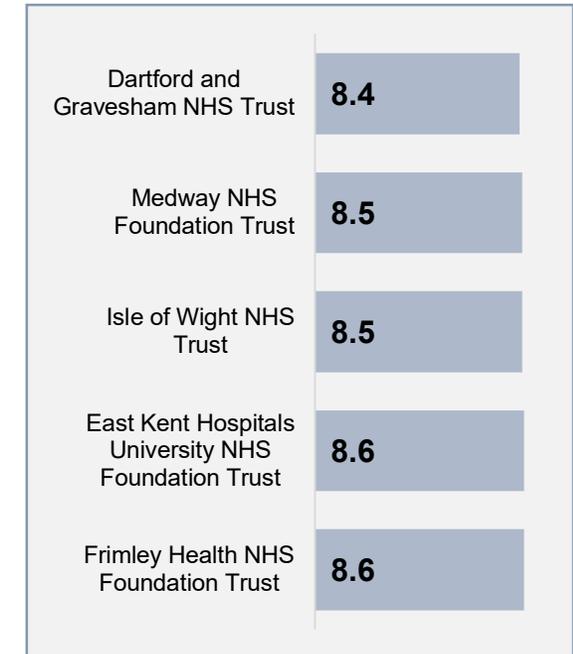
Each vertical line represents an individual NHS trust
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region

Trusts with the highest scores



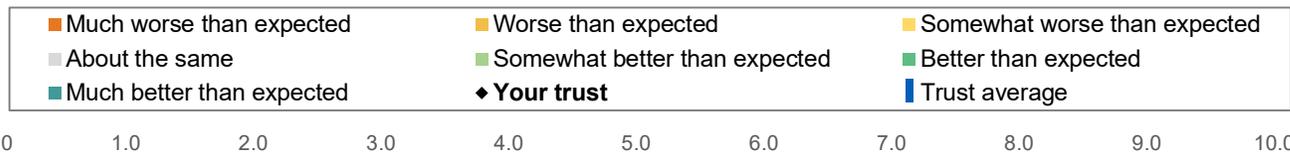
Trusts with the lowest scores



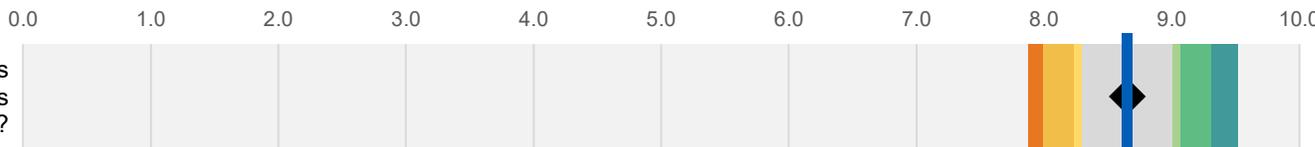
Section 3. Doctors (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.



Q16. When you asked doctors questions, did you get answers you could understand?



About the same

Number of respondents (your trust)	Your trust score	All trusts in England		
		Trust average score	Lowest score	Highest score
461	8.7	8.7	7.9	9.5

Q17. Did you have confidence and trust in the doctors treating you?



About the same

504	9.1	9.1	8.5	9.8
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Q18. When doctors spoke about your care in front of you, were you included in the conversation?



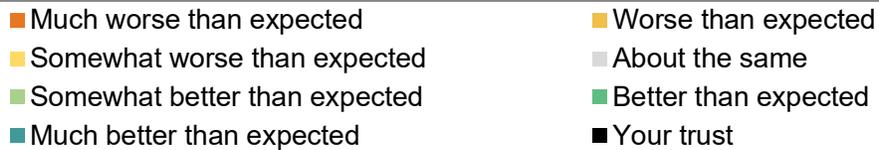
About the same

500	8.6	8.5	7.9	9.4
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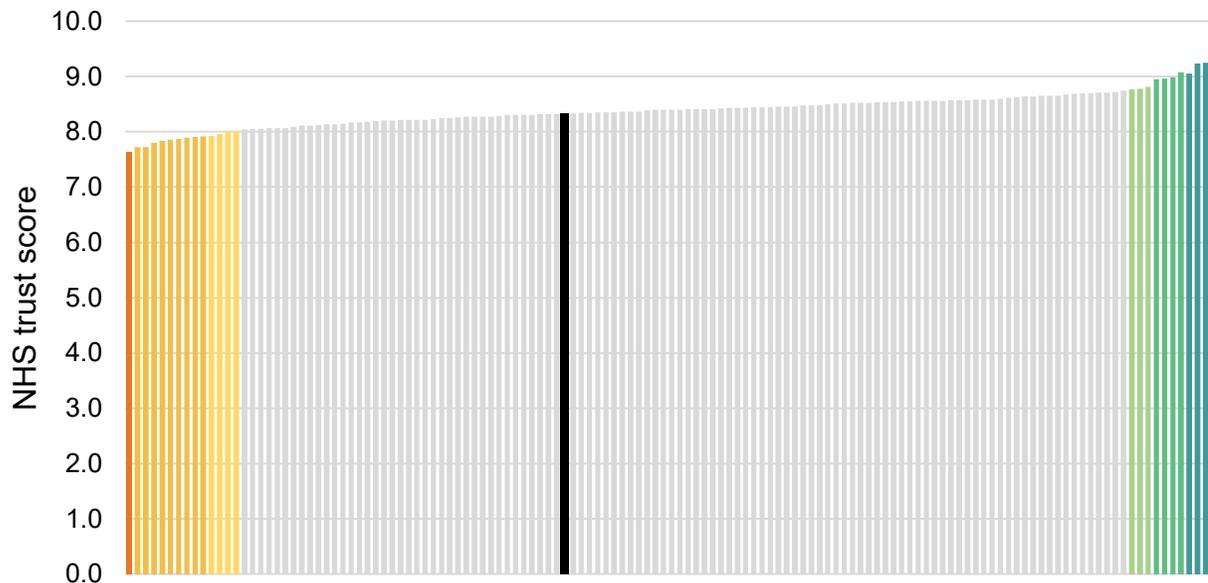
Section 4. Nurses

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



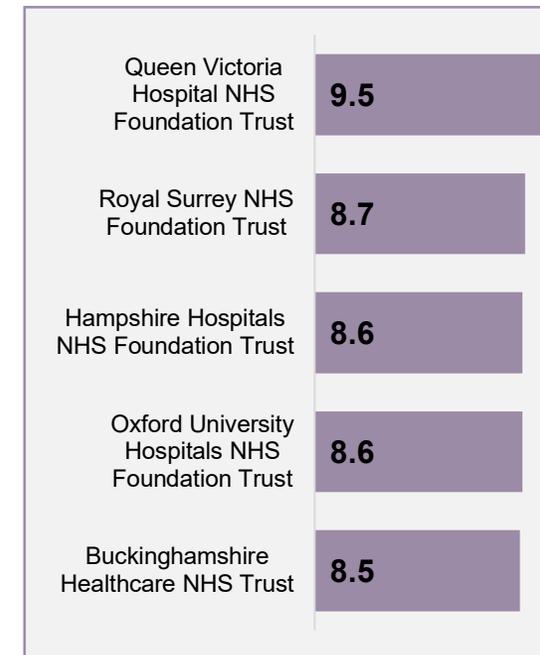
Your trust section score = 8.3 (About the same)



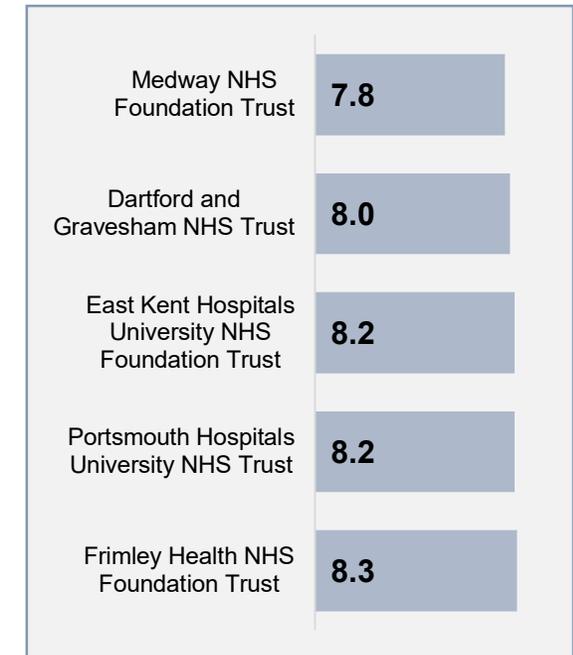
Each vertical line represents an individual NHS trust
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region

Trusts with the highest scores



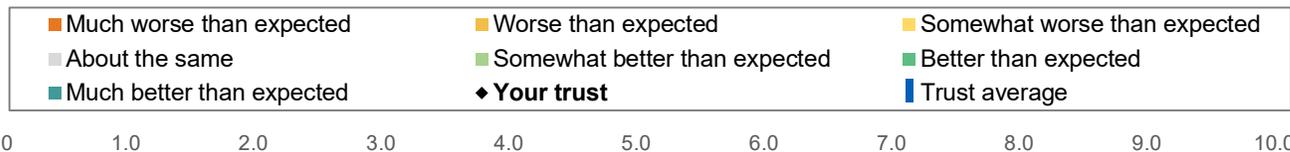
Trusts with the lowest scores



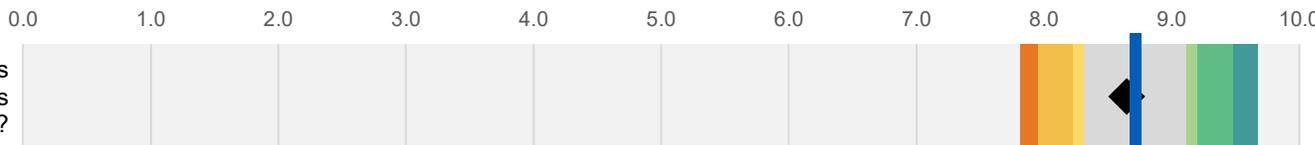
Section 4. Nurses (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.



Q19. When you asked nurses questions, did you get answers you could understand?



About the same

Number of respondents (your trust)	Your trust score	All trusts in England		
		Trust average score	Lowest score	Highest score
464	8.6	8.7	7.8	9.7

Q20. Did you have confidence and trust in the nurses treating you?



About the same

506	8.9	9.0	8.2	9.6
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Q21. When nurses spoke about your care in front of you, were you included in the conversation?



About the same

497	8.6	8.6	7.7	9.5
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Q22. In your opinion, were there enough nurses on duty to care for you in hospital?



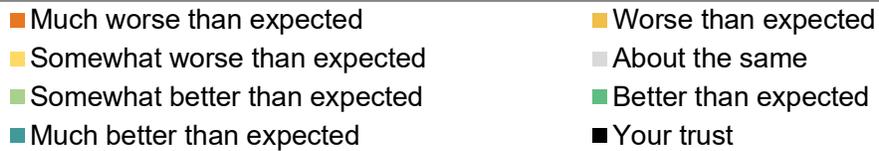
About the same

503	7.2	7.3	5.9	9.1
-----	-----	-----	-----	-----

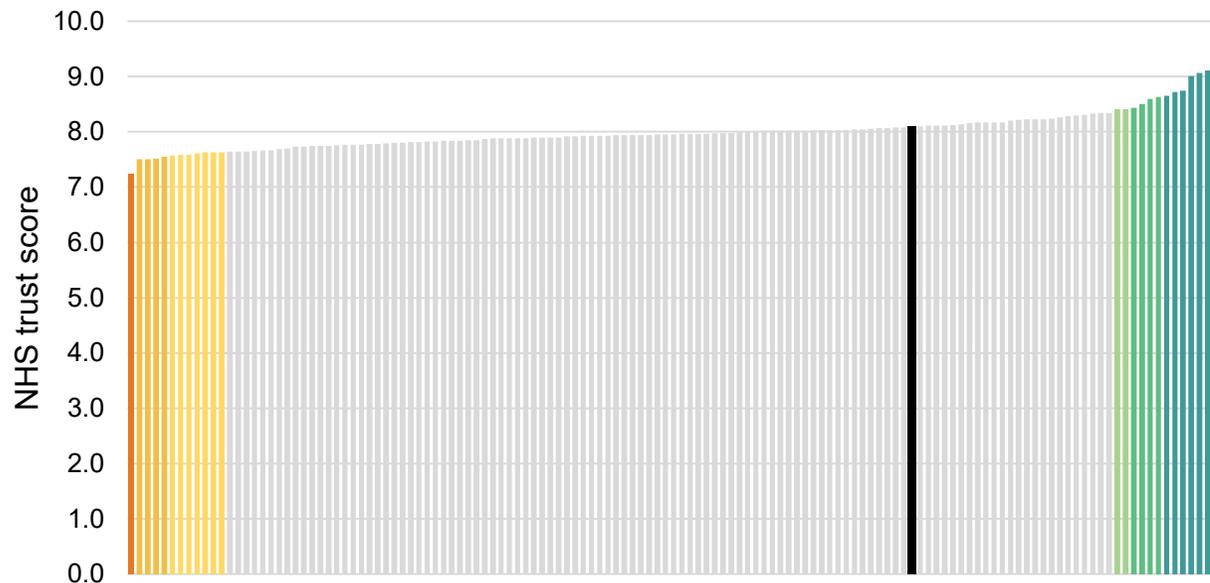
Section 5. Your care and treatment

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



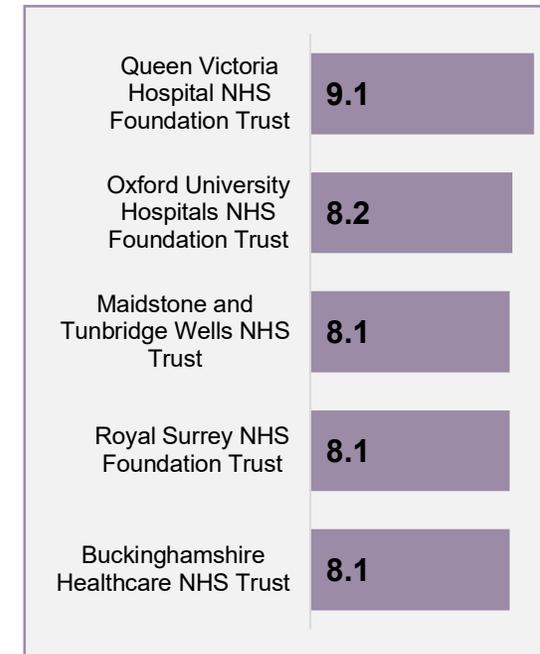
Your trust section score = 8.1 (About the same)



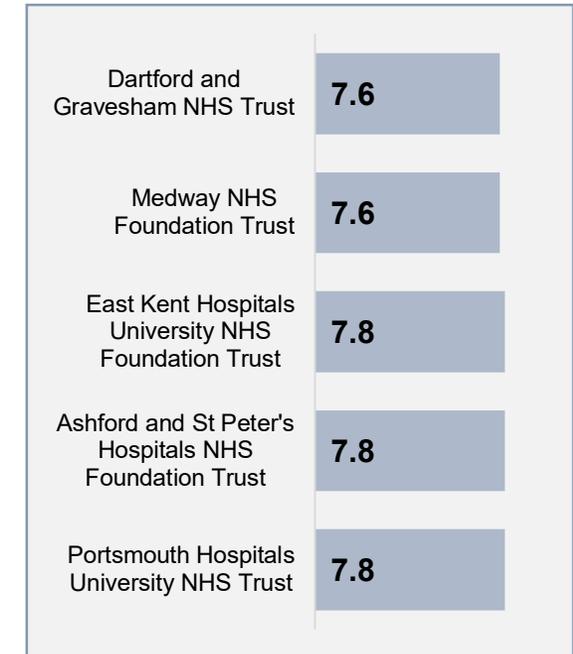
Each vertical line represents an individual NHS trust
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region

Trusts with the highest scores



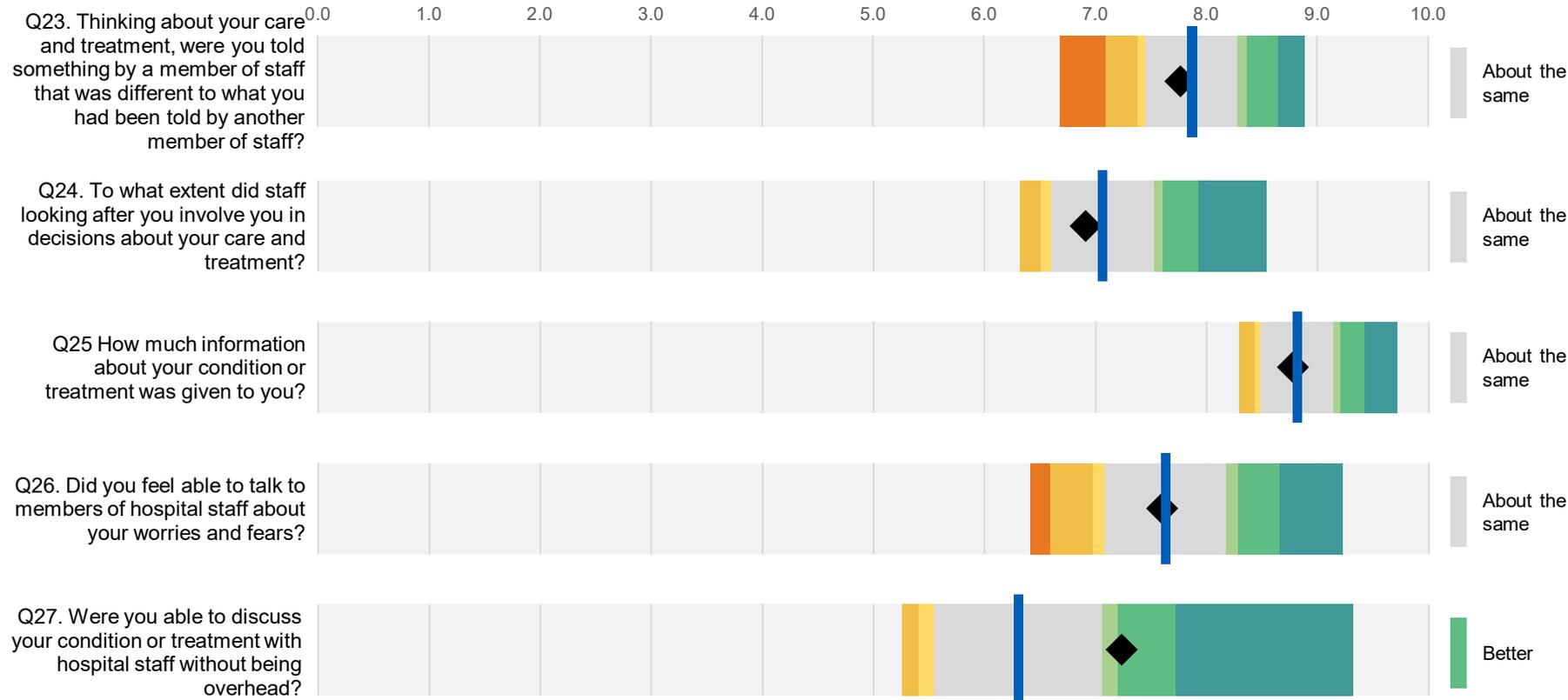
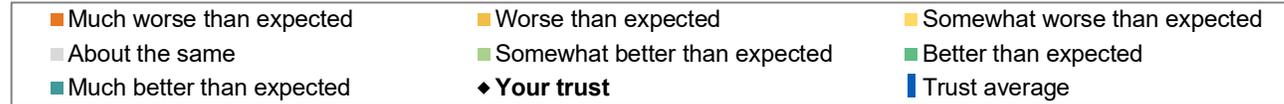
Trusts with the lowest scores



Section 5. Your care and treatment (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.



Number of respondents (your trust)	Your trust score	All trusts in England		
		Trust average score	Lowest score	Highest score
455	7.8	7.9	6.7	8.9

474	6.9	7.1	6.3	8.5
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498	8.8	8.8	8.3	9.7
-----	-----	-----	-----	-----

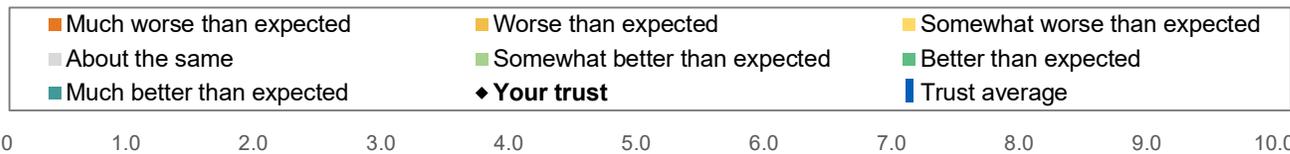
421	7.6	7.6	6.4	9.2
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455	7.2	6.3	5.3	9.3
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Section 5. Your care and treatment (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.



Q28. Were you given enough privacy when being examined or treated?



About the same

Number of respondents (your trust)	Your trust score	All trusts in England		
		Trust average score	Lowest score	Highest score
502	9.5	9.4	9.0	9.9

Q29. Do you think the hospital staff did everything they could to help control your pain?



About the same

411	8.9	8.8	8.1	9.6
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Q30. Were you able to get a member of staff to help you when you needed attention?



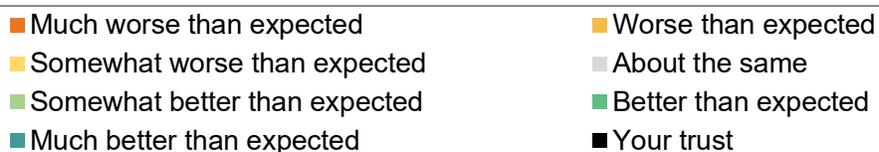
About the same

469	8.1	8.1	7.3	9.4
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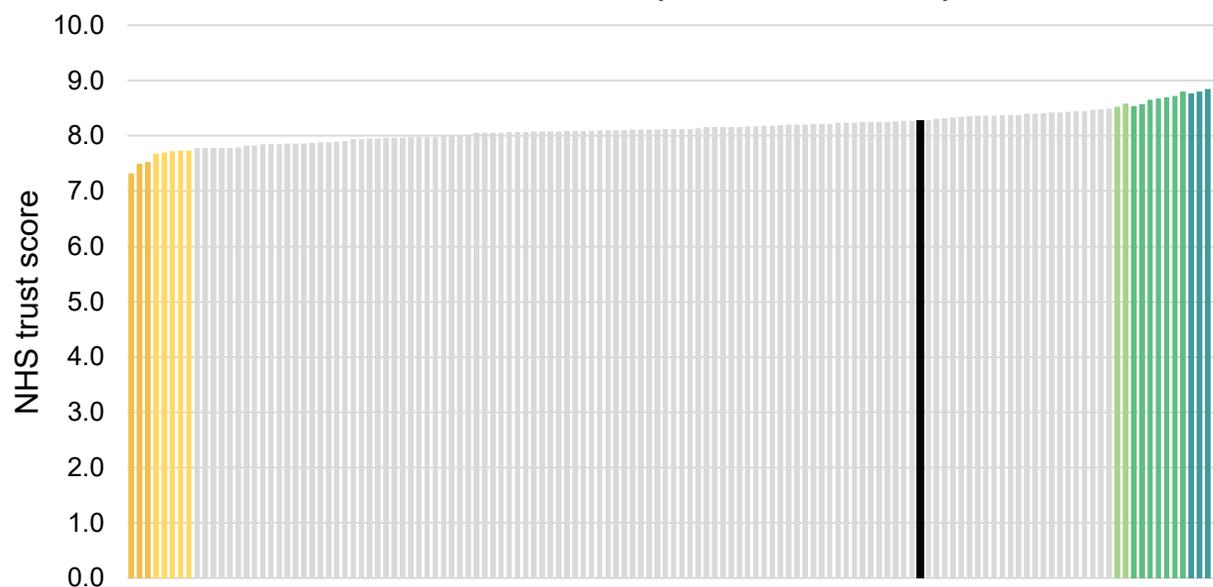
Section 6. Operations and procedures

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



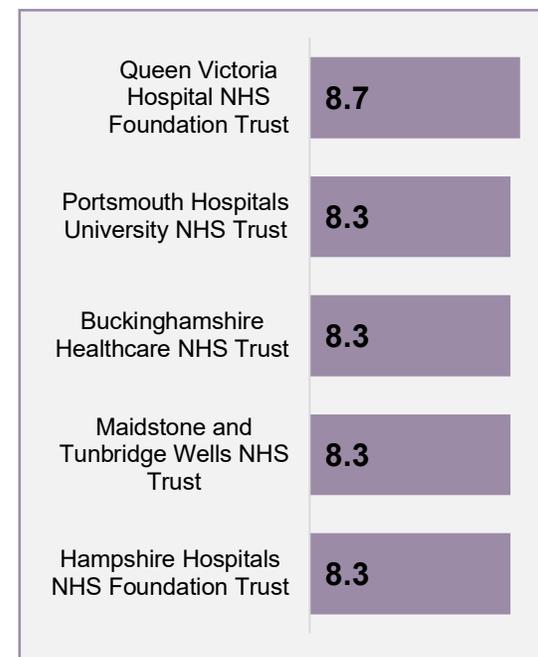
Your trust section score = 8.3 (About the same)



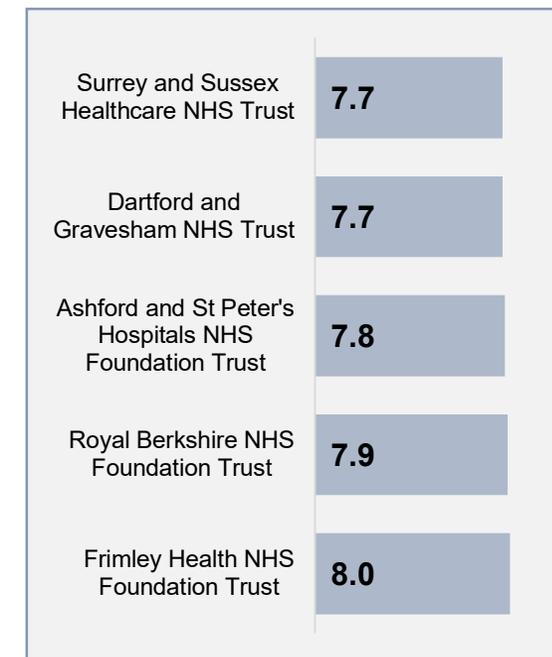
Each vertical line represents an individual NHS trust
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region

Trusts with the highest scores



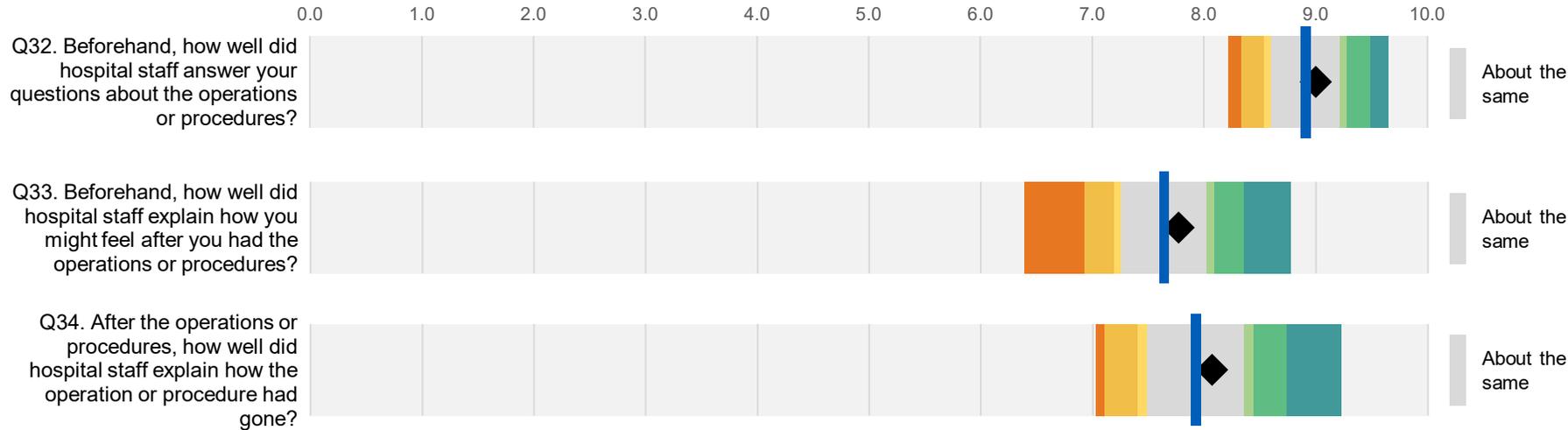
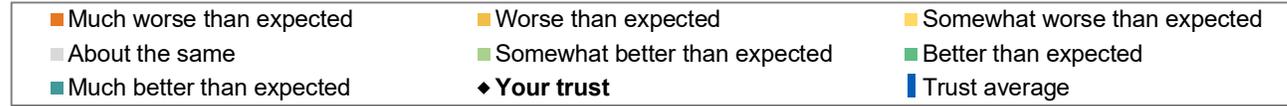
Trusts with the lowest scores



Section 6. Operations and procedures (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.



Number of respondents (your trust)	Your trust score	All trusts in England		
		Trust average score	Lowest score	Highest score
257	9.0	8.9	8.2	9.7

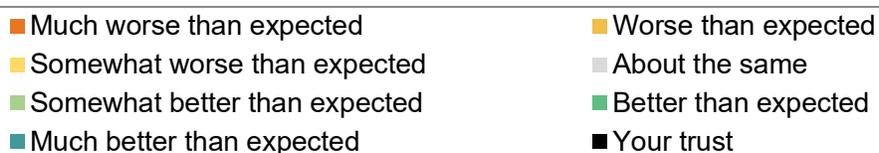
264	7.8	7.6	6.4	8.8
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268	8.1	7.9	7.0	9.2
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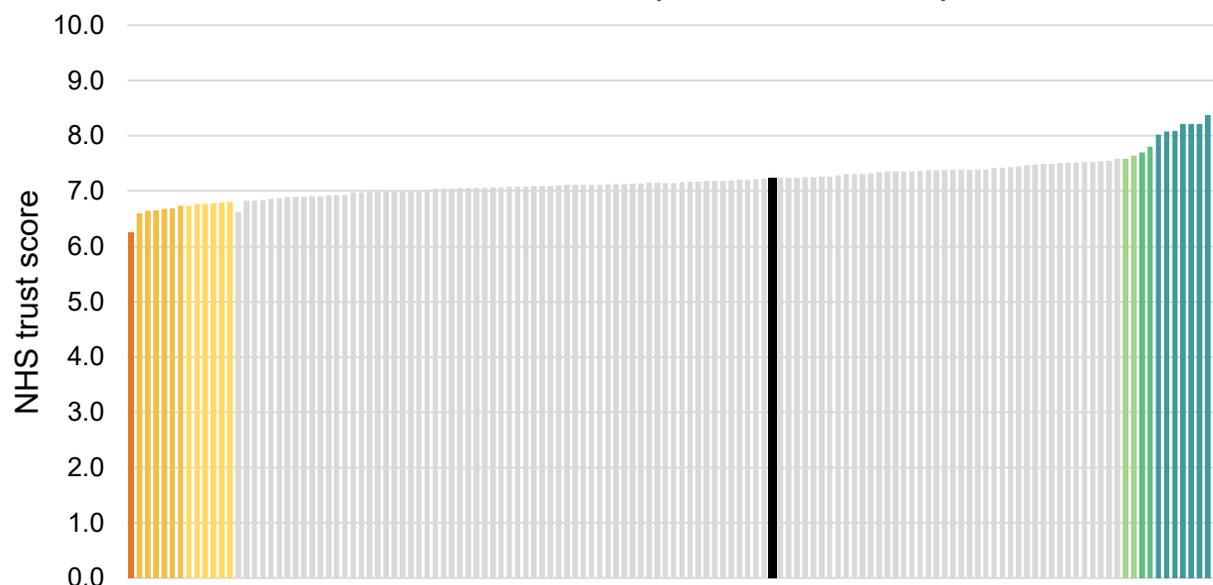
Section 7. Leaving hospital

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



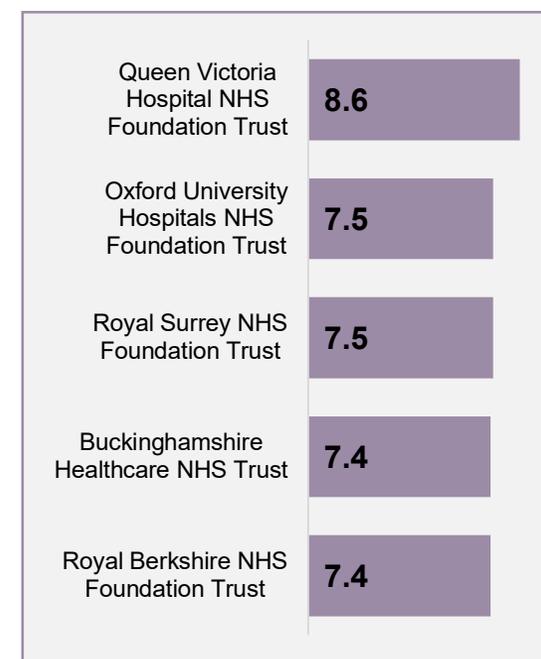
Your trust section score = 7.2 (About the same)



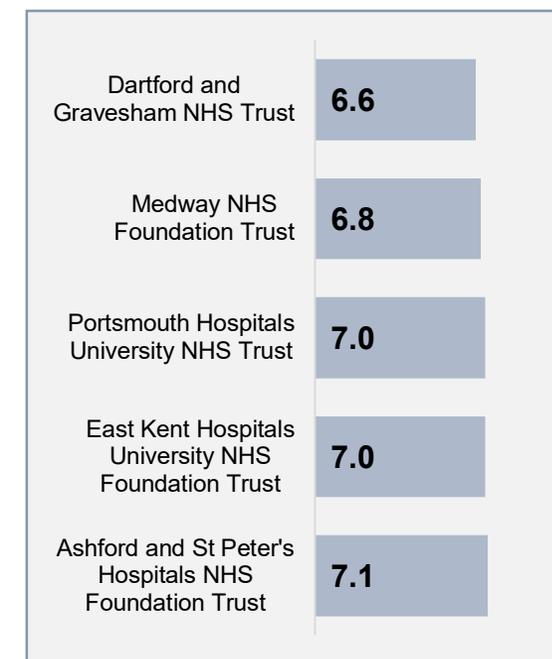
Each vertical line represents an individual NHS trust
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region

Trusts with the highest scores



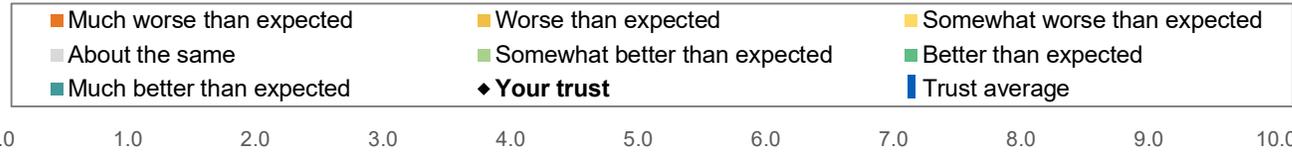
Trusts with the lowest scores



Section 7. Leaving hospital (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.



Q35. To what extent did staff involve you in decisions about you leaving hospital?



About the same

Number of respondents (your trust)	Your trust score	All trusts in England		
		Trust average score	Lowest score	Highest score
501	6.8	6.9	6.2	8.5

Q36. To what extent did hospital staff take your family or home situation into account when planning for you to leave hospital?



About the same

388	7.2	7.2	6.5	9.0
-----	-----	-----	-----	-----

Q37. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?



About the same

203	8.8	8.3	5.6	9.6
-----	-----	-----	-----	-----

Q38. Were you given enough notice about when you were going to leave hospital?



About the same

507	6.8	7.0	6.0	8.5
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Q39. Before you left hospital, were you given any information about what you should or should not do after leaving hospital?



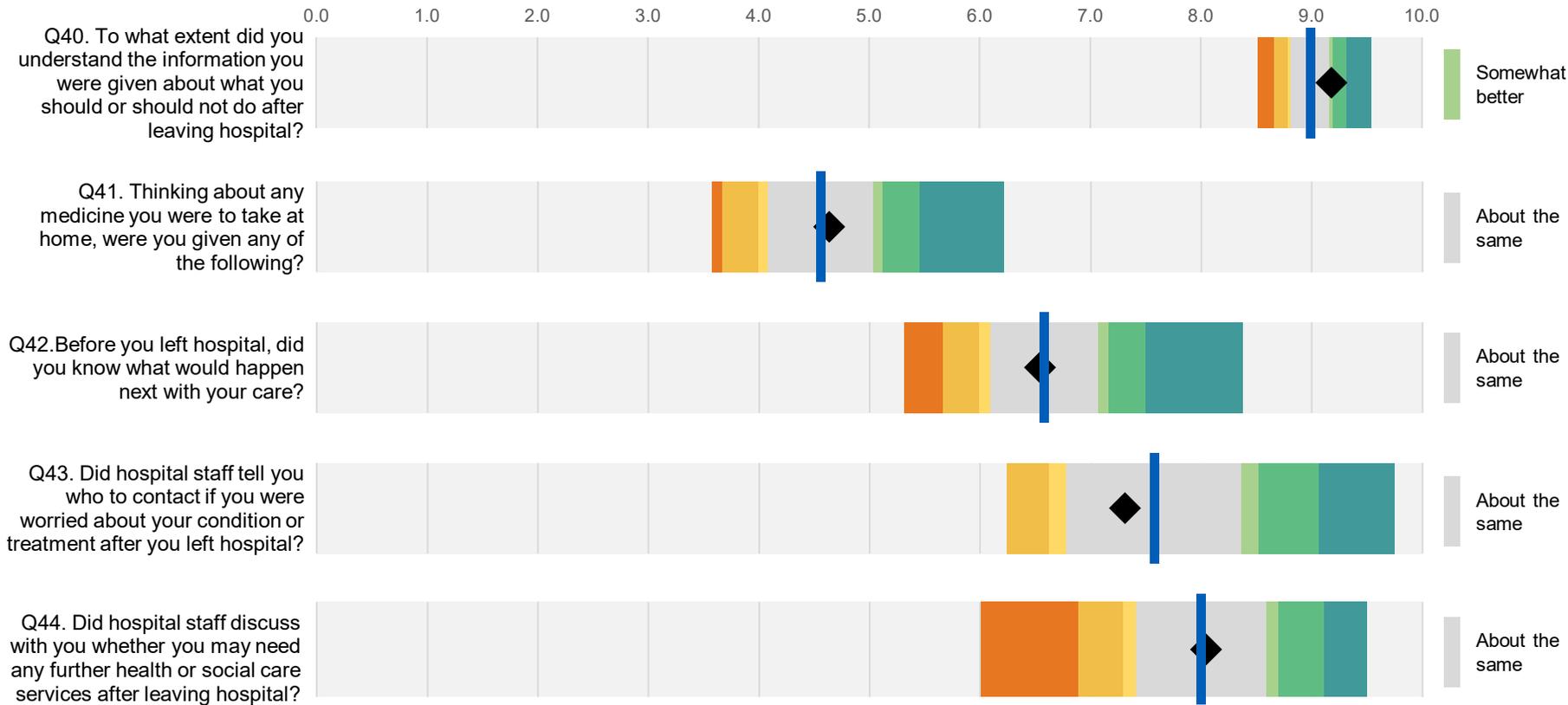
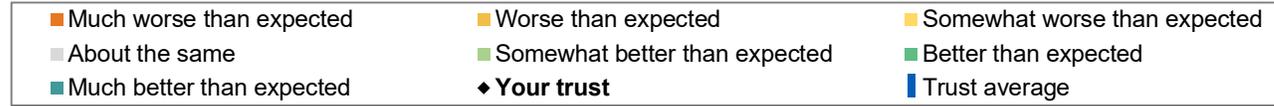
About the same

482	8.0	8.0	7.0	9.7
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Section 7. Leaving hospital (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.



Number of respondents (your trust)	Your trust score	All trusts in England		
		Trust average score	Lowest score	Highest score
370	9.2	9.0	8.5	9.5

380	4.6	4.6	3.6	6.2
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457	6.5	6.6	5.3	8.4
-----	-----	-----	-----	-----

463	7.3	7.6	6.2	9.7
-----	-----	-----	-----	-----

270	8.0	8.0	6.0	9.5
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Section 7. Leaving hospital (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.



Number of respondents (your trust)	Your trust score	All trusts in England		
		Trust average score	Lowest score	Highest score
261	6.2	6.2	3.9	8.2

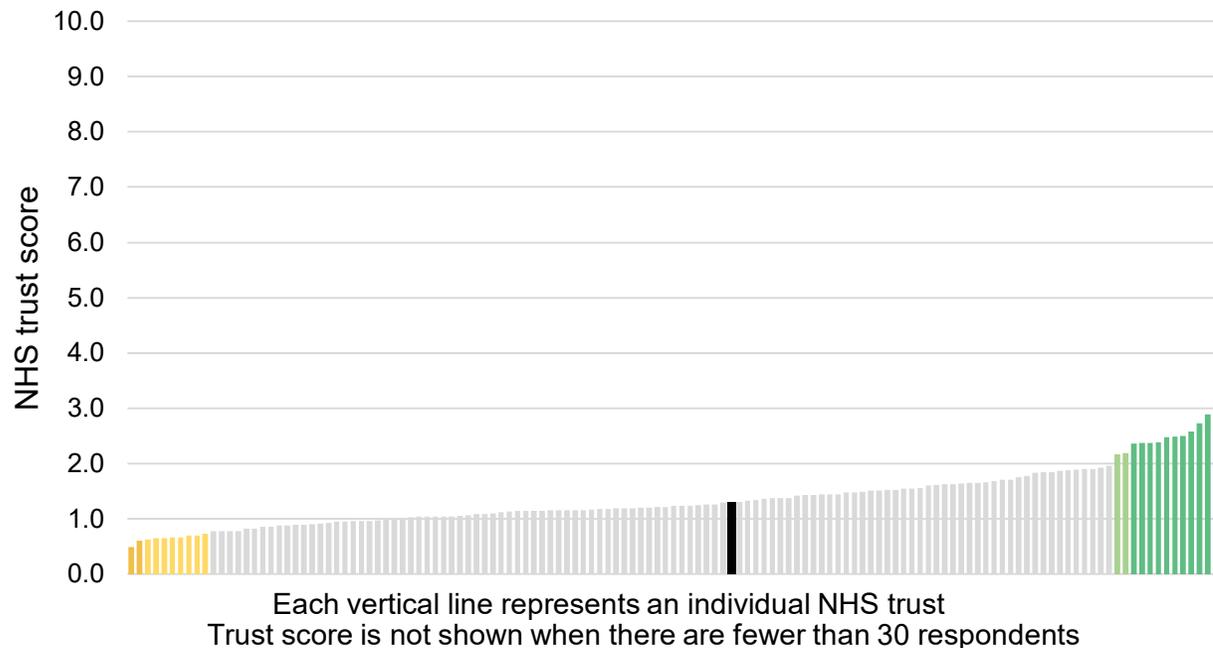
Section 8. Feedback on the quality of your care

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

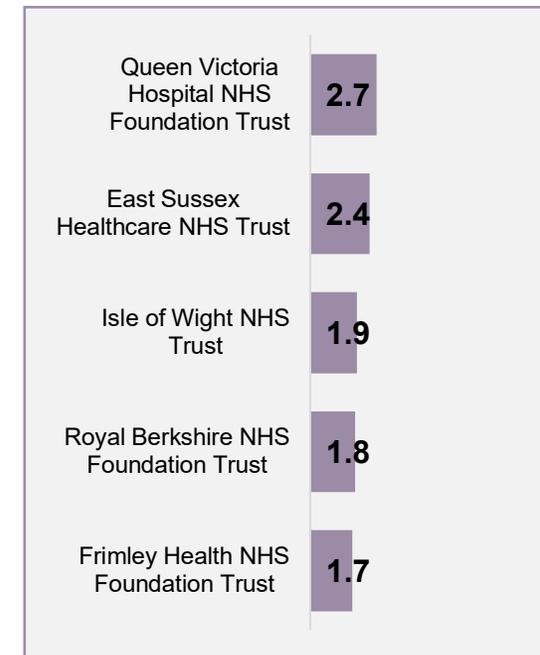


Your trust section score = 1.3 (About the same)

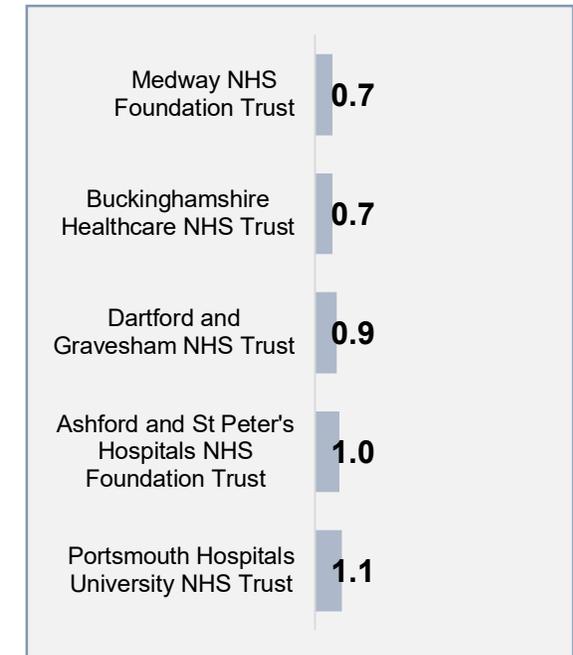


Comparison with other trusts within your region

Trusts with the highest scores



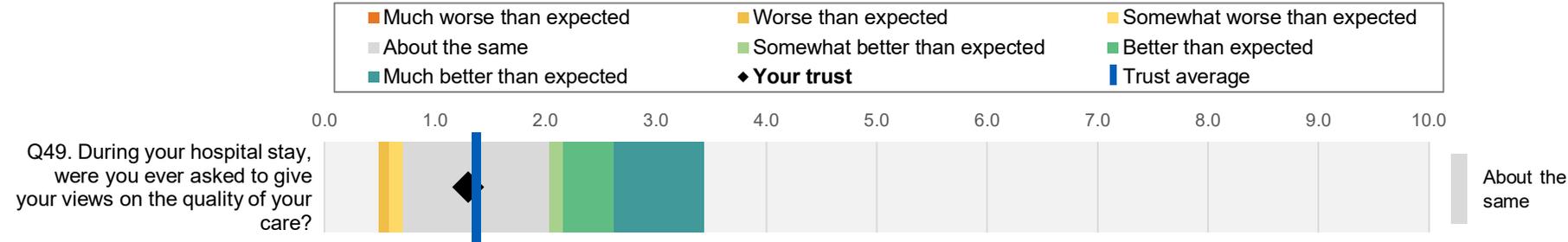
Trusts with the lowest scores



Section 8. Feedback on the quality of your care (continued)

Question score

Trust score is not shown when there are fewer than 30 respondents.

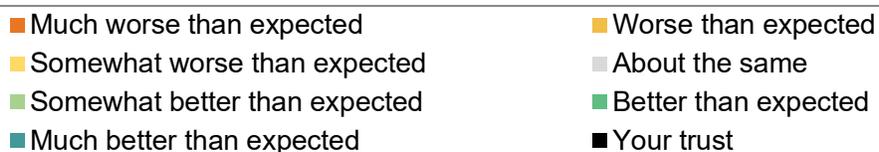


Number of respondents (your trust)	Your trust score	All trusts in England		
		Trust average score	Lowest score	Highest score
437	1.3	1.4	0.5	3.4

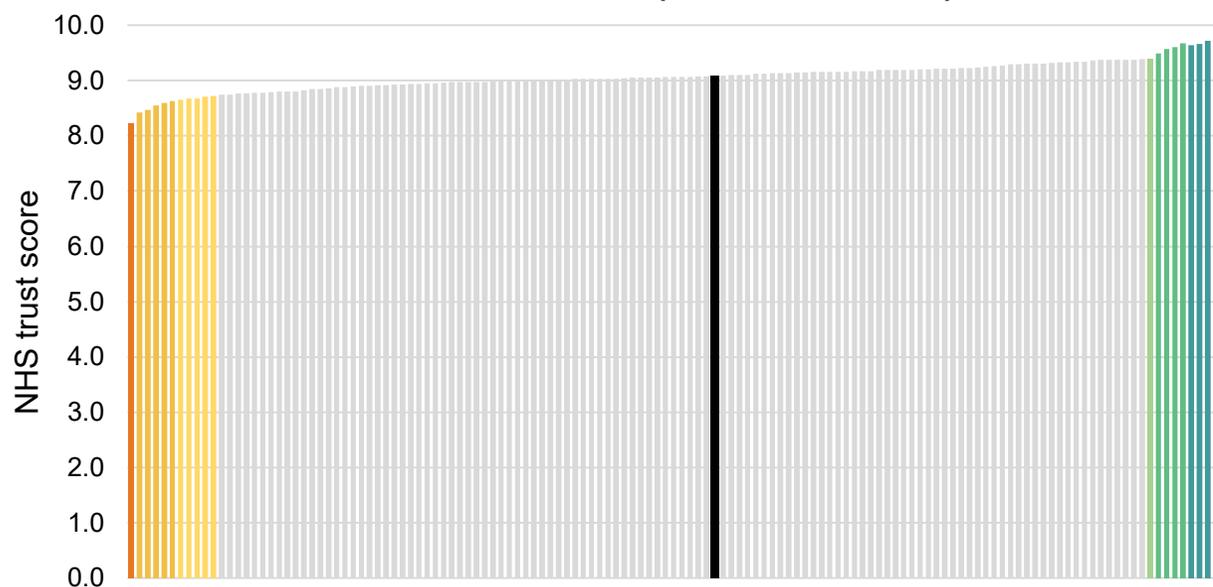
Section 9. Respect and dignity

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



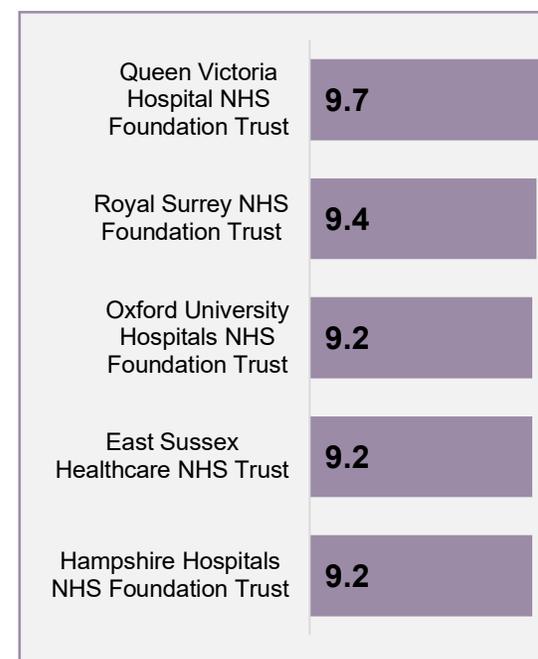
Your trust section score = 9.1 (About the same)



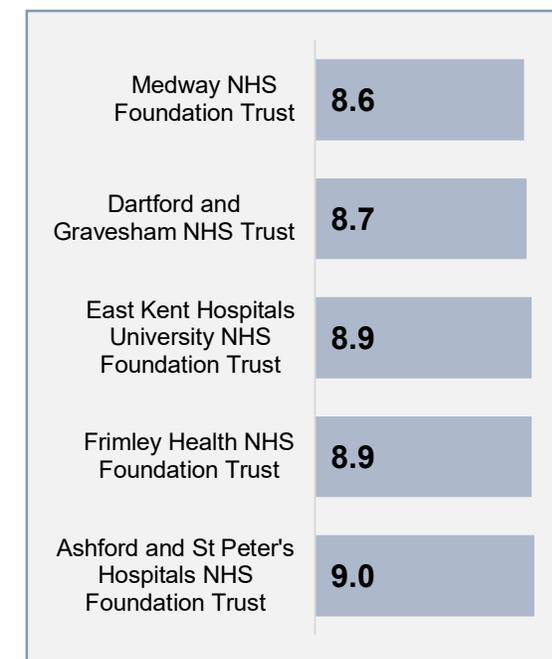
Each vertical line represents an individual NHS trust
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region

Trusts with the highest scores



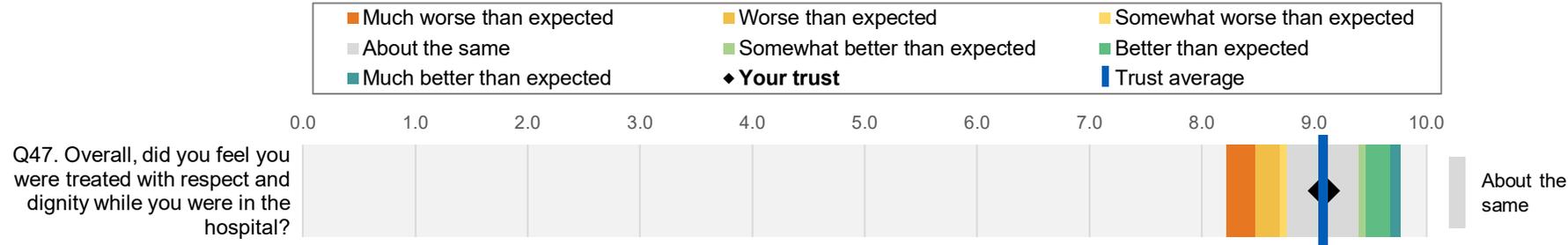
Trusts with the lowest scores



Section 9. Respect and dignity (continued)

Question score

Trust score is not shown when there are fewer than 30 respondents.

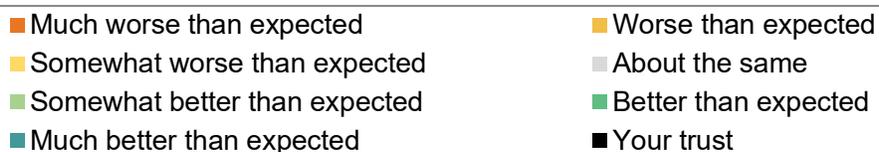


Number of respondents (your trust)	Your trust score	All trusts in England		
		Trust average score	Lowest score	Highest score
505	9.1	9.1	8.2	9.8

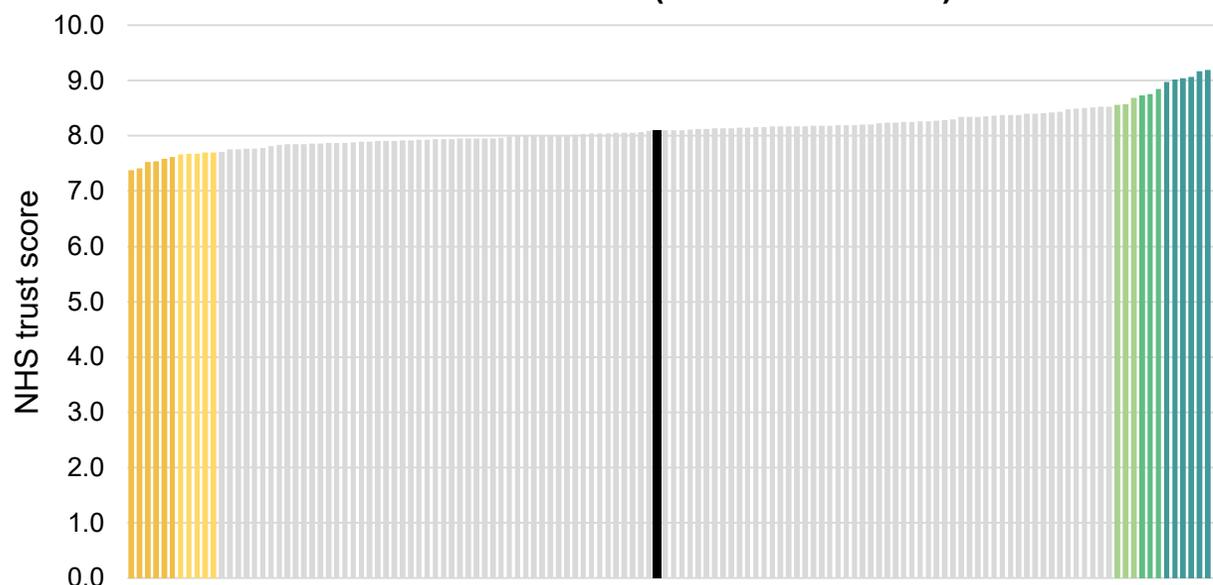
Section 10. Overall experience

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



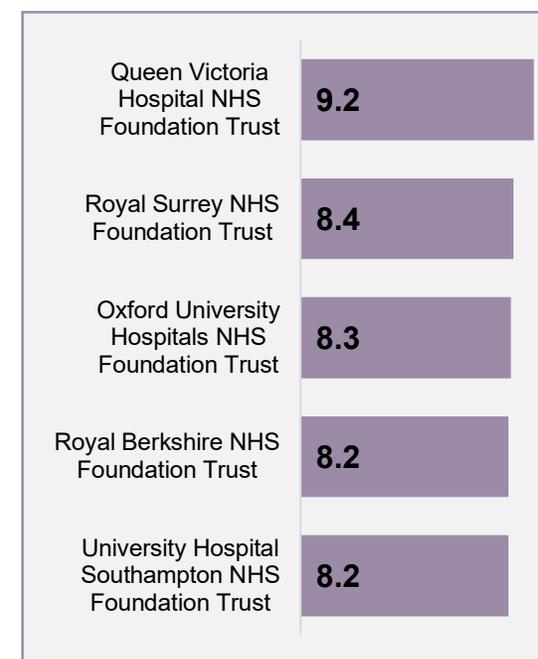
Your trust section score = 8.1 (About the same)



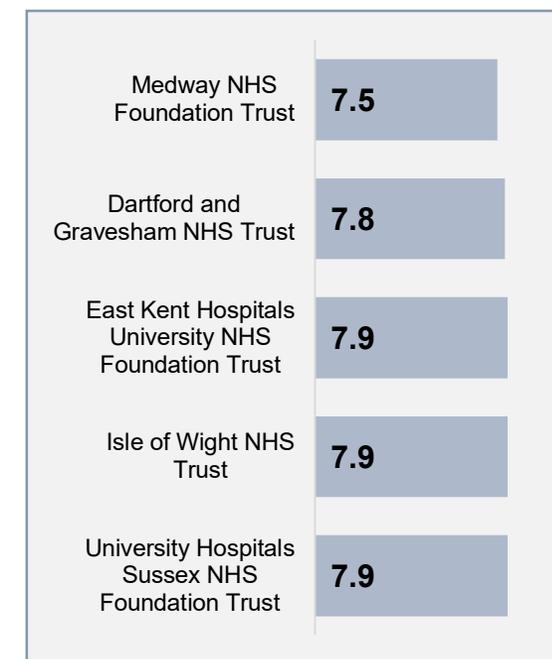
Each vertical line represents an individual NHS trust
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region

Trusts with the highest scores



Trusts with the lowest scores



Section 10. Overall experience (continued)

Question score

Trust score is not shown when there are fewer than 30 respondents.



Number of respondents (your trust)	Your trust score	All trusts in England		
		Trust average score	Lowest score	Highest score
503	8.1	8.1	7.4	9.4

Trust results

This section includes:

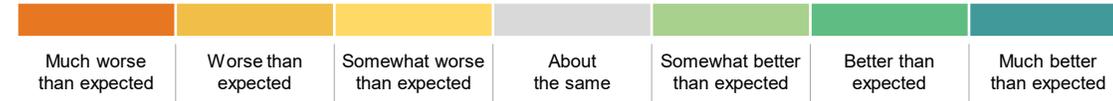
- an overview of results for your trust for each question, including:
 - the score for your trust
 - a breakdown of scores across sites within your trust
- if fewer than 30 responses were received from patients discharged from a site, no scores will be displayed for that site



Admission to hospital

Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital?

Results for your trust



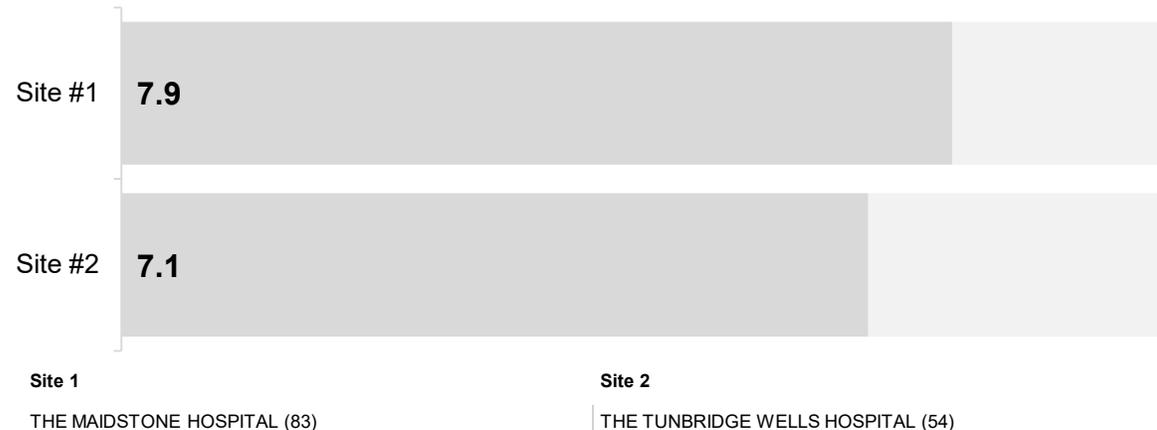
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

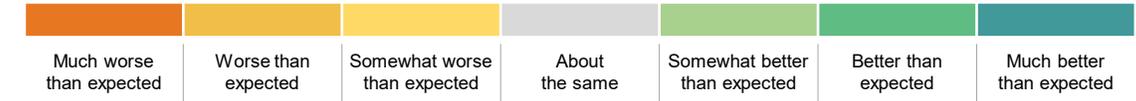


Admission to hospital

Appendix 1

Q3. How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?

Results for your trust



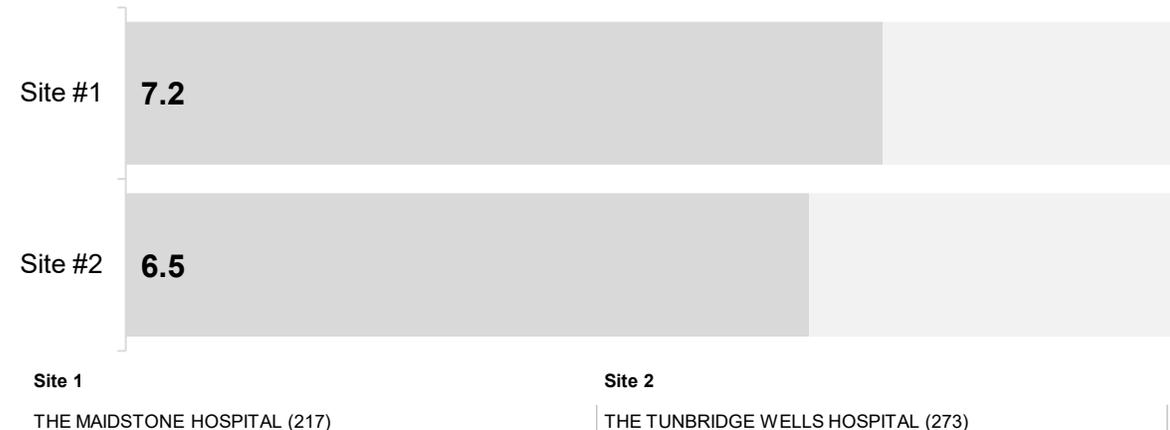
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

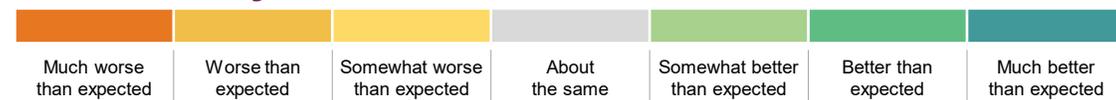
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



The hospital and ward

Q4. Did you get help from staff to keep in touch with your family and friends?

Results for your trust



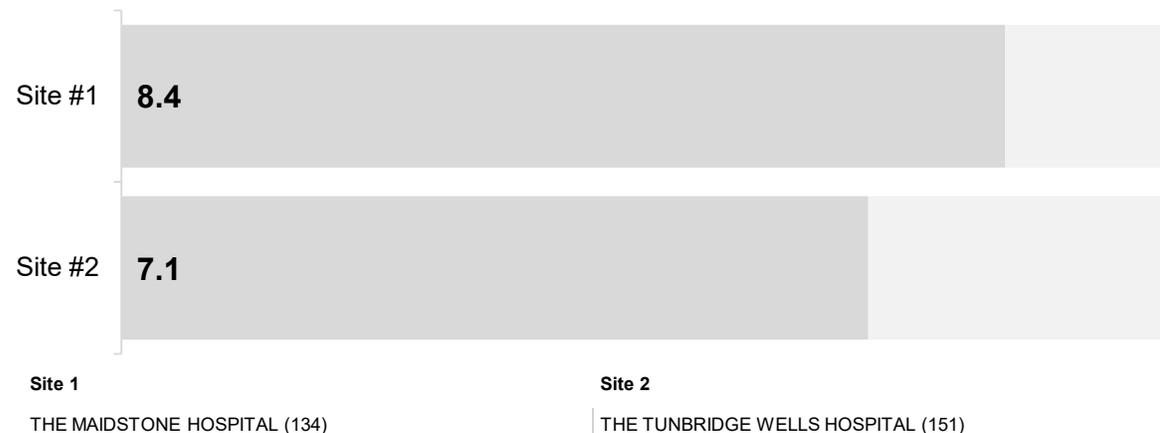
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Site 1
THE MAIDSTONE HOSPITAL (134)

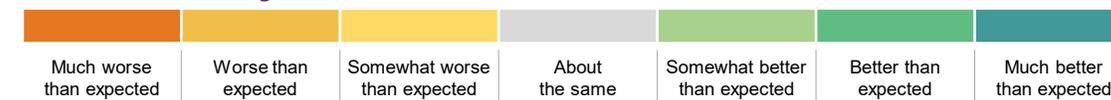
Site 2
THE TUNBRIDGE WELLS HOSPITAL (151)

The hospital and ward

Appendix 1

Q5. Were you ever prevented from sleeping at night by noise from other patients?

Results for your trust



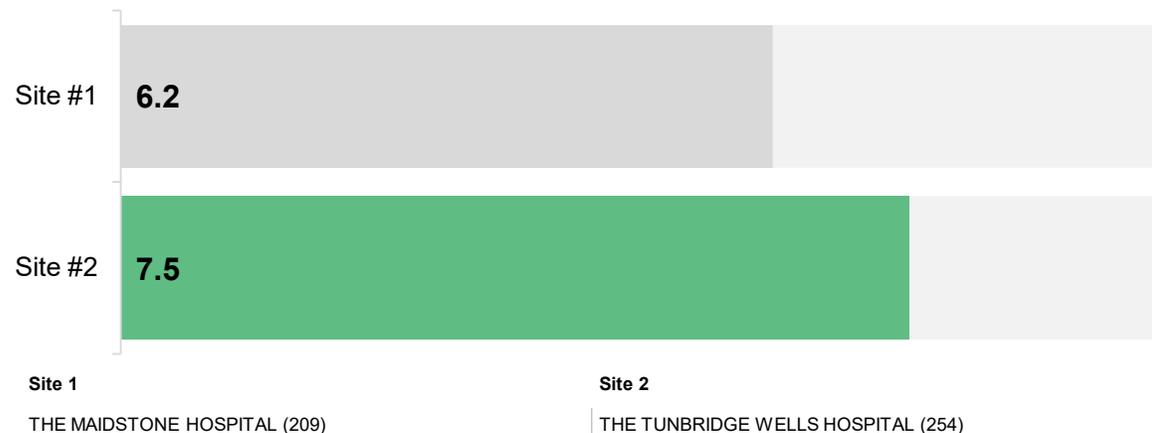
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



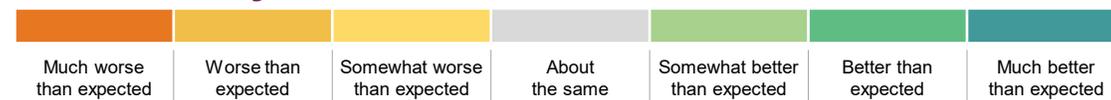
Site 1
THE MAIDSTONE HOSPITAL (209)

Site 2
THE TUNBRIDGE WELLS HOSPITAL (254)

The hospital and ward

Q5. Were you ever prevented from sleeping at night by noise from staff?

Results for your trust



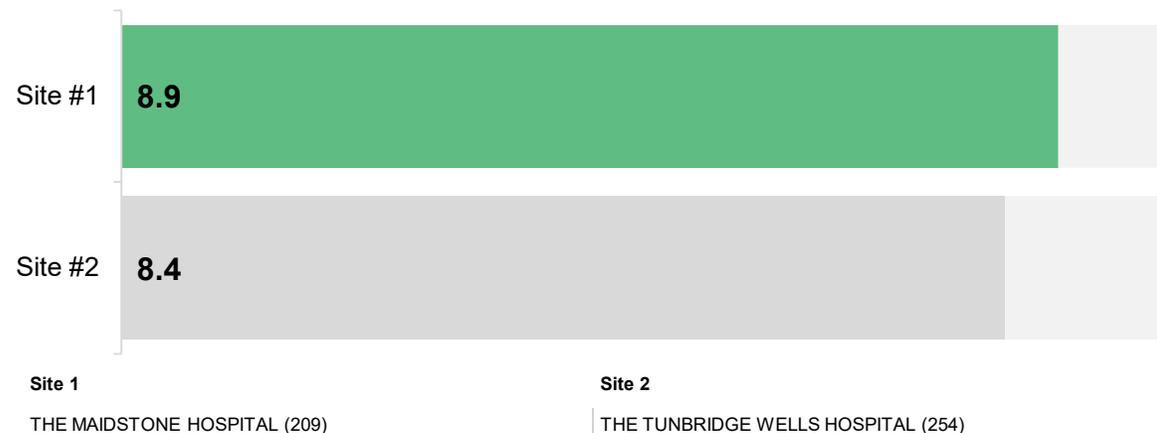
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

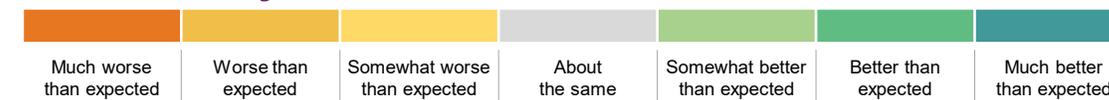
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



The hospital and ward

Q5. Were you ever prevented from sleeping at night by hospital lighting?

Results for your trust



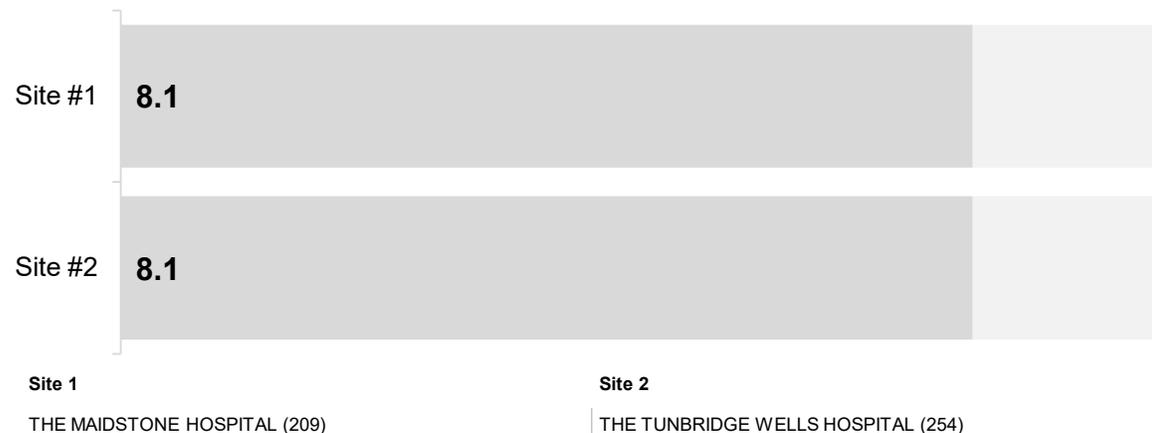
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

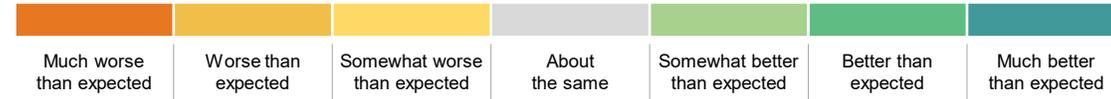
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



The hospital and ward

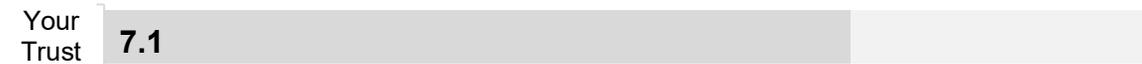
Q7. Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?

Results for your trust



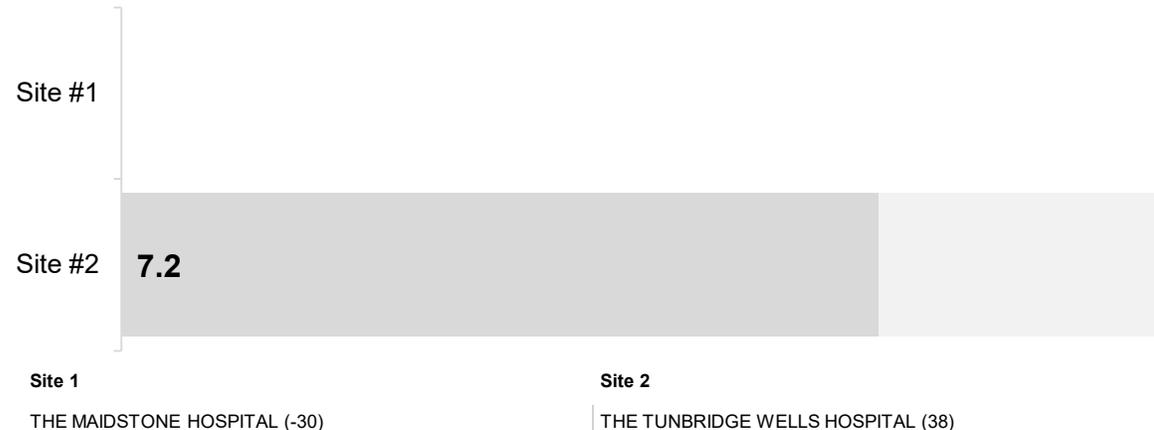
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

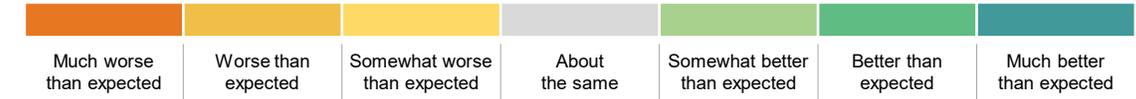


The hospital and ward

Appendix 1

Q8. How clean was the hospital room or ward that you were in?

Results for your trust



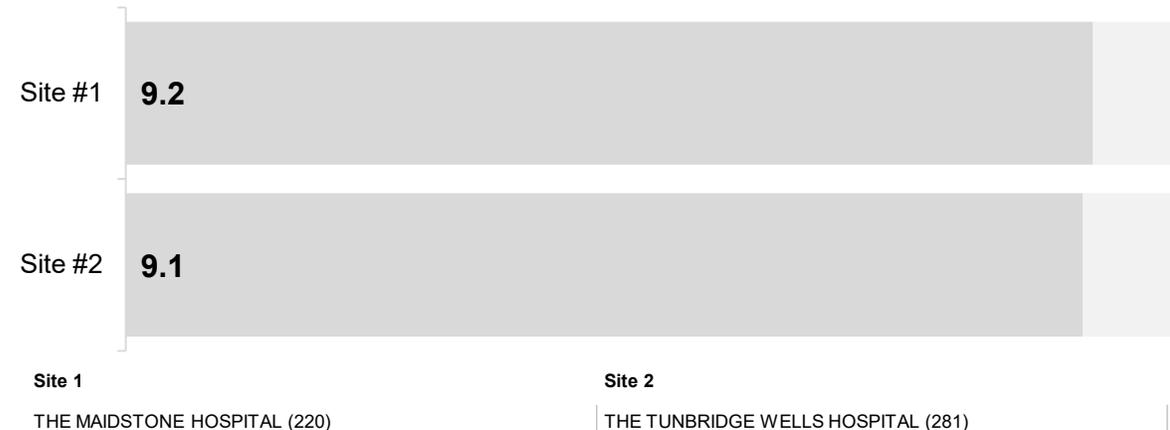
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

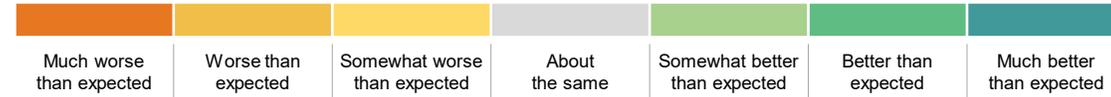
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



The hospital and ward

Q9. Did you get enough help from staff to wash or keep yourself clean?

Results for your trust



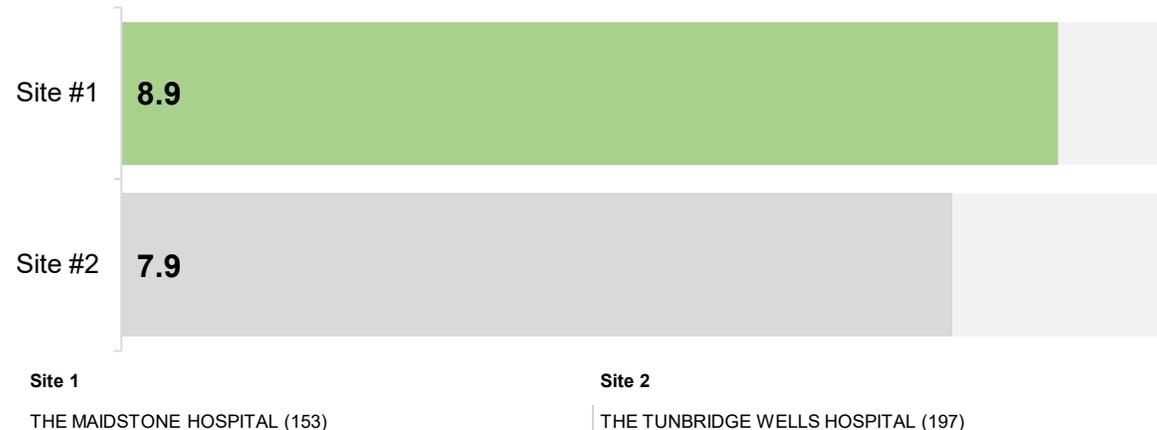
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

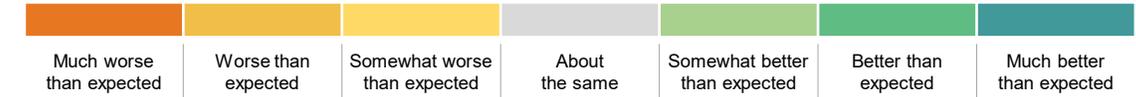


The hospital and ward

Appendix 1

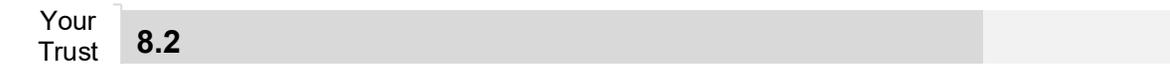
Q10. If you brought medication with you to hospital, were you able to take it when you needed to?

Results for your trust



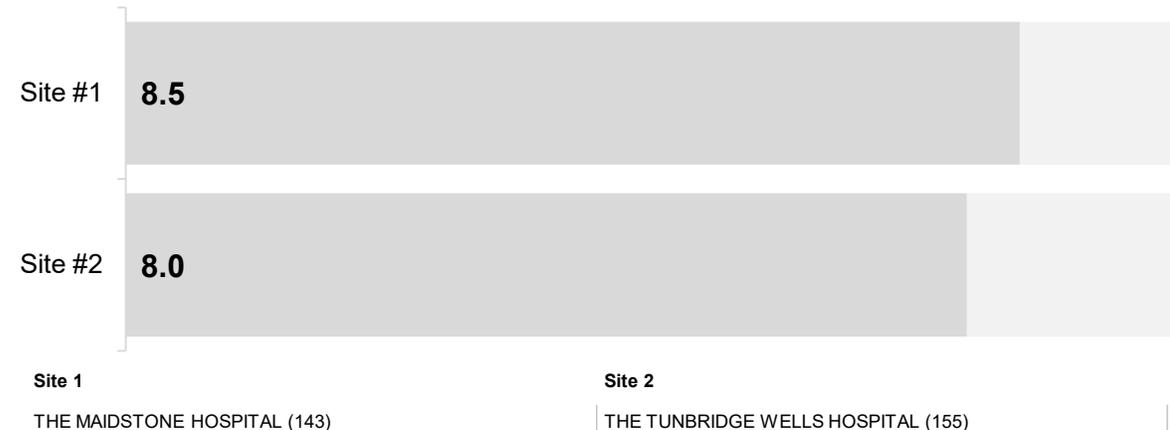
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

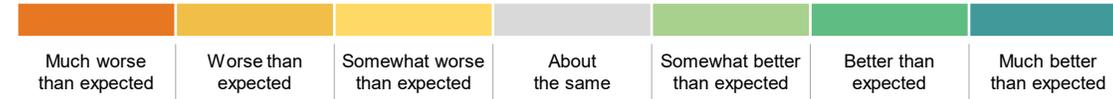
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



The hospital and ward

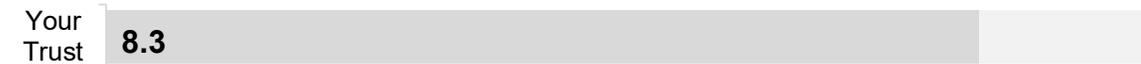
Q11. Were you offered food that met any dietary needs or requirements you had?

Results for your trust



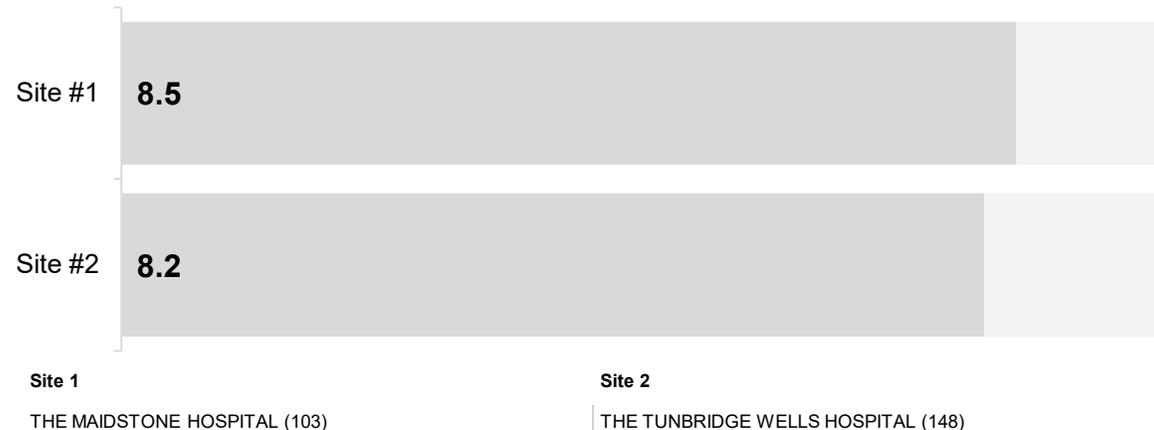
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

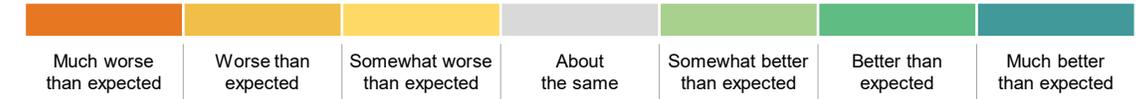


The hospital and ward

Appendix 1

Q12. How would you rate the hospital food?

Results for your trust



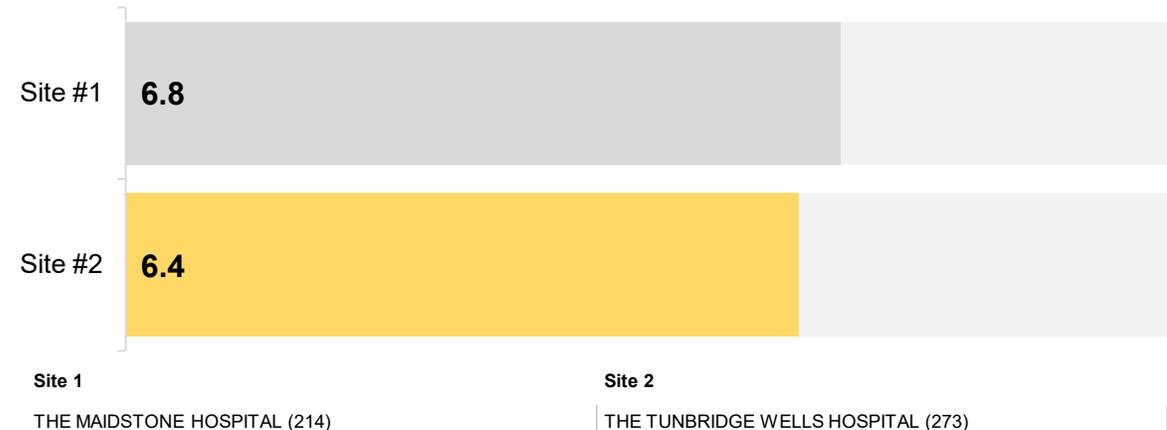
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

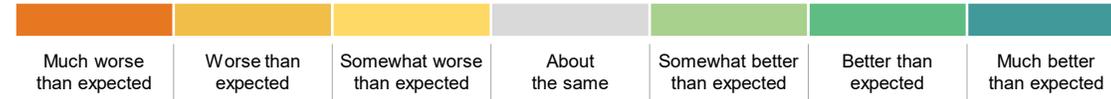
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



The hospital and ward

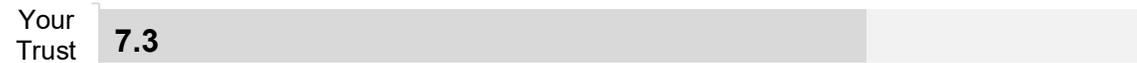
Q13. Did you get enough help from staff to eat your meals?

Results for your trust



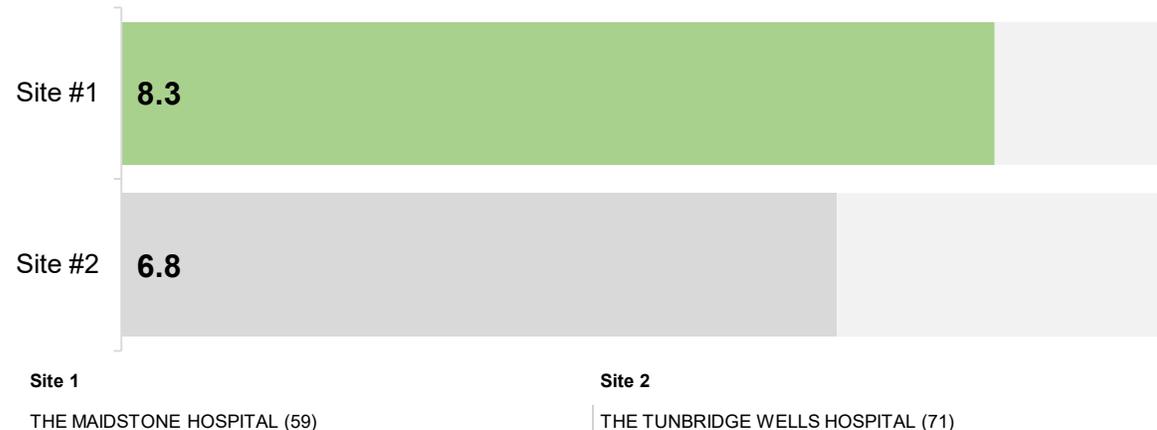
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

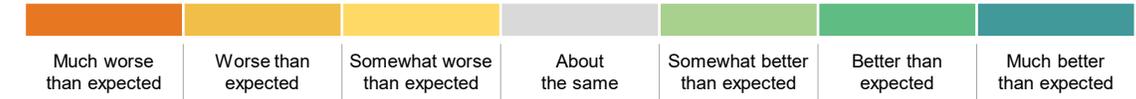


The hospital and ward

Appendix 1

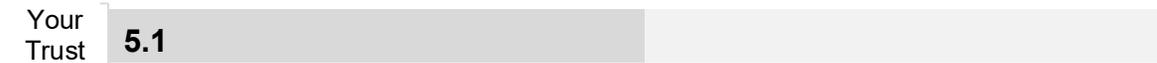
Q14. Were you able to get hospital food outside of set meal times?

Results for your trust



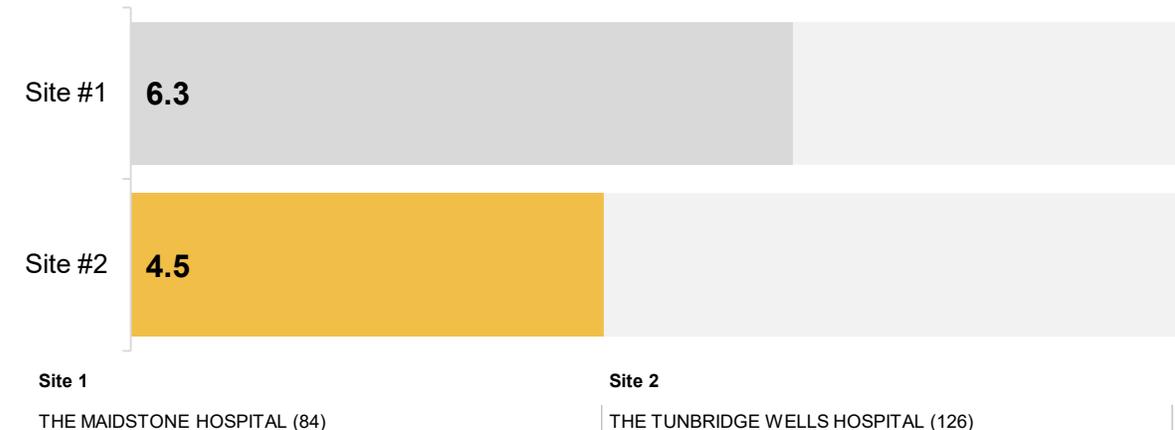
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

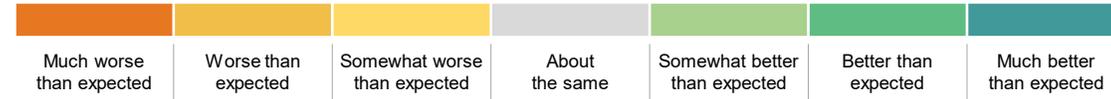
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



The hospital and ward

Q15. During your time in hospital, did you get enough to drink?

Results for your trust



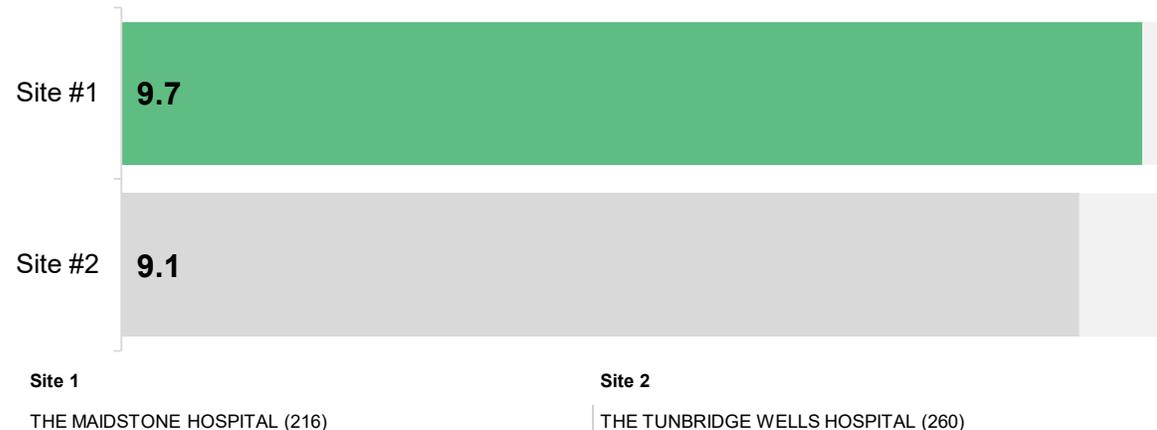
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

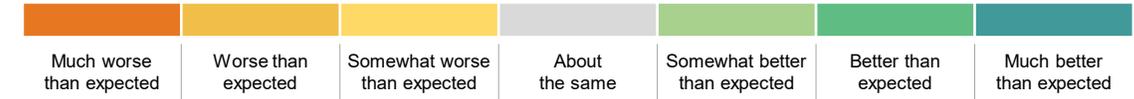


Doctors

Appendix 1

Q16. When you asked doctors questions, did you get answers you could understand?

Results for your trust



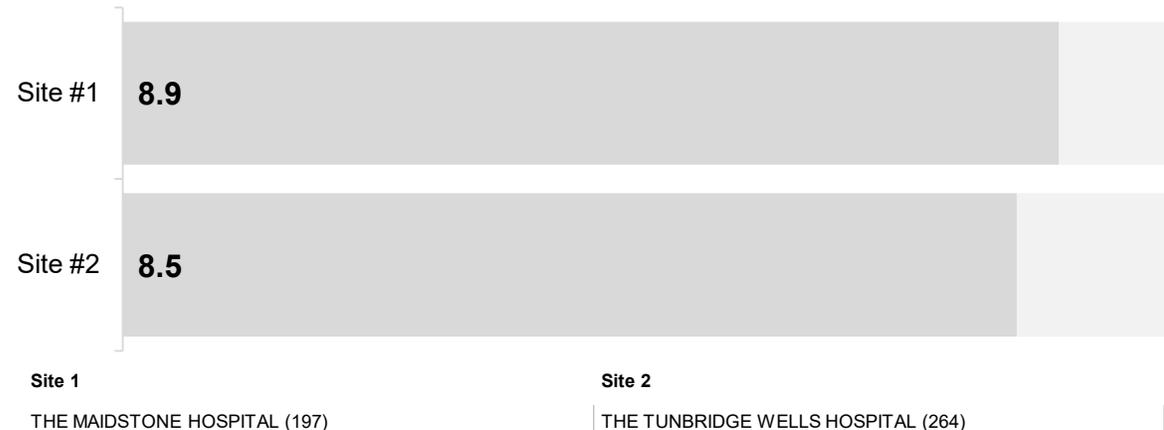
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

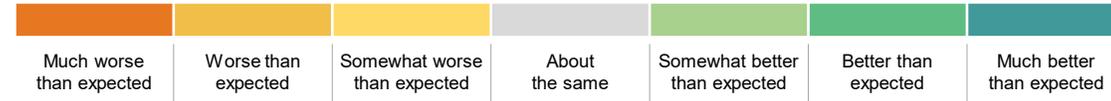
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Doctors

Q17. Did you have confidence and trust in the doctors treating you?

Results for your trust



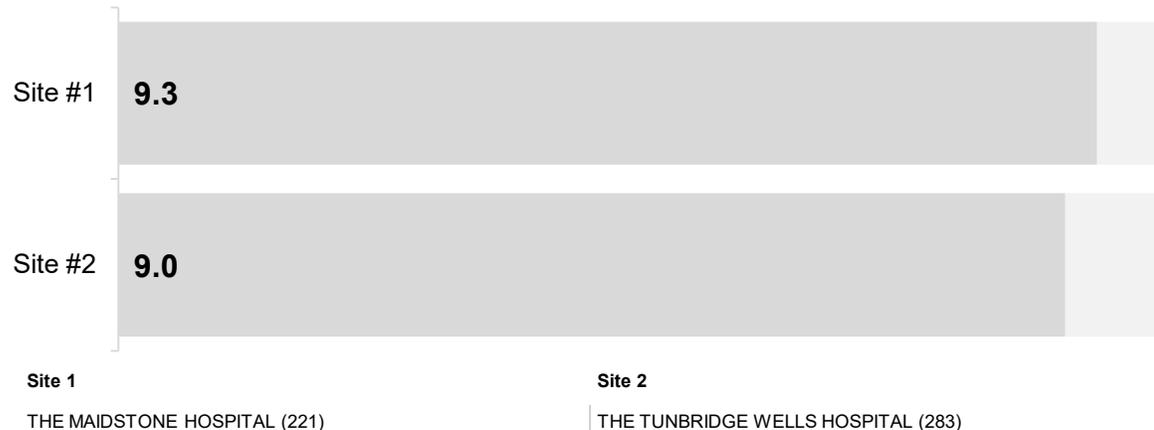
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Site 1
THE MAIDSTONE HOSPITAL (221)

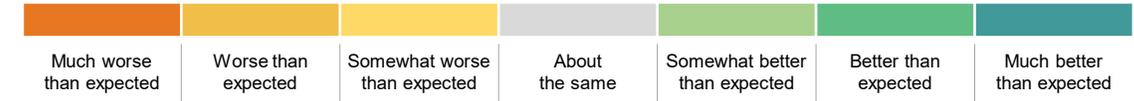
Site 2
THE TUNBRIDGE WELLS HOSPITAL (283)

Doctors

Appendix 1

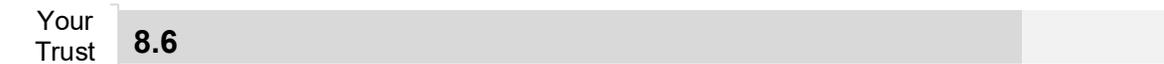
Q18. When doctors spoke about your care in front of you, were you included in the conversation?

Results for your trust



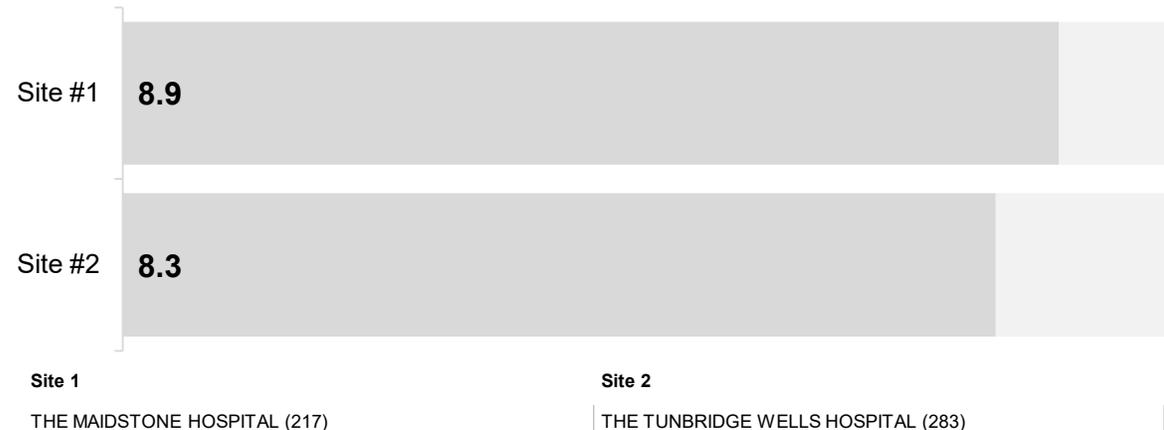
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



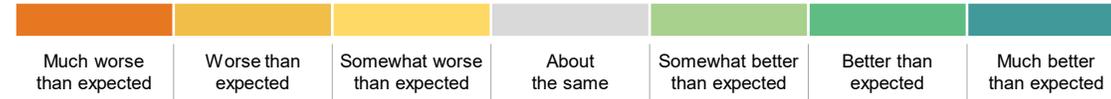
Site 1
THE MAIDSTONE HOSPITAL (217)

Site 2
THE TUNBRIDGE WELLS HOSPITAL (283)

Nurses

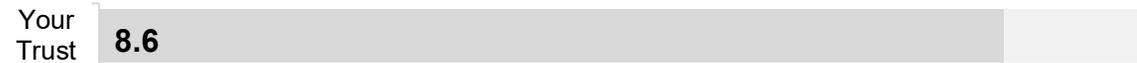
Q19. When you asked nurses questions, did you get answers you could understand?

Results for your trust



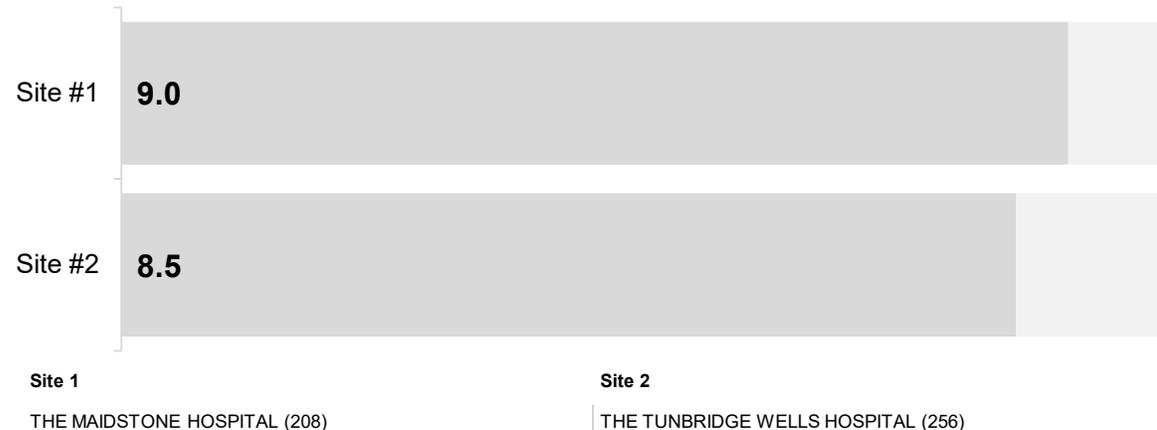
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

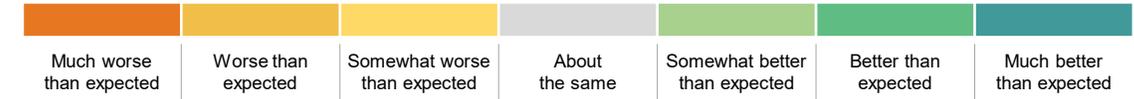


Nurses

Appendix 1

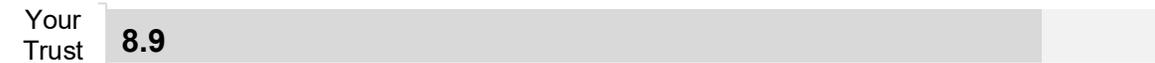
Q20. Did you have confidence and trust in the nurses treating you?

Results for your trust



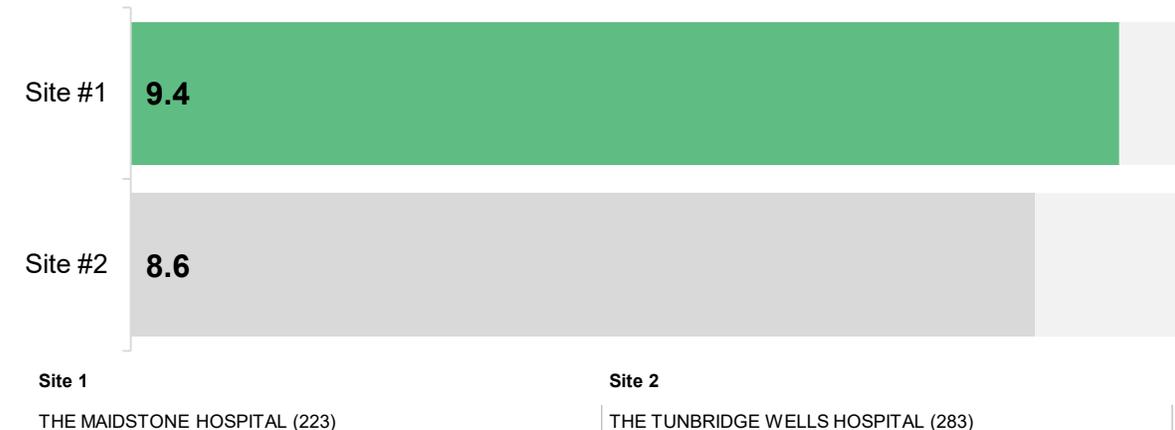
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

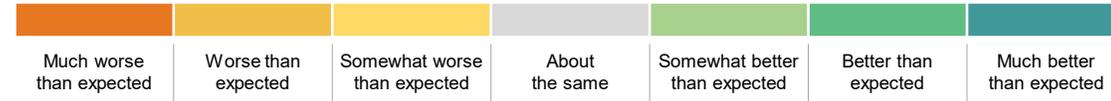
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Nurses

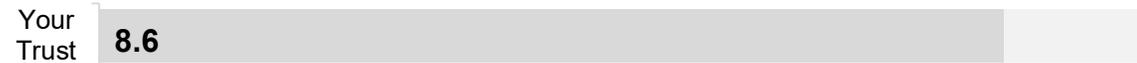
Q21. When nurses spoke about your care in front of you, were you included in the conversation?

Results for your trust



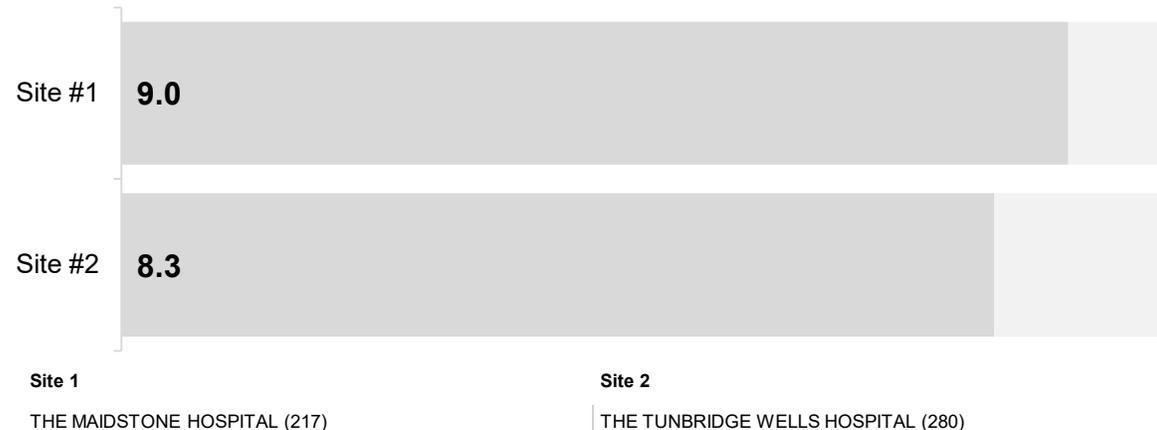
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Site 1
THE MAIDSTONE HOSPITAL (217)

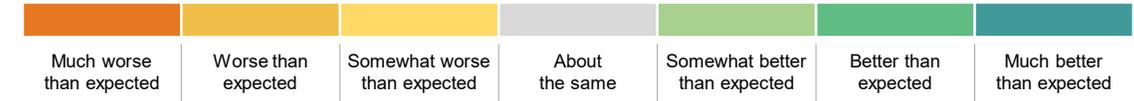
Site 2
THE TUNBRIDGE WELLS HOSPITAL (280)

Nurses

Appendix 1

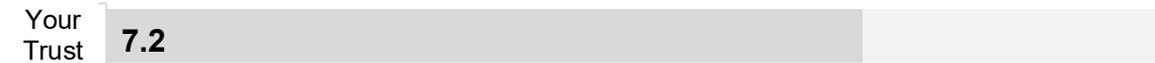
Q22. In your opinion, were there enough nurses on duty to care for you in hospital?

Results for your trust



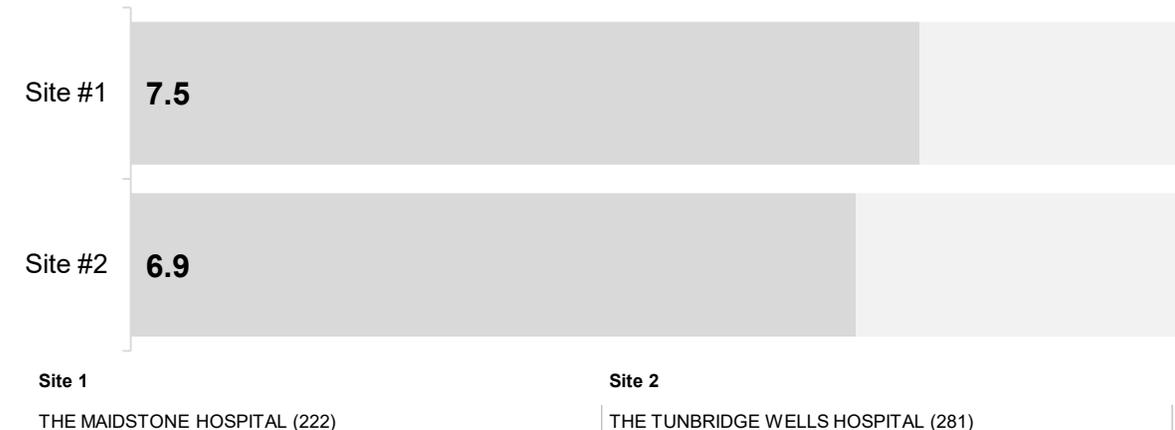
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



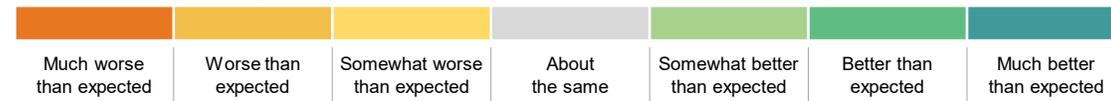
Site 1
THE MAIDSTONE HOSPITAL (222)

Site 2
THE TUNBRIDGE WELLS HOSPITAL (281)

Your care and treatment

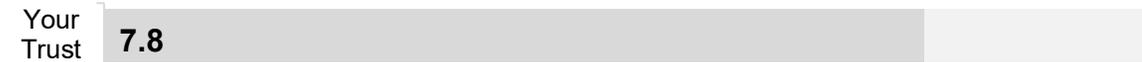
Q23. Thinking about your care and treatment, were you told something by a member of staff that was different to what you had been told by another member of staff?

Results for your trust



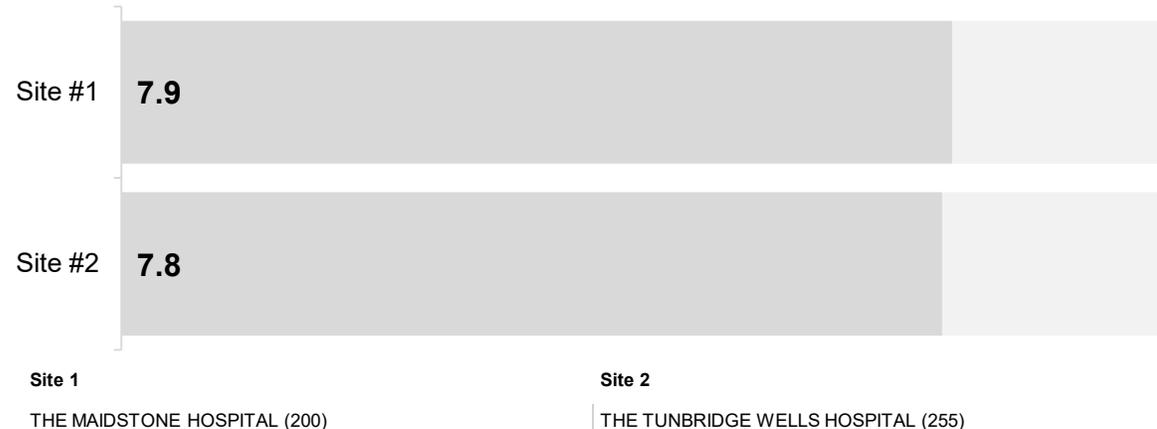
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

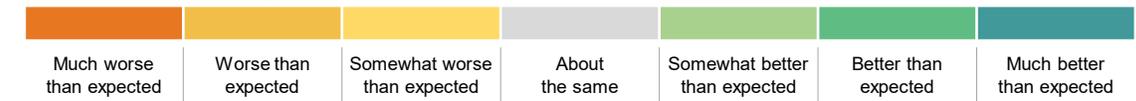


Your care and treatment

Appendix 1

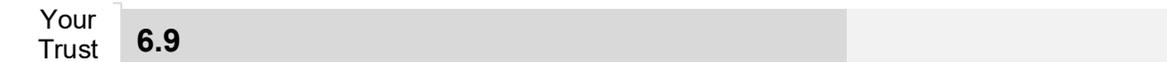
Q24. To what extent did staff looking after you involve you in decisions about your care and treatment?

Results for your trust



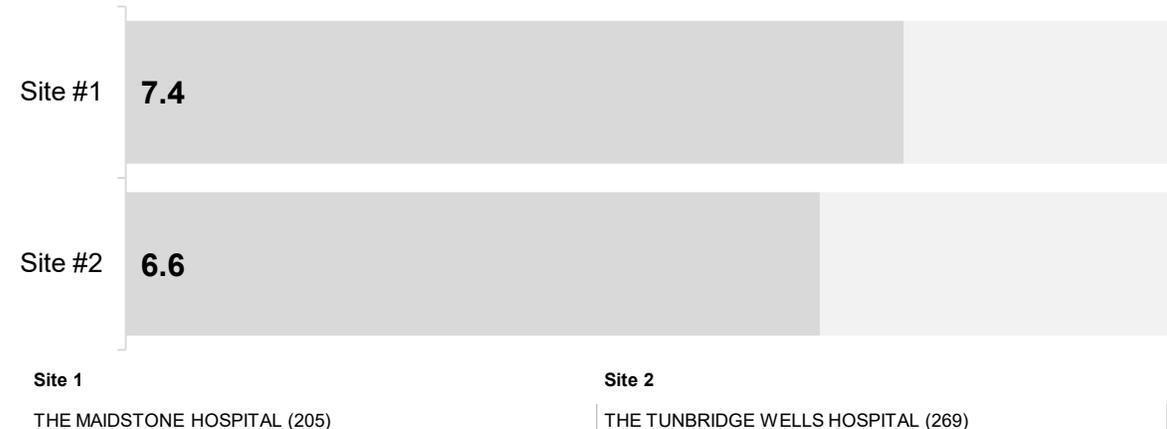
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

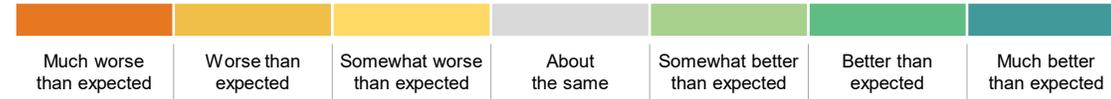
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Your care and treatment

Q25. How much information about your condition or treatment was given to you?

Results for your trust



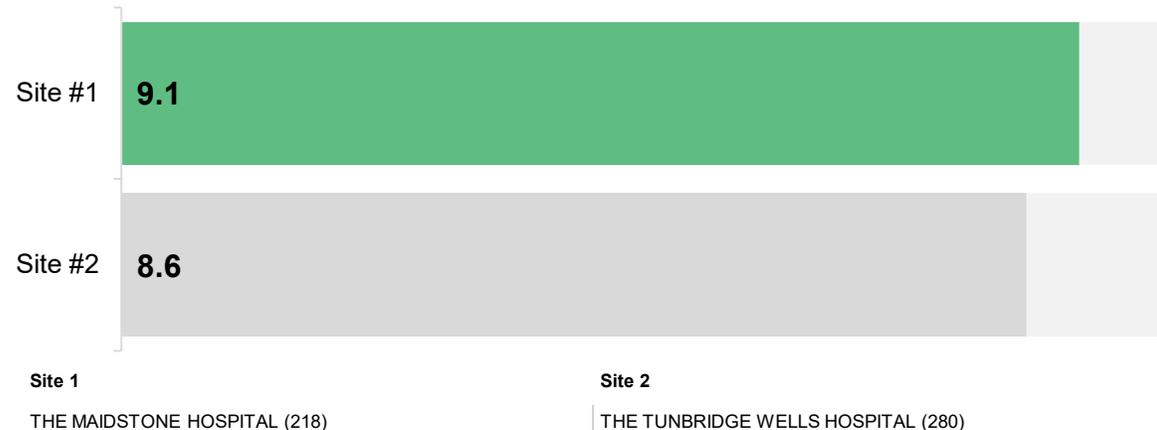
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

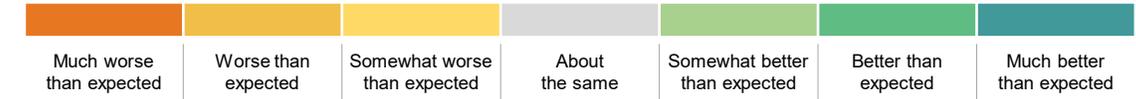


Your care and treatment

Appendix 1

Q26. Did you feel able to talk to members of hospital staff about your worries and fears?

Results for your trust



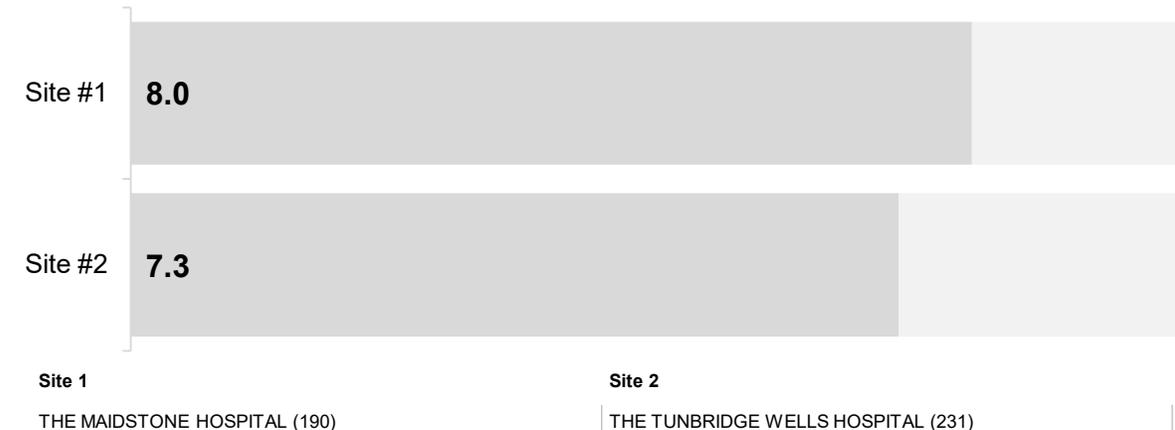
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

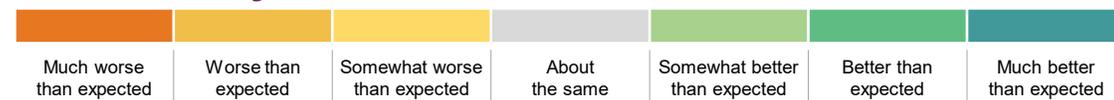
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Your care and treatment

Q27. Were you able to discuss your condition or treatment with hospital staff without being overheard?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

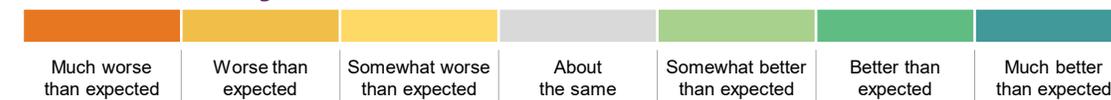


Your care and treatment

Appendix 1

Q28. Were you given enough privacy when being examined or treated?

Results for your trust



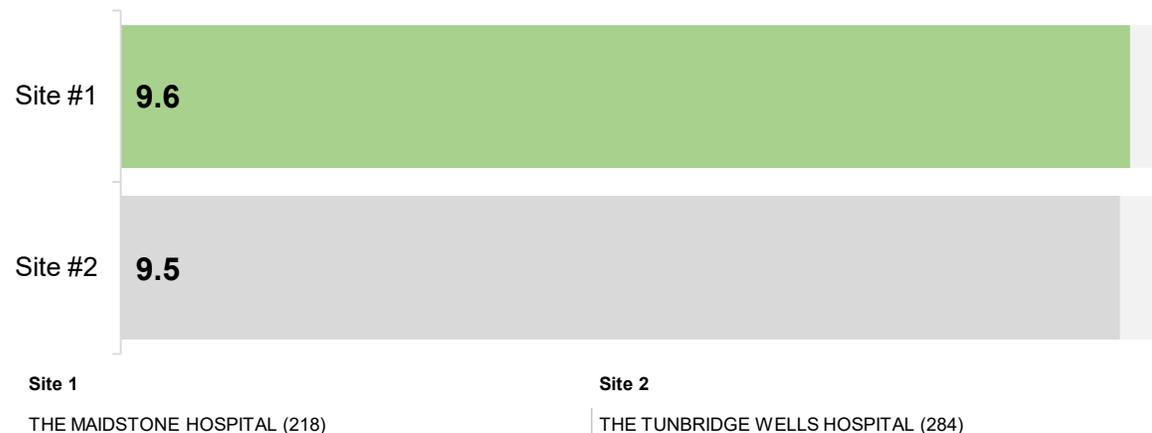
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

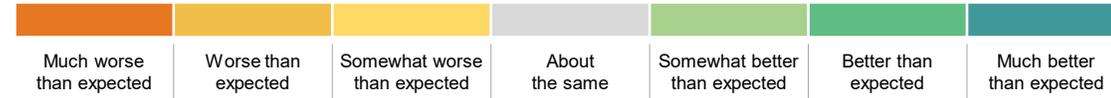
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Your care and treatment

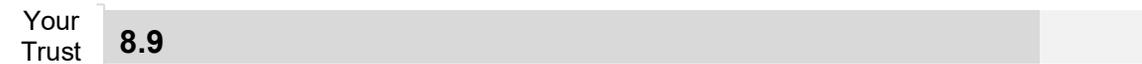
Q29. Do you think the hospital staff did everything they could to help control your pain?

Results for your trust



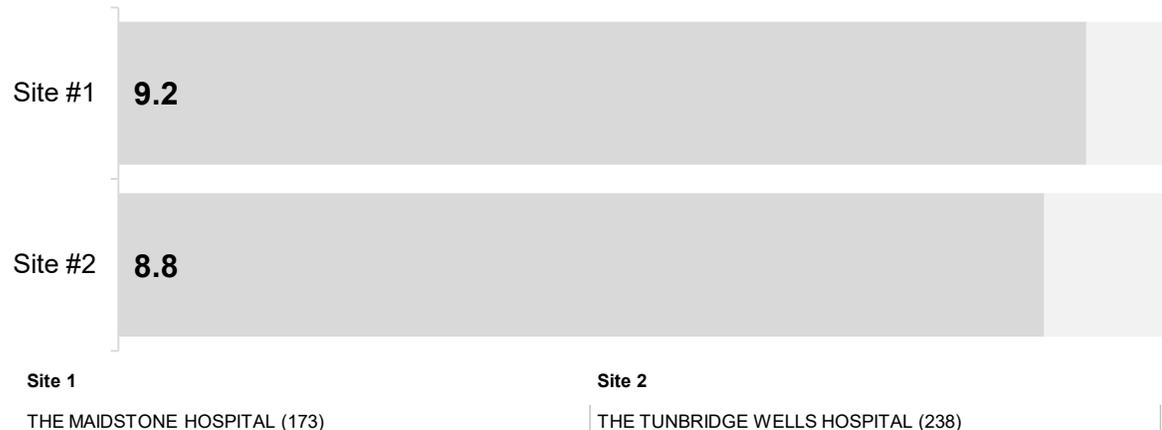
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

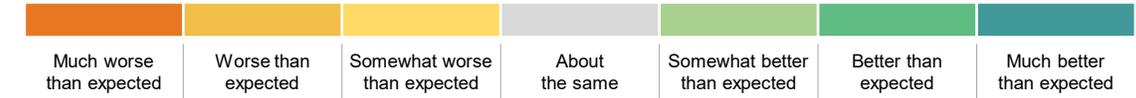


Your care and treatment

Appendix 1

Q30. Were you able to get a member of staff to help you when you needed attention?

Results for your trust



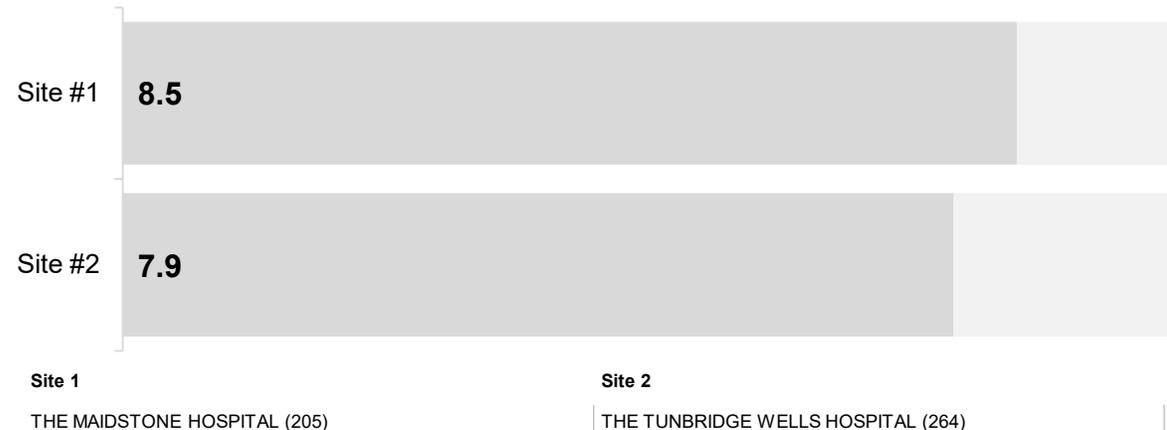
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

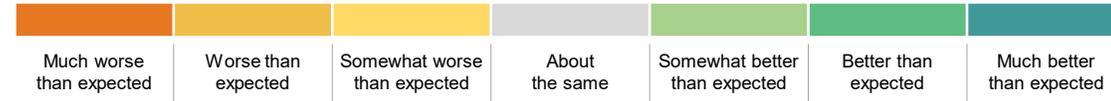
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Operations and procedures

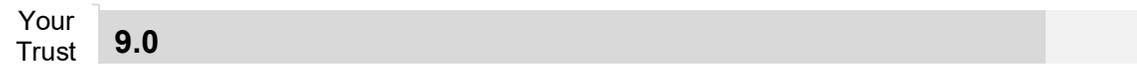
Q32. Beforehand, how well did hospital staff answer your questions about the operations or procedures?

Results for your trust



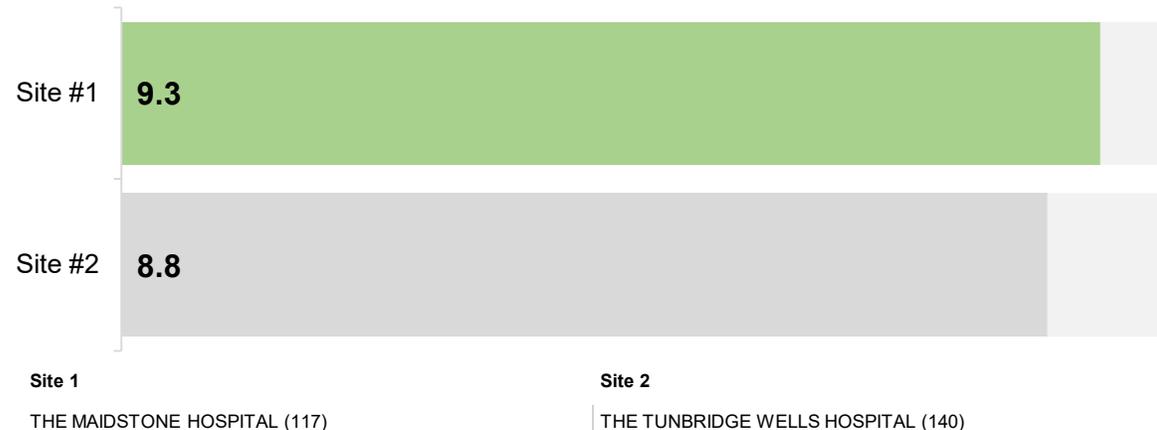
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

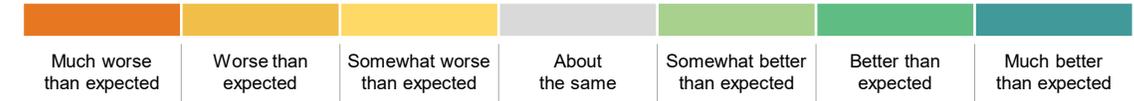


Operations and procedures

Appendix 1

Q33. Beforehand, how well did hospital staff explain how you might feel after you had the operations or procedures?

Results for your trust



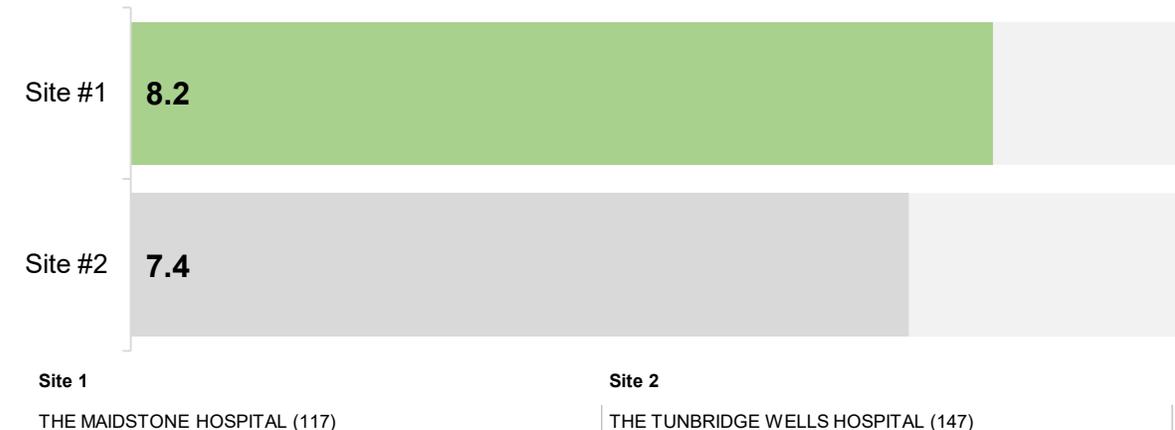
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

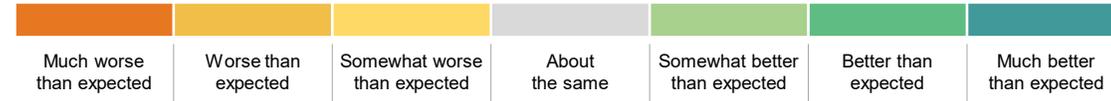
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Operations and procedures

Q34. After the operations or procedures, how well did hospital staff explain how the operation or procedure had gone?

Results for your trust



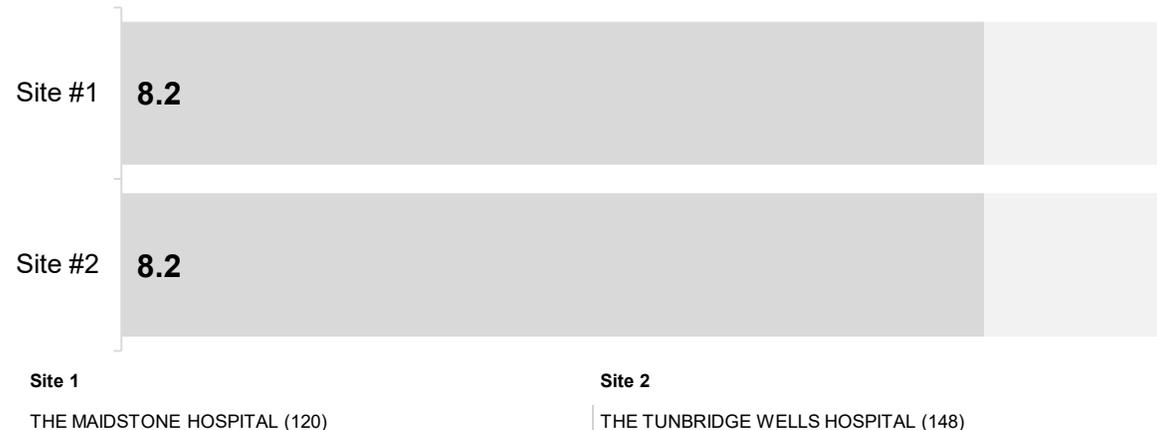
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

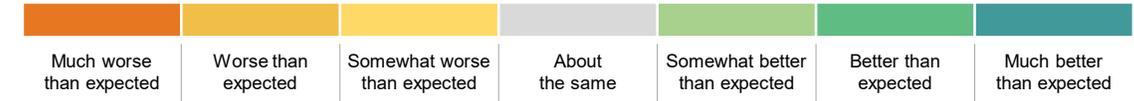


Leaving hospital

Appendix 1

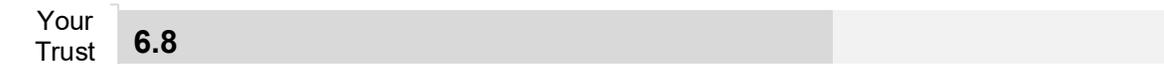
Q35. To what extent did staff involve you in decisions about you leaving hospital?

Results for your trust



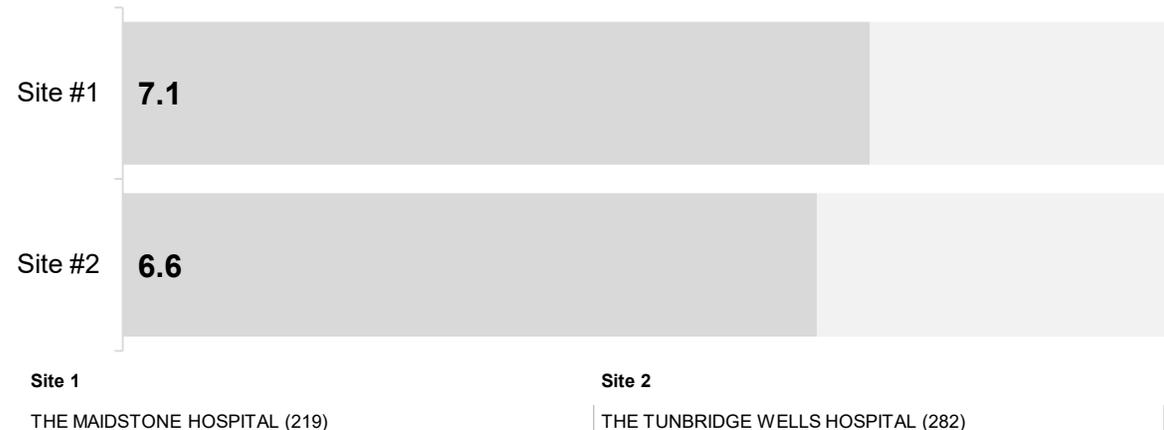
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

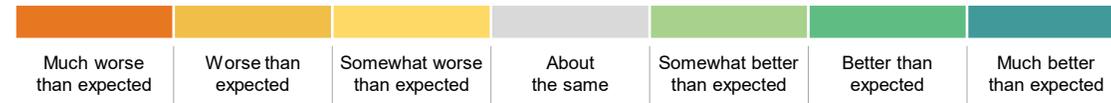
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Leaving hospital

Q36. To what extent did hospital staff take your family or home situation into account when planning for you to leave hospital?

Results for your trust



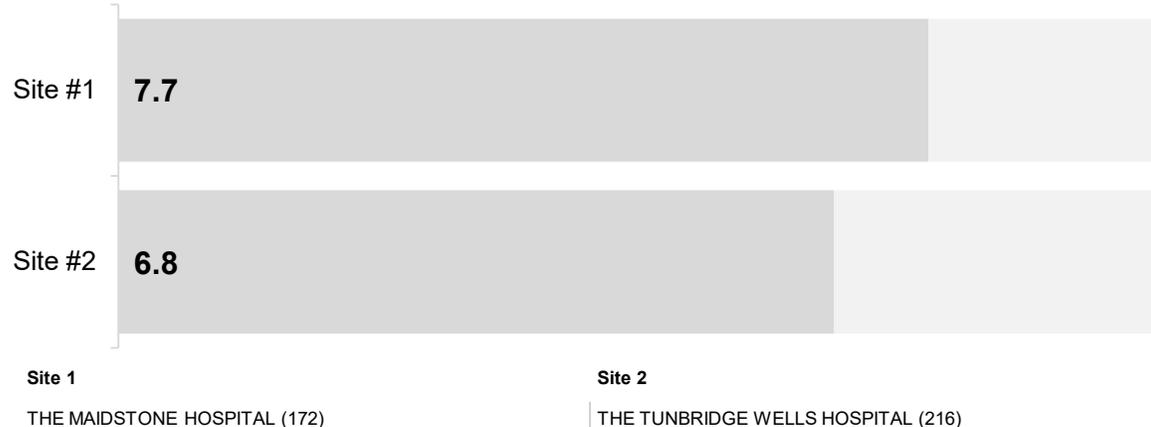
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

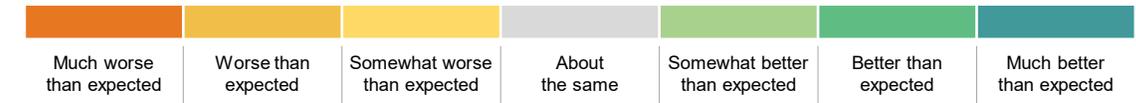


Leaving hospital

Appendix 1

Q37. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?

Results for your trust



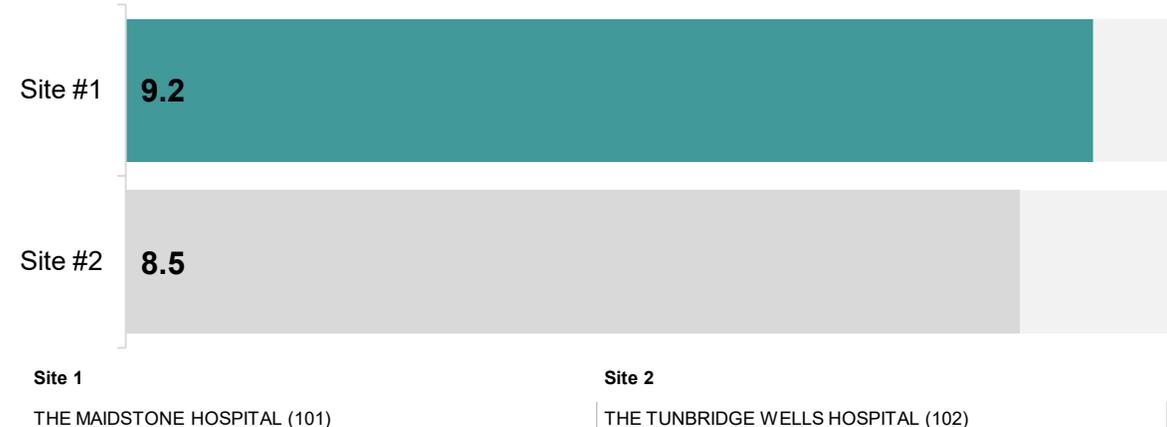
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

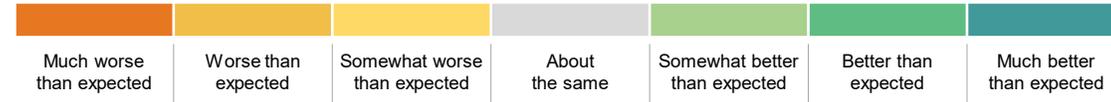
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Leaving hospital

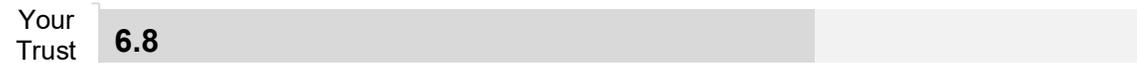
Q38. Were you given enough notice about when you were going to leave hospital?

Results for your trust



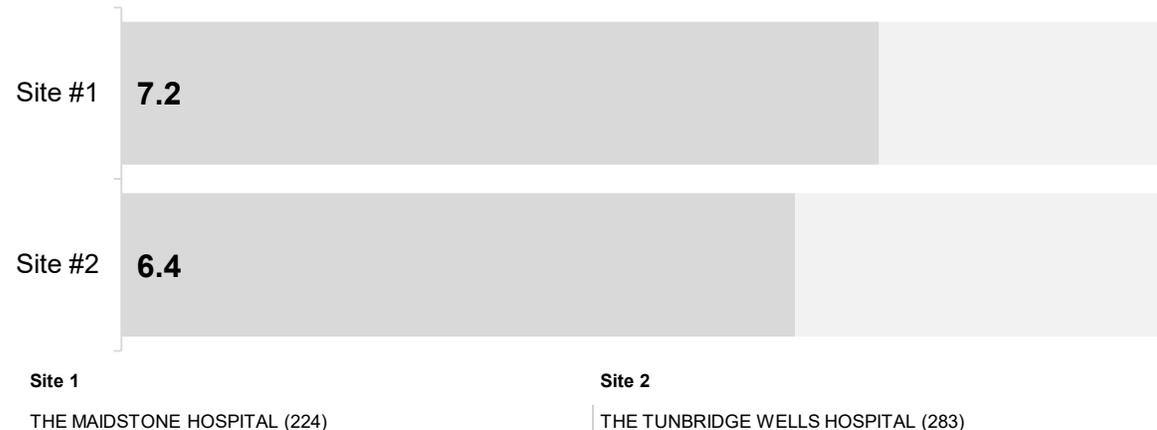
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

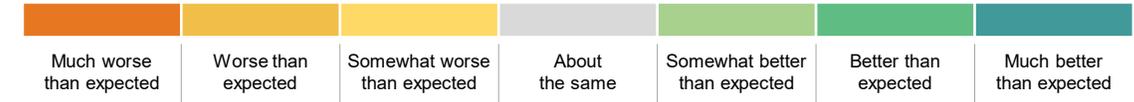


Leaving hospital

Appendix 1

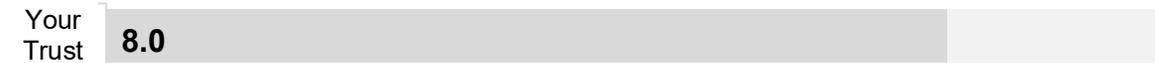
Q39. Before you left hospital, were you given any information about what you should or should not do after leaving hospital?

Results for your trust



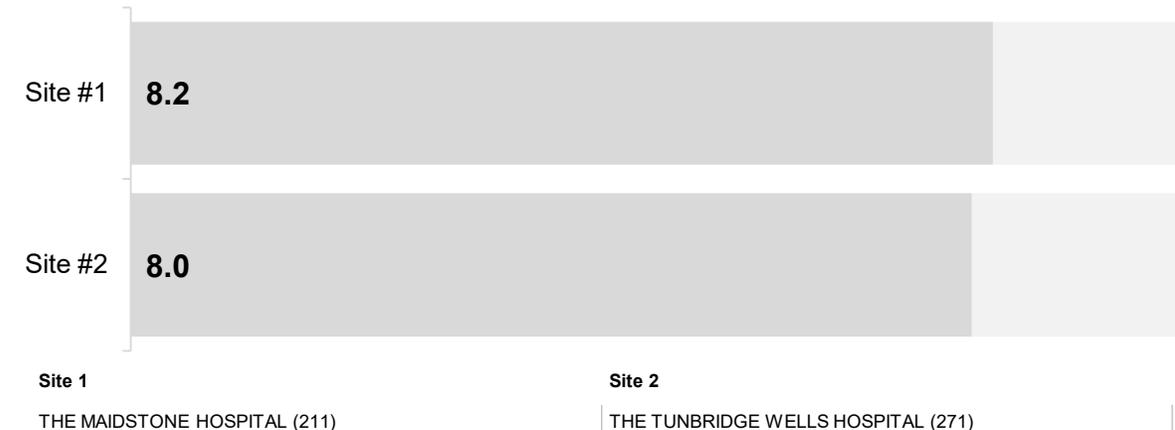
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

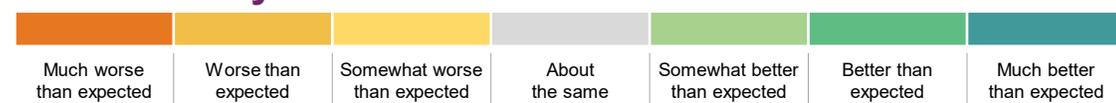
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Leaving hospital

Q40. To what extent did you understand the information you were given about what you should or should not do after leaving hospital?

Results for your trust



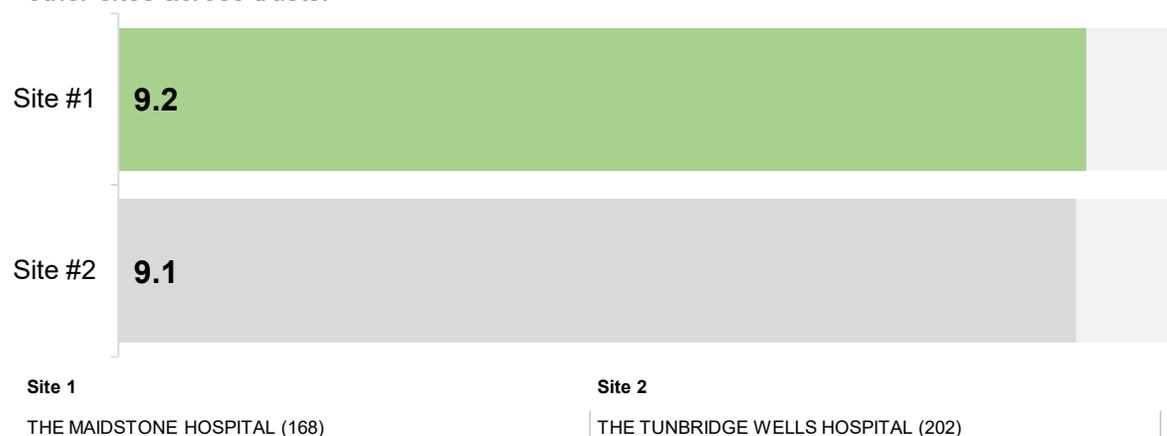
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

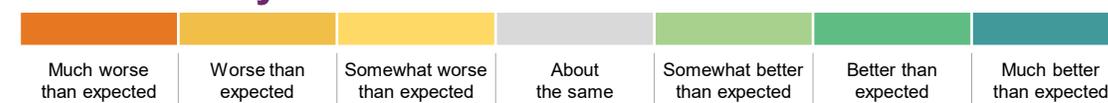


Leaving hospital

Appendix 1

Q41. Thinking about any medicine you were to take at home, were you given any of the following?

Results for your trust



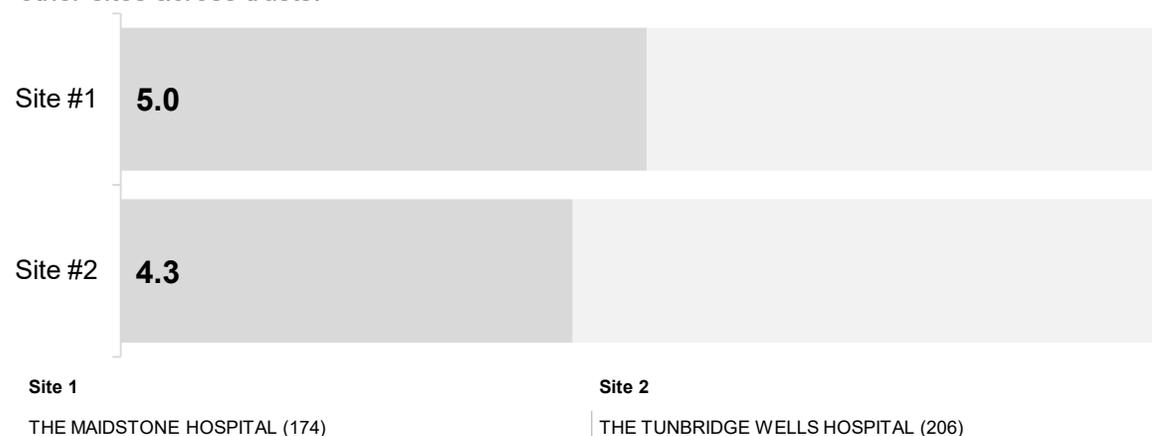
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

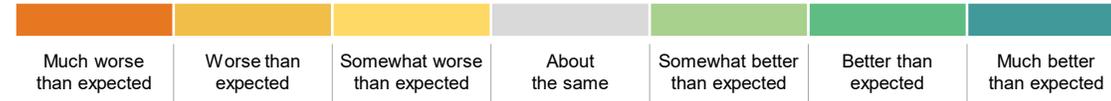
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Leaving hospital

Q42. Before you left hospital, did you know what would happen next with your care?

Results for your trust



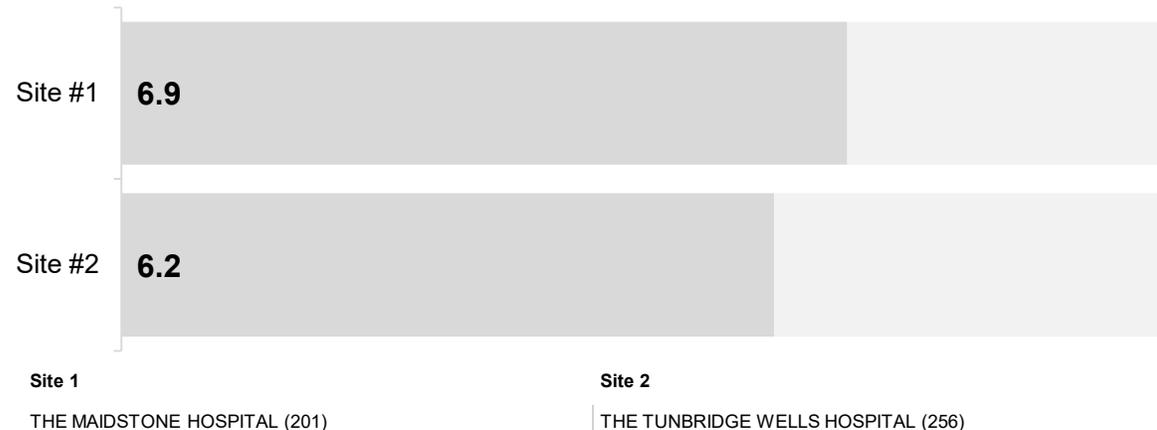
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

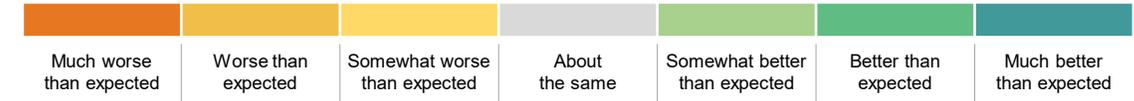


Leaving hospital

Appendix 1

Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Results for your trust



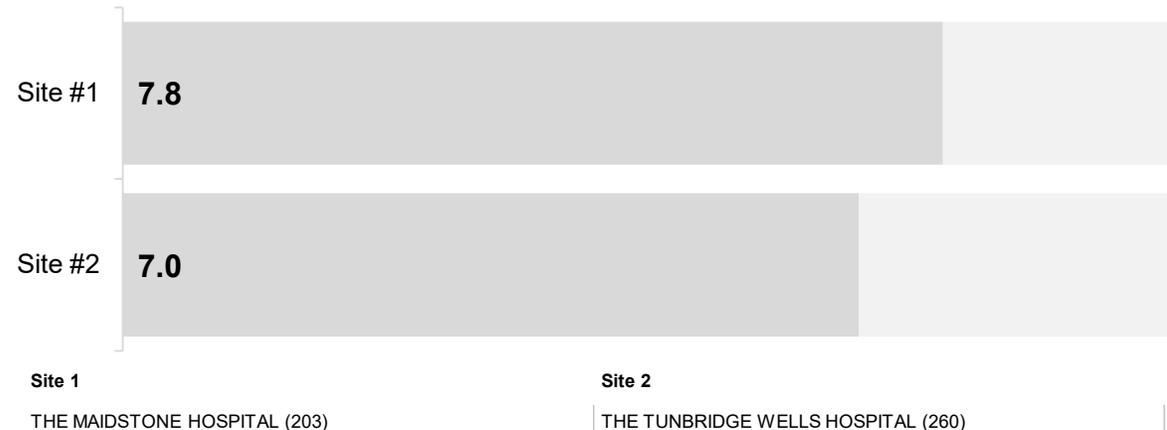
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

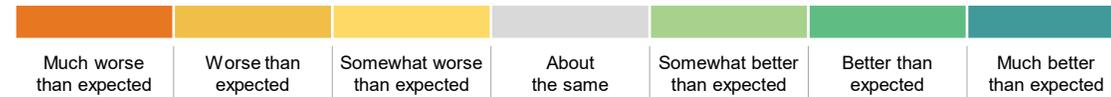
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Leaving hospital

Q44. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?

Results for your trust



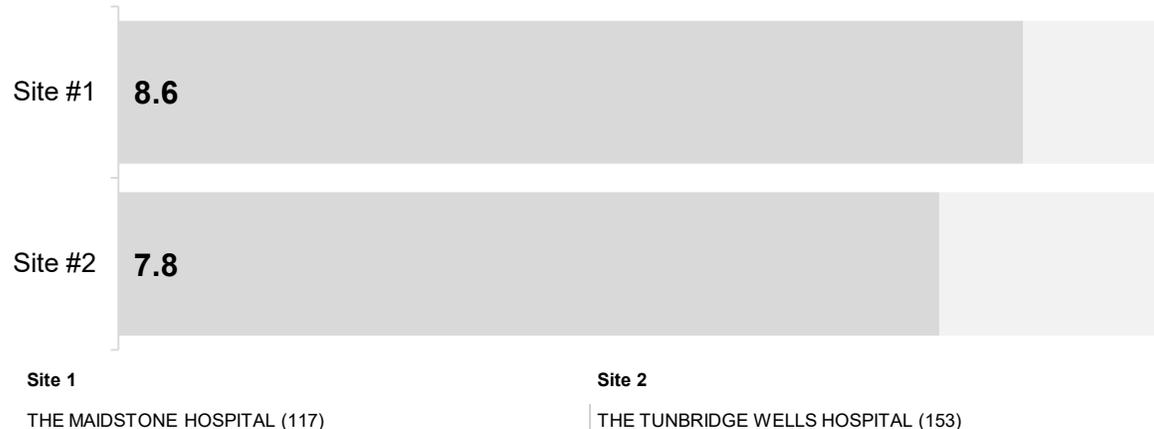
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

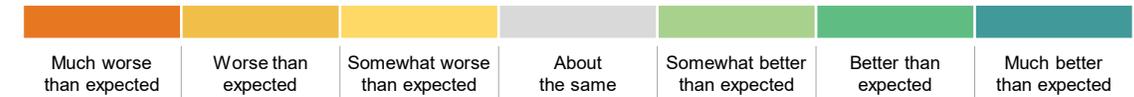


Leaving hospital

Appendix 1

Q46. After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition?

Results for your trust



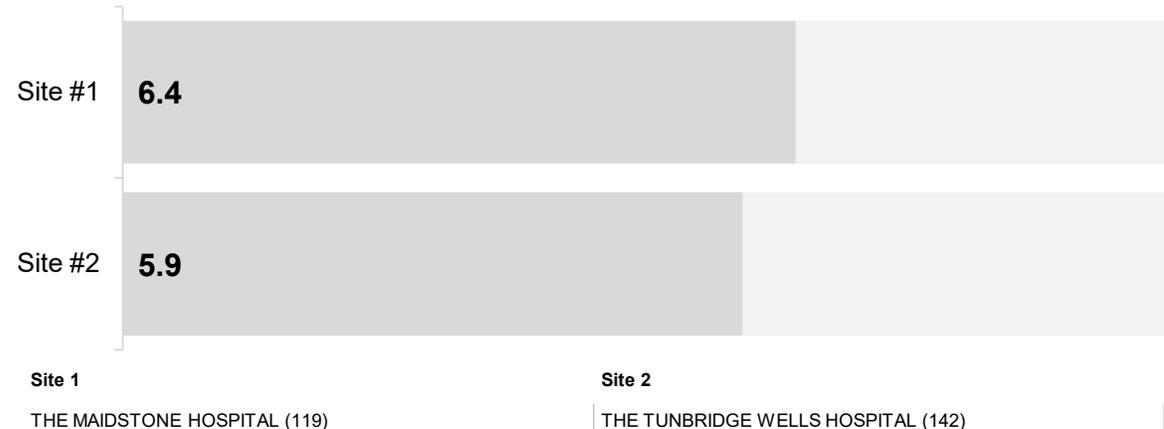
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

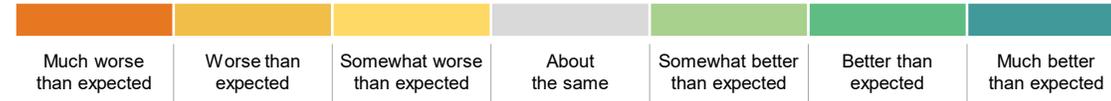
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Feedback on care

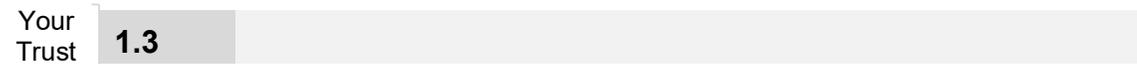
Q49. During your hospital stay, were you ever asked to give your views on the quality of your care?

Results for your trust



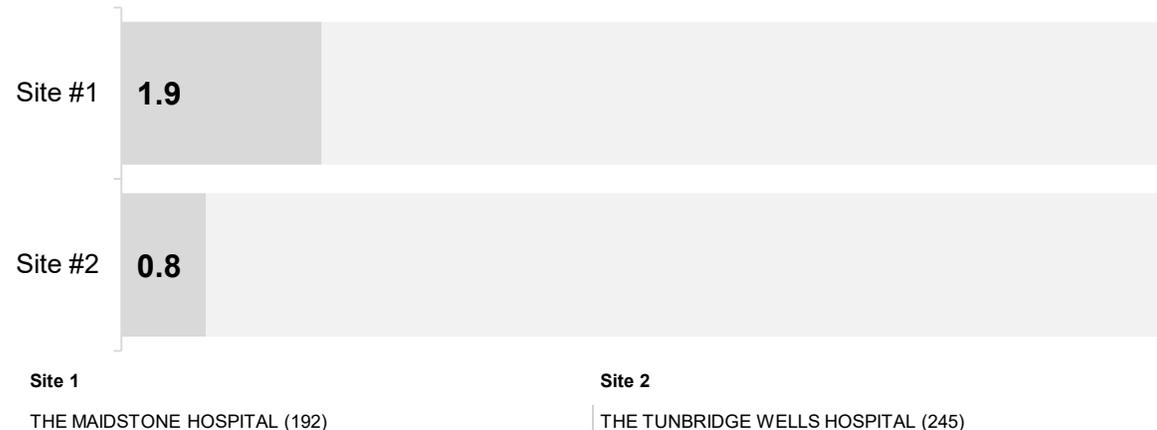
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

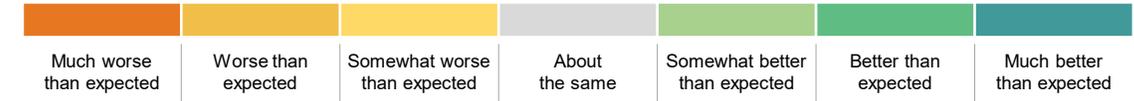


Respect and dignity

Appendix 1

Q47. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

Results for your trust



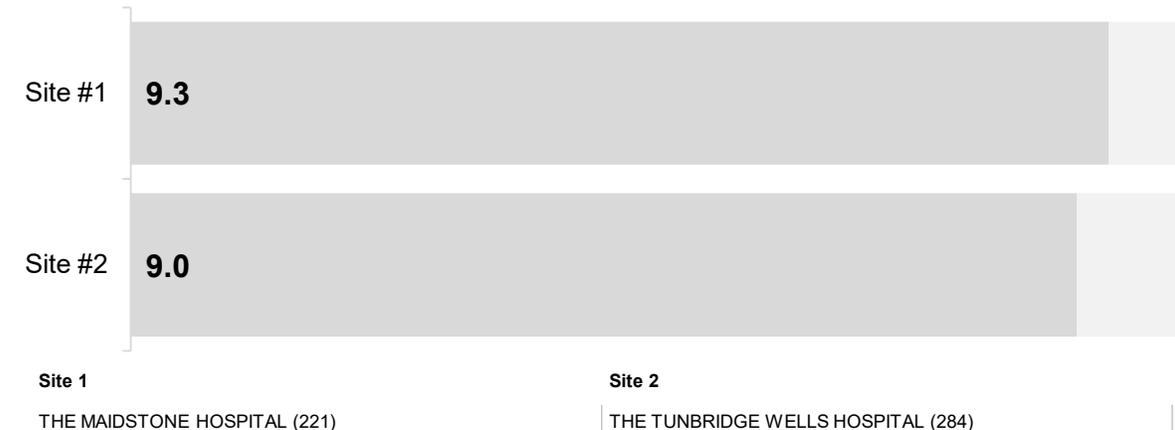
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

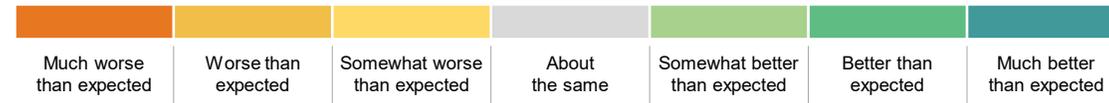
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Overall

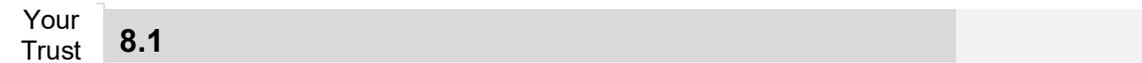
Q48. Overall, how was your experience while you were in the hospital?

Results for your trust



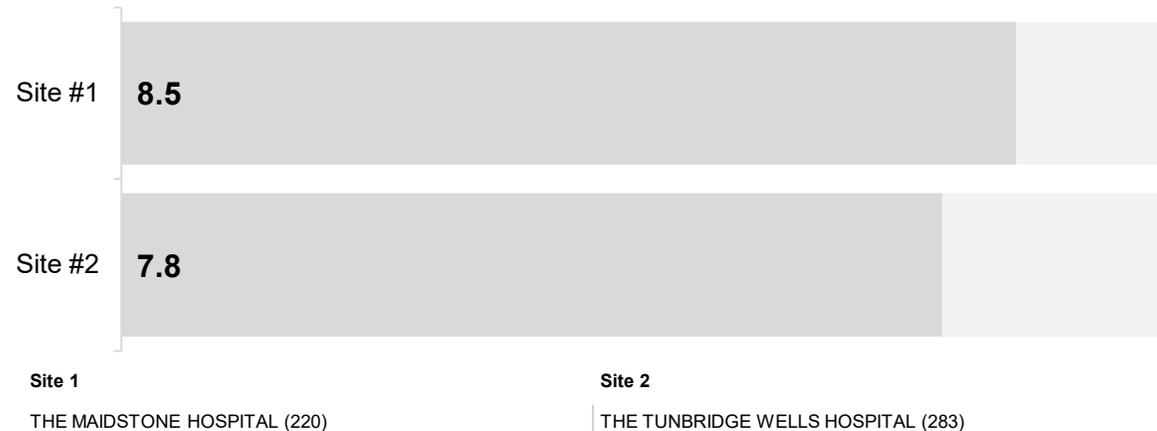
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



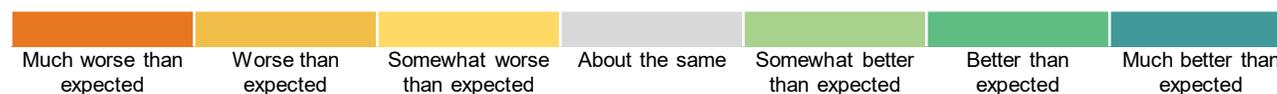
Trends over time

This section includes:

- your mean trust score for each evaluative question in the survey
- where comparable data is available, statistical significance testing using a two sample t-test has been carried out against the 2020 survey results for each relevant question. Where a change in results is shown as 'significant', this indicates that this change is not due to random chance, but is likely due to some particular factor at your trust. Significant increases are indicated with a up arrow and significant decreases are indicated with a down arrow.
- the following questions were new or changed for 2021 and therefore are not included in this section: Q4, Q11, Q12, Q14, Q27, Q40

Trends over time – Admission to hospital

The following table displays changes since 2020, and whether those changes are statistically significant.



Number of respondents	2021 Trust Score	2020 Trust Score
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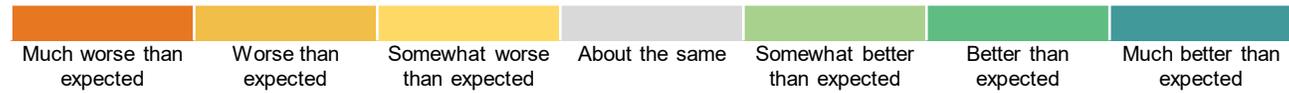
The hospital and ward				
Q2.	How did you feel about the length of time you were on the waiting list before your admission to hospital?	137	7.5	7.7
Q3.	How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?	490	6.8▼	7.4

▼▲ Significant difference between 2021 and 2020

Blank No significant difference between 2021 and 2020

Trends over time – The hospital and ward

The following table displays changes since 2020, and whether those changes are statistically significant. The following questions were new or changed for 2021 and therefore are not included in this section: Q4, Q11, Q12, Q14.

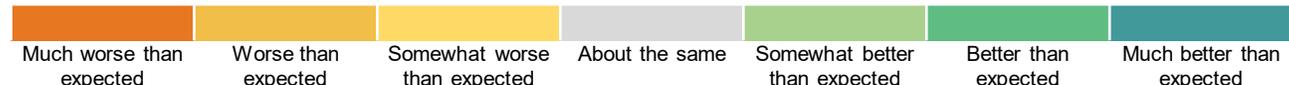
		Number of respondents	2021 Trust Score	2020 Trust Score
				
The hospital and ward				
Q5.	Were you ever prevented from sleeping at night by noise from other patients?	463	7.0	7.4
Q5.	Were you ever prevented from sleeping at night by noise from staff?	463	8.6	8.5
Q5.	Were you ever prevented from sleeping at night by hospital lighting?	463	8.1	8.5
Q7.	Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?	63	7.1	6.9
Q8.	How clean was the hospital room or ward that you were in?	501	9.1 ▼	9.3
Q9.	Did you get enough help from staff to wash or keep yourself clean?	350	8.2	8.4
Q10.	If you brought medication with you to hospital, were you able to take it when you needed to?	298	8.2 ▼	8.7
Q13.	Did you get enough help from staff to eat your meals?	130	7.3	8.0
Q15.	During your time in hospital, did you get enough to drink?	476	9.3	9.5

▼▲ Significant difference between 2021 and 2020

Blank No significant difference between 2021 and 2020

Trends over time – Doctors / Nurses

The following table displays changes since 2020, and whether those changes are statistically significant.

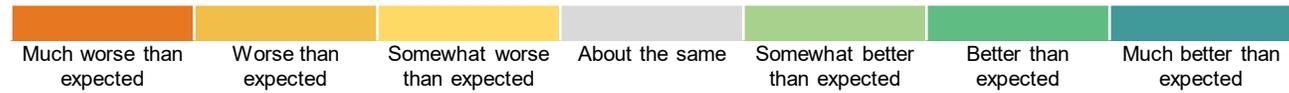
		Number of respondents	2021 Trust Score	2020 Trust Score
				
Doctors				
Q16.	When you asked doctors questions, did you get answers you could understand?	461	8.7	8.8
Q17.	Did you have confidence and trust in the doctors treating you?	504	9.1	9.2
Q18.	When doctors spoke about your care in front of you, were you included in the conversation?	500	8.6	8.8
Nurses				
Q19.	When you asked nurses questions, did you get answers you could understand?	464	8.6	8.9
Q20.	Did you have confidence and trust in the nurses treating you?	506	8.9	9.1
Q21.	When nurses spoke about your care in front of you, were you included in the conversation?	497	8.6▼	8.9
Q22.	In your opinion, were there enough nurses on duty to care for you in hospital?	503	7.2▼	8.0

▼▲ Significant difference between 2021 and 2020

Blank No significant difference between 2021 and 2020

Trends over time – Your care and treatment

The following table displays changes since 2020, and whether those changes are statistically significant. The following questions were new or changed for 2021 and therefore are not included in this section: Q27.

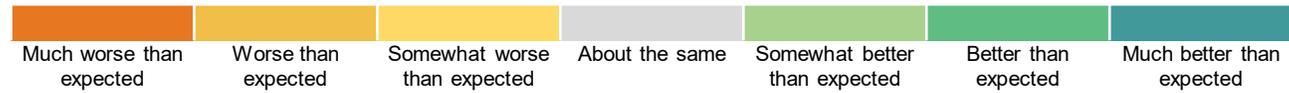
		Number of respondents	2021 Trust Score	2020 Trust Score
				
The hospital and ward				
Q23.	Thinking about your care and treatment, were you told something by a member of staff that was different to what you had been told by another member of staff?	455	7.8	7.9
Q24.	To what extent did staff looking after you involve you in decisions about your care and treatment?	474	6.9	7.1
Q25.	How much information about your condition or treatment was given to you?	498	8.8	8.9
Q26.	Did you feel able to talk to members of hospital staff about your worries and fears?	421	7.6	7.8
Q28.	Were you given enough privacy when being examined or treated?	502	9.5▼	9.7
Q29.	Do you think the hospital staff did everything they could to help control your pain?	411	8.9▼	9.2
Q30.	Were you able to get a member of staff to help you when you needed attention?	469	8.1	8.5

▼▲ Significant difference between 2021 and 2020

Blank No significant difference between 2021 and 2020

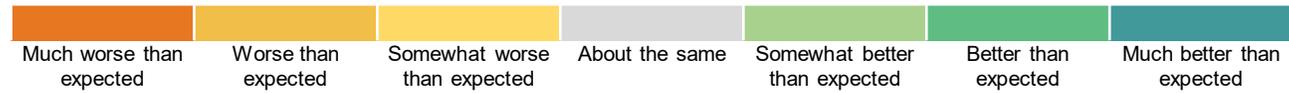
Trends over time – Operations and procedures

The following table displays changes since 2020, and whether those changes are statistically significant.

		Number of respondents	2021 Trust Score	2020 Trust Score
				
Admission to hospital				
Q32.	Beforehand, how well did hospital staff answer your questions about the operations or procedures?	257	9.0	8.9
Q33.	Beforehand, how well did hospital staff explain how you might feel after you had the operations or procedures?	264	7.8	7.9
Q34.	After the operations or procedures, how well did hospital staff explain how the operation or procedure had gone?	268	8.1	7.6
▼▲	Significant difference between 2021 and 2020			
Blank	No significant difference between 2021 and 2020			

Trends over time – Leaving hospital

The following table displays changes since 2020, and whether those changes are statistically significant. The following questions were new or changed for 2021 and therefore are not included in this section: Q40.

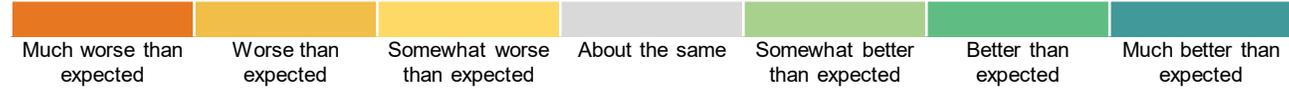
		Number of respondents	2021 Trust Score	2020 Trust Score
				
The hospital and ward				
Q35.	To what extent did staff involve you in decisions about you leaving hospital?	501	6.8	6.8
Q36.	To what extent did hospital staff take your family or home situation into account when planning for you to leave hospital?	388	7.2	7.2
Q37.	Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?	203	8.8	9.0
Q38.	Were you given enough notice about when you were going to leave hospital?	507	6.8	7.2
Q39.	Before you left hospital, were you given any information about what you should or should not do after leaving hospital?	482	8.0▲	7.0
Q41.	Thinking about any medicine you were to take at home, were you given any of the following?	380	4.6	5.0
Q42.	Before you left hospital, did you know what would happen next with your care?	457	6.5	6.6
Q43.	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	463	7.3	7.4
Q44.	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	270	8.0	8.1
Q46.	After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition?	261	6.2	6.6

▼▲ Significant difference between 2021 and 2020

Blank No significant difference between 2021 and 2020

Trends over time – Feedback on care / Respect and dignity / Overall

The following table displays changes since 2020, and whether those changes are statistically significant.

		Number of respondents	2021 Trust Score	2020 Trust Score
				
Feedback on care				
Q49.	During your hospital stay, were you ever asked to give your views on the quality of your care?	437	1.3	1.0
Respect and dignity				
Q47.	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	505	9.1	9.3
Overall				
Q48.	Overall, how was your experience while you were in the hospital?	503	8.1 ▼	8.4
▼▲	Significant difference between 2021 and 2020			
Blank	No significant difference between 2021 and 2020			

For further information

Please contact the Coordination Centre for Mixed Methods:
InpatientCoordination@ipsos.com



Appendix



Comparison to other trusts

The questions at which your trust has performed much worse or worse compared with all other trusts are listed below. The questions where your trust has performed about the same compared with all other trusts have not been listed.

Much worse than expected

- Your trust has not performed "better than expected" for any questions.

Worse than expected

- Your trust has not performed "much better than expected" for any questions.

Comparison to other trusts

The questions at which your trust has performed somewhat worse or somewhat better compared with all other trusts are listed below. The questions where your trust has performed about the same compared with all other trusts have not been listed.

Somewhat worse than expected

- Your trust has not performed "better than expected" for any questions.

Somewhat better than expected

- Q5. Were you ever prevented from sleeping at night by noise from other patients?
- Q5. Were you ever prevented from sleeping at night by noise from staff?
- Q40. To what extent did you understand the information you were given about what you should or should not do after leaving hospital?

Comparison to other trusts

The questions at which your trust has performed better or much better compared with all other trusts are listed below. The questions where your trust has performed about the same compared with all other trusts have not been listed.

Better than expected

- Q27. Were you able to discuss your condition or treatment with hospital staff without being overheard?

Much better than expected

- Your trust has not performed "much better than expected" for any questions.

Comparison to 2020 results

The questions in this report where your trust showed a statistically significant increase or decrease compared to 2020 results are listed below.

Significant Increase	Point change	Significant Decrease	Point change
Q39. Before you left hospital, were you given any information about what you should or should not do after leaving hospital?	+1.0	Q22. In your opinion, were there enough nurses on duty to care for you in hospital?	-0.8
		Q3. How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?	-0.5
		Q10. If you brought medication with you to hospital, were you able to take it when you needed to?	-0.5
		Q29. Do you think the hospital staff did everything they could to help control your pain?	-0.3
		Q21. When nurses spoke about your care in front of you, were you included in the conversation?	-0.3
		Q48. Overall, how was your experience while you were in the hospital?	-0.3
		Q8. How clean was the hospital room or ward that you were in?	-0.3
		Q28. Were you given enough privacy when being examined or treated?	-0.2

NHS Adult Inpatient Survey 2021

Results for Maidstone and Tunbridge Wells NHS Trust

Where patient experience is best

- ✓ Noise from other patients: patients not being bothered by noise at night from other patients
- ✓ Privacy for discussions: patients being able to discuss their condition or treatment with hospital staff without being overheard
- ✓ Equipment and adaptations in the home: hospital staff discussing if any equipment or home adaptations were needed when leaving hospital
- ✓ Noise from staff: patients not being bothered by noise at night from staff
- ✓ Changing wards during the night: staff explaining the reason for patients needing to change wards during the night

Where patient experience could improve

- Food outside set meal times: patients being able to get hospital food outside of set meal times, if needed
- Quality of food: patients describing the hospital food as good
- Contact: patients being given information about who to contact if they were worried about their condition or treatment after leaving hospital
- Help with eating: patients being given enough help from staff to eat meals, if needed
- Involvement in decisions: patients being involved in decisions about leaving hospital, if they wanted to be

These topics are calculated by comparing your trust's results to the average of all trusts. "Where patient experience is best": These are the five results for your trust that are highest compared with the average of all trusts. "Where patient experience could improve": These are the five results for your trust that are lowest compared with the average of all trusts.

This survey looked at the experiences of people who were discharged from an NHS acute hospital in November 2021. Between January 2022 and May 2022, a questionnaire was sent to 1250 inpatients at Maidstone and Tunbridge Wells NHS Trust who had attended in late 2021. Responses were received from 514 patients at this trust. If you have any questions about the survey and our results, please contact [NHS TRUST TO INSERT CONTACT DETAILS].



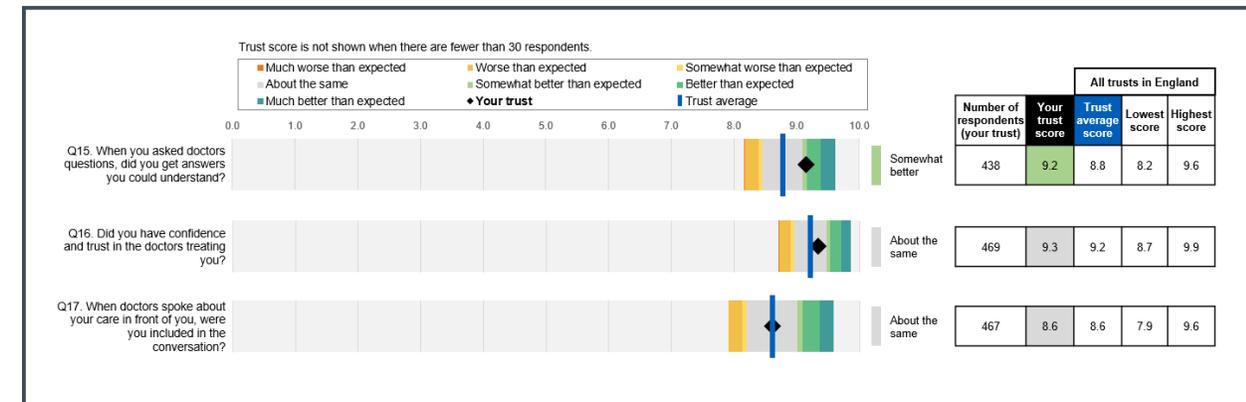
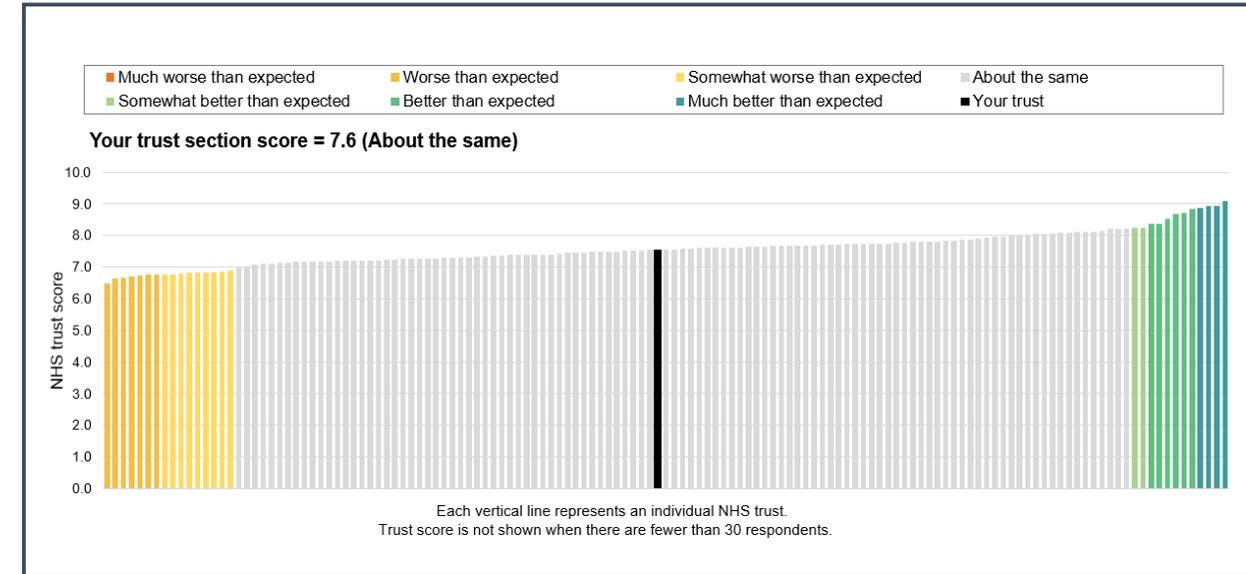
How to interpret benchmarking in this report

Trust level benchmarking

The charts in the 'benchmarking' section show how the score for your trust compares to the range of scores achieved by all trusts taking part in the survey. The black line shows the score for your trust. The graphs are divided into seven sections, comparing the score for your trust to most other trusts in the survey:

- If your trust's score lies in the **dark green section** of the graph, its result is 'Much better than expected'.
- If your trust's score lies in the **mid-green section** of the graph, its result is 'Better than expected'.
- If your trust's score lies in the **light green section** of the graph, its result is 'Somewhat better than expected'.
- If your trust's score lies in the **grey section** of the graph, its result is 'About the same'.
- If your trust's score lies in the **yellow section** of the graph, its result is 'Somewhat worse than expected'.
- If your trust's score lies in the **light orange section** of the graph, its result is 'Worse than expected'.
- If your trust's score lies in the **dark orange section** of the graph, its result is 'Much worse than expected'.

These groupings are based on a rigorous statistical analysis of the data termed the 'expected range' technique.



How to interpret benchmarking in this report (continued)

Trust level benchmarking

The 'much better than expected', 'better than expected', 'somewhat better than expected', 'about the same', 'somewhat worse than expected', 'worse than expected' and 'much worse than expected' categories are based on an analysis technique called the 'expected range'. Expected range determines the range within which a trust's score could fall without differing significantly from the average, taking into account the number of respondents for each trust, to indicate whether the trust has performed significantly above or below what would be expected.

If it is within this expected range, we say that the trust's performance is 'about the same' as other trusts. Where a trust is identified as performing 'better' or 'worse' than the majority of other trusts, the result is unlikely to have occurred by chance.

The question score charts show the trust scores compared to the minimum and maximum scores achieved by any trust. In some cases this minimum or maximum limit will mean that one or more of the bands are not visible – because the range of other bands is broad enough to include the highest or lowest score achieved by a trust this year. This could be because there were few respondents, meaning the confidence intervals around your data are slightly larger, or because there was limited variation between trusts for this question this year.

In some cases, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust. This occurs as the bandings are calculated through standard error rather than standard deviation. Standard error takes into account the number of responses achieved by a trust, and therefore the banding may differ for a trust with a low numbers of responses.

Site level benchmarking

The charts in the 'trust results' section present site level benchmarking. This allows you to compare the results for sites within your trust with all other sites across trusts. It is important to note that there may be differences between the average score of the sites provided and the overall score for the trust. This may be related to the size of the sites, results for suppressed sites or weighting, as sites and trusts are weighted separately. In addition, if a single site result is presented for a trust, the 'expected range' category may differ: although the score achieved will be the same for both the site and for the trust, the upper and lower boundary levels will differ between the two due to them being calculated differently in each case.

If fewer than 30 responses were received from patients discharged from a site, no scores will be displayed for that site.

Additional information on the 'expected range' analysis technique can be found in the survey technical report on the [NHS Surveys website](#).

An example of scoring

Each evaluative question is scored on a scale from 0 to 10. The scores represent the extent to which the patient's experience could be improved. A score of 0 is assigned to all responses that reflect considerable scope for improvement, whereas a score of 10 refers to the most positive patient experience possible. Where a number of options lay between the negative and positive responses, they are placed at equal intervals along the scale. Where options were provided that did not have any bearing on the trust's performance in terms of patient experience, the responses are classified as "not applicable" and a score is not given. Similarly, where respondents stated they could not remember or did not know the answer to a question, a score is not given.

Calculating an individual respondent's score

The following provides an example for the scoring system applied for each respondent. For question 15 "When you asked doctors questions, did you get answers you could understand":

- The answer code "Yes, always" would be given a score of 10, as this refers to the most positive patient experience possible.
- The answer code "Sometimes" would be given a score of 5, as it is placed at an equal interval along the scale.
- The answer code "No, never" would be given a score of 0, as this response reflects considerable scope for improvement.
- The answer codes "I did not have any questions" and "I did not feel able to ask questions" would not be scored, as they do not have a clear bearing on the trust's performance in terms of patient experience.

Calculating the trust score for each question

The weighted mean score for each trust, for each question, is calculated by dividing the sum of the weighted scores for a question by the weighted sum of all eligible respondents to the question for each trust. An example of this is provided in the [survey technical document](#).

Calculating the section score

An arithmetic mean of each trust's question scores is taken to provide a score for each section.

Quarterly Maternity Services report**Acting Head of Midwifery and Gynaecology**

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 Healthcare Safety 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 training report

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, 14.09.22, Executive Team Meeting, 20.09.22

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

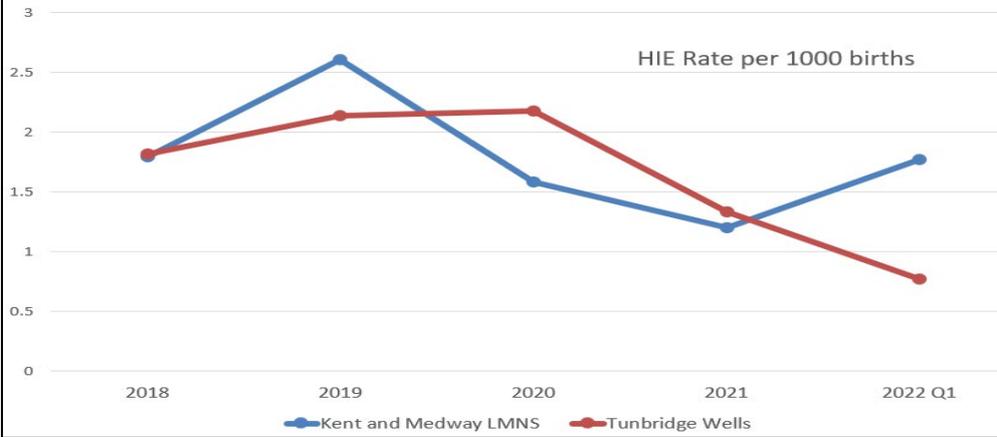
Report to: Trust Board

Report from: Maternity Services

Date: September 2022 (reporting period July 2022 to August 2022)

Subject: Maternity Services Quarterly Update Report

<p>Summary</p>	<p>This report provides an overview of the following for July to August 2022:</p> <ul style="list-style-type: none"> • Number and summary of Serious Incidents (SIs) declared for Maternity Services ** • Number of Healthcare Safety Investigation Branch (HSIB) cases reported ** • Number of Perinatal Mortality Review Tool (PMRT) case reviews* • Key themes • Learning • Recommendations and actions • Progress in implementing Saving Babies Lives Care Bundle v2* • Staffing review summary* • Training report <p>*Clinical Negligence Scheme for Trusts (CNST) requirement **Ockenden recommendation requirement</p>						
<p>Number of Internal SI's Declared</p>	<p>1 case - see summary in the table below:</p> <table border="1" data-bbox="383 963 1428 1209"> <thead> <tr> <th>STEIS Ref</th> <th>Clinical Area</th> <th>Synopsis</th> </tr> </thead> <tbody> <tr> <td>2022/16751</td> <td>Delivery Suite, TWH</td> <td>HSIB investigation – see below Immediate learning identified at 72 hour review Learning actions shared</td> </tr> </tbody> </table>	STEIS Ref	Clinical Area	Synopsis	2022/16751	Delivery Suite, TWH	HSIB investigation – see below Immediate learning identified at 72 hour review Learning actions shared
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	<p style="text-align: center;">Serious incidents per month</p>						

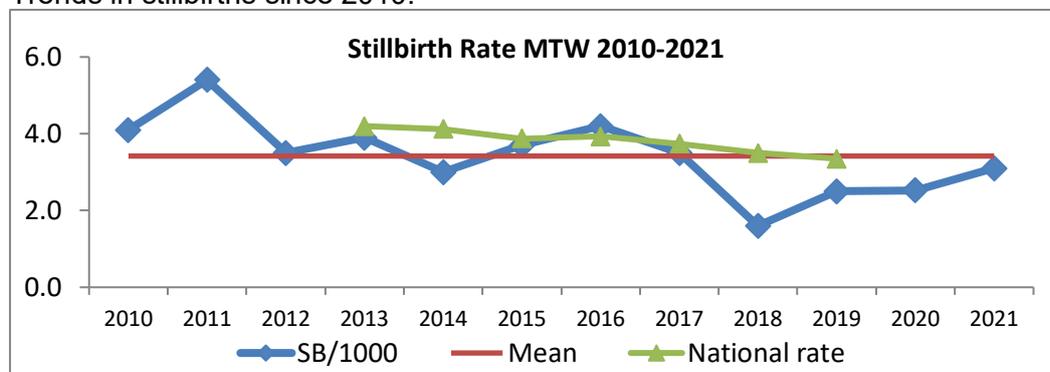
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Number of PMRT case reviews

4 – please see summary in the table below:

<i>Number of stillbirths and late fetal losses (For review)</i>	<i>Reviews completed</i>	<i>Number of cases with care likely to have made a difference to the outcome for the baby</i>	<i>Cause of death</i>
4	4	0	3 – undetermined 1 – placental abruption
<i>Number of neonatal deaths (For review)</i>	<i>Reviews completed</i>	<i>Number of cases with care likely to have made a difference to the outcome for the baby</i>	<i>Cause of death</i>
0	0	0	
<i>Top 5 contributory factors relevant to deaths reviewed</i>			
Staff Factors – Cognitive Factors		There were concerns about baby’s growth but they were not acted upon appropriately Baby was small, scans were indicated and performed but baby was not identified as growth restricted	
Task Factors - Guidelines, Policies and Procedures		Patient attended triage for assessment for reduced fetal movements but had 2yo son present – wasn’t able to be seen due to this and asked to attend later once sorted childcare	
<i>Actions planned to share learning and mitigate risk</i>			
Discussions planned between Triage Manager, Safeguarding Midwife and other key stakeholders around management of individuals attending appointments with children when there is a need for urgent care			

Trends in stillbirths since 2010:

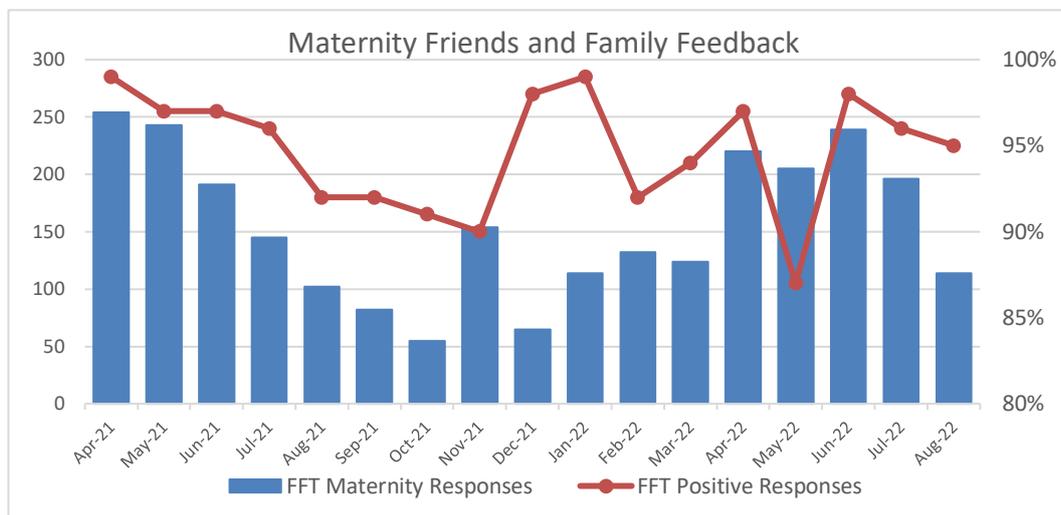


	<p>Trends in stillbirths since 2018 in LMNS:</p> <p>12 month rolling Stillbirth Rate (per 1000 births)</p> <p>— KM LMNS — MTW</p>
<p>Themes and Trends from investigations and case reviews</p>	<ul style="list-style-type: none"> • Inconsistent compliance with growth assessment protocol – on risk register and action taken to increase compliance with additional update training sessions and inclusion in new Fetal Surveillance Training Day • Staff shortages impacting services. Home birth service currently suspended and occasional closure of birth centres required to enable redeployment of staff to TWH
<p>Risk Register</p>	<ul style="list-style-type: none"> • 2 red risks: <ul style="list-style-type: none"> - Lack of maternity training days to meet mandatory training requirements. Escalated through SDR, currently a cost pressure to division - Delayed induction of labour (new risk), due to insufficient midwifery staff to provide care following transfer to delivery suite
<p>Complaints</p>	<p>Number of new and themes from new formal complaints 7 amber complaints received Main themes:</p> <ul style="list-style-type: none"> ▪ Communication about care planning ▪ Incorrect treatment / procedures not followed ▪ Concern about care <p>Key themes identified from closed complaints 11 Complaints closed 2 upheld, 2 partially upheld, 7 not upheld Themes:</p> <ul style="list-style-type: none"> ▪ Ensure good communication and explanations, in both planned and emergency procedures and contacts ▪ Concerns about lack of support and care in labour due to staffing pressures and covid restrictions

Friends and Family feedback

- The number of responses averaged 155 per month with good response rates being achieved despite recent staffing challenges. Positive feedback range 95-96%
- Work continues on the action plan developed following analysis of CQC Maternity Survey 2021, pending appointment of new Maternity Voices Partnership Chair

Trends in FFT feedback:



Recommendations and Actions

- Continue roll out of fetal surveillance training to support learning and decision making
- Increase opportunities for multi-disciplinary training in maternity and neonatal emergency scenarios
- Collaboration with LMNS projects to review fetal monitoring and induction of labour guidance and develop system wide guidelines
- Contribution to LMNS peer review group to provide mutual assurance and support with Ockenden and CNST actions
- Project to implement integrated Growth assessment charts into the maternity information system, to support staff with accurate plotting and prompts for decision making, has begun with support required from IT department

Progress with Implementation of Saving Babies Lives Care Bundle version 2	Element	Compliance data		Actions
	Smoking in pregnancy	CO monitoring at booking	95%	SiP midwife working with community and ANC teams to improve compliance
		CO monitoring at 36 weeks	87%	
	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	89%	
	Fetal monitoring	Staff attended annual MDT fetal monitoring training	71%	Training challenges due to staffing issues and high activity – action plan in place
		Lead midwife (0.6 wte) and Lead obstetrician (0.1 wte) appointed	100%	Obstetrician appointed Midwife appointed
	Preterm births	Live births <34 weeks having full dose of steroids within 7 days of birth	57%	All cases reviewed to ensure steroids given appropriately
		Live births occurring more than 7 days after first course of steroids	6%	All cases reviewed to ensure steroids given appropriately
Singleton live births < 30 weeks receiving MgSO4 within 24 hours before birth		86%	All cases reviewed to ensure MgSO4 given appropriately	
Women giving birth in an appropriate care setting for their gestation		100%	All cases reviewed to ensure transferred considered appropriately	
Progress with maternity multidisciplinary staff training	Compliance with maternity specific training		July 2022	
	Fetal monitoring		70%	
	Neonatal resus (PROMPT*)		76%	
	Practical Obstetric Multi-professional Training (PROMPT)		79%	
	Gap & Grow- E learning (annual update)		64%	
	Gap & Grow workshop		96%	
	Avoiding Term Admissions to Neonatal Unit (ATAIN)		92%	
<p>Staffing challenges have continued to impact compliance across a number of topics. Management team taking a focused approach to releasing staff for mandatory training. The team are also looking at ways to improve the re-booking process when training days are cancelled.</p>				

Progress with clinical workforce planning	Workforce	Latest review	Progress with actions
	Maternity workforce	Senior management safety review October 2021 Workforce review, H O'Dell, Maternity Clinical Advisor Clinical Delivery and Networks, Maternity NHS England and NHS Improvement-South East, March 2022	<i>Ockenden money is supporting some of the identified shortfall with a further business case being developed to support remaining shortfall</i> <i>Plan for further review Sept / October 22</i>
	Obstetric medical workforce	Review September 2021	<i>New consultants in post and job plans provide increased weekend cover</i>
	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	<i>Business case in progress for NNU BCP to meet BAPM recommendations</i>
Maternity Continuity of Carer Plan	<p>Established Phoenix Young Parent Continuity Team continues to work effectively.</p> <p>Crowborough community based continuity teams dis-established due to staffing pressures and are not currently able to be re-established until safe staffing numbers are achieved.</p> <p>MCoC – long term plan timeline trajectory is yet to be agreed. Under review by Divisional Triumvirate</p>		
Ockenden Report Recommendations	<p>An Insight Visit by the Regional Maternity Team took place in July to review evidence of compliance and actions to meet recommendations from Ockenden Part 1.</p> <p>A draft report has been received and reviewed for accuracy – full report to be shared when available.</p> <p>Recommendations from Ockenden Final Report will have a detailed review following publication of the Kirkup Report into Maternity Services in East Kent, as proposed by the Regional Maternity Team.</p> <p>Initial review of 89 sub-actions from the recommendations identified:</p>		

		Sub-actions	%
	Compliant	29	33%
	Partially compliant	34	38%
	Non-compliant	20	22%
Perinatal Quality & Safety Dashboard	Included in appendices		
Related Regulatory Requirements	Response to the Ockenden Report, December 2020 & April 2021 CNST Maternity Incentive Scheme – year four, May 2022 Transforming perinatal safety, December 2020		
Author:	Rachel Thomas, Deputy Head of Midwifery and Gynaecology Susan Powley, Matron for Governance, IT & Projects		
Paper reviewed by:	Maternity Board Divisional Board - Governance		
Action Required by the Trust Board			

Update on the West Kent and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)	Director of Strategy, Planning and Partnerships
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The enclosed report provides information and updates on the establishment of the Kent & Medway Integrated Care Board (ICB) and the West Kent Health Care Partnership (WKHCP).

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 18/10/22

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

Information and discussion to facilitate feedback between MTW, the HCP and the wider system.

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

West Kent HCP and K&M ICB update
October 2022

Kent & Medway Integrated Care Board

The Kent and Medway ICB replaced the Clinical Commissioning Group on 1st July 2022. The majority of posts are now confirmed (below):

- Chief Finance Officer – Ivor Duffy
- Chief Medical Officer – Dr Kate Langford
- Executive Director Corporate Governance – Mike Gilbert
- Chief of Staff – Natalie Davies
- Chief Nurse – Eileen Sills
- Chief Strategy Officer – Vincent Badu
- Chief People Officer – Rebecca Brad
- Interim Chief Digital Officer – Morfydd Williams
- Chief Delivery Officer - Lee Martin
- Interim Executive Director Communications and Engagement – Matt Tee

The areas each executive is responsible for is attached at Appendix 1.

Updates

There was a provider collaborative meeting on Friday 7th October attend by Miles and David Highton from the Trust. The session covered the principles of working together, possible areas for joint working and consideration of models in other areas. There will be discussions to develop this further over the coming weeks.

The ICB are planning a 'Together, we can' symposium on Friday 28th October which will be focussed on bringing together senior leaders and influencers from across Kent and Medway to consider how we develop the **Together, we can** movement that will build trust, establish and strengthen relationships between individuals, communities and organisations.

In particular, it will:

- set out the stall of the new integrated care landscape
- consider the interdependencies of various partnerships and how we might work together
- look to develop a collective vision
- start to think about the practical steps we need to take in delivering a Kent and Medway Integrated Care Strategy for everyone.

MTW will be sending 3 representatives; Maureen Choong, Neil Griffiths and Rachel Jones.

West Kent Health & Care Partnership Highlights

The partnership is working to develop a stronger neighbourhood team model based on the GP Primary Care Network areas to address the high demands and to better use the community services and additional practice roles. This work is being explored practically through the local development of a mental health Multi-Disciplinary Team in the Weald area. The area model for integrated neighbourhood teams has been discussed in the last 6 months by the HCP executive group as part of an NHSE place development programme and will further be explored at the away day on 20th October.

Conversations continue around the delegation of responsibility to place. The ICB have stated a vision for HCPs that describes a joint ambition that services are co-designed, commissioned and delivered in partnership with local communities. Services will reflect their lives, their needs and

their lived experiences. The H&CPs will be responsible for bringing together these plans and ensuring they are delivered. They will:

- work towards becoming Integrated Care Organisations over the next 5 years
- commission and deliver at place level activity which addresses the wider determinants of health
- develop a compelling and widely owned vision for tackling health inequalities
- join up commissioning and planning functions
- develop asset-based approaches which build on the strengths of these communities
- and invest in systems leadership - a collaborative approach to leadership.

Kent and Medway partners see Health and Care Partnerships as the “engine rooms” of our ICS.

The ICB have also outlined the responsibilities that they will retain and therefore would not be delegated to HCP’s and these are:

- Strategy
- System Leadership and interface with NHSE and system
- Oversight and Assurance
- Transformation
- System Commissioner
- Facilitation

Work is underway to consider the remaining functions currently supported by the ICB including the resource currently allocated to deliver those functions with respect to delegation. West Kent HCP has proposed the delegations in our area is concluded by the end of quarter 4 to ensure we minimise disruption over winter. Medway and East Kent will aim to conclude their delegation process this calendar year. The process will involve:

- Partner and staff engagement workshops
- Agreement on proposed areas for delegation
- Agreement on support resources required to deliver the delegation
- MOU setting out the formal delegation and any staff movements
- Formal staff agreements e.g. secondments

Meanwhile the HCP team continue to support partners to deliver a range of programmes. Significant developments this quarter include:

- Agreement on 3 longer term priorities: 1) Sustainable Primary Care and 2) Effective Discharge / Flow and 3) Preventative priority of food and income poverty
- Completion of an executive system leadership programme
- Agreement of the initial Population Health Management (PHM) approach and priorities for action including: Updating the West Kent Needs Assessment, implementing our Health inequalities projects, establish a central repository for West Kent data, agree a strategic approach to engagement and coproduction (complete), develop staff skills and understanding of how to apply PHM approach.
- Developed a cross organisational understanding of West Kent workforce pressures
- All West Kent GP practices have full oversight of their demand and capacity following an extensive programme to configure, embed and understand the Apex tool designed.
- Put in place plans to deliver extended virtual ward offer by December 2022
- Voluntary sector provider commissioned to develop a West Kent Voluntary Sector Alliance to support the work of the WK HCP.

WKHCP Risks and Challenges

The 2 top rated red risks are:

Workforce - All providers are identifying capacity issues with staffing core services and 2022/23 planning. Of particular note are ongoing shortages of domiciliary care staff in social care. primary care staffing capacity to meet increasing demands presenting at practices also raised as an issue and nursing capacity pressures in secondary care.

Demand pressures - Pressures across WK system arising from range of sources including: planned care backlog; Covid/Post Covid related demand; new ways of working i.e. VCA/remote consultations, vaccination/booster programme and urgent care demand.

Appendix 1

Chief Medical Officer
Kate Langford

Chief Nursing Officer
Dame Eileen Sills

Chief Finance Officer
Ivor Duffy

Chief People Officer
Rebecca Brad

Executive Director of
Communications and
Engagement
Matt Tee

Development and delivery of long-term clinical strategy	Development and delivery of long-term clinical strategy	System financial strategy and plans	System people strategy and plans	Communications and engagement strategy
Clinical priorities to reduce unwarranted variation	Quality Assurance and improvement	Internal and external audit	System workforce planning and information	Communications and stakeholder relations ICB and ICS
Clinical lead for Population health management (PHM)	Quality improvement support (across HCPs and providers)	Contracting and procurement	System leadership development and OD	Patient and Public Engagement (ICS NHS body & system wide programmes)
Clinical leadership of health inequalities strategy	Infection prevention and control	System open book accounting	Leadership and co-ordination for system workforce transformation	Citizen engagement and public consultation
Clinical leadership of clinical networks	Safeguarding	New contractual forms	Careers, role development, volunteering & education sector engagement	Reputation management and promotion
Leading development of clinical workforce (with CNO)	Leading development of clinical workforce (with CMO)	Capital planning and management	Health and wellbeing inc well-being guardian	Organisational communications
Clinical input into strategic change agendas (with CNO)	Clinical input into strategic change agendas (with CMO)	Risk sharing models – revenue and capital	Equality, diversity and inclusion	
Quality and patient safety (with CNO)	Quality and patient safety (with CMO)	Co-ordination of system capital bids	Talent and succession planning	
Clinical leadership of dentistry and optometry	Programmes – Maternity and CHC	Contract analytics	Primary care education and workforce development	
Research and development	Vaccination programme (COVID and flu)	Financial productivity and efficiency	Care sector development and change programmes	
Clinical input into EPRR	Clinical input into EPRR	ICB/ICS procurement	Collaborative Trust workforce transformation programmes	
Medicines Optimisation	Caldicott		ICB organisational human resources and OD function	

Chief Strategy Officer Vincent Badu	Chief Delivery Officer Lee Martin	Interim Chief Digital Officer Morfydd Williams	Executive Director of Corporate Governance Mike Gilbert	Chief of Staff Natalie Davies
System strategy and 5-year plan – vision, purpose, priorities, ambition and outcome setting	Integrated population health and commissioning	System digital strategy including place and organisational strategy	System governance inc. place	Horizon scanning/ understanding of forthcoming policy direction
NHSE/I relationship manager	NHSEI relationship manager	Data and analytics ethics strategy	Organisational governance inc Board assurance and reporting structure	Strategic support to the Chief Executive on range of activities
HWB/HOSC/HASC relationship	Operational and strategic planning	Leadership and co-ordination for digital transformation	Risk management	Strategic PMO coordination function
Architecture & interactions	Place and provider performance management and pathway improvement - supporting HCPs and providers with their responses to the System Oversight Framework	Digital and data programme delivery	Freedom to Speak Up	System development inc provider collaboratives
With system development team support work to HCP and provider collaborative development	Leadership of the commissioning functions:	GP IT operating model	Company Secretary	System programme assurance (monitoring delivering of programmes and impact)
Specialist Services transformation inc pathology and imaging	Core GMS contract and primary care commissioning, cancer, CYP, MH, LDA personalised care and community care	Digital and data workforce development	Legal, indemnity and non-clinical service contracts	Performance monitoring and assurance and NHSEI relationship for oversight System Oversight Framework – SOF (System, HCP and provider oversight)
ICS Partnerships	Specialist and POD	PHM analytics	Estate – ICS body and system strategy and delivery	Delivery and oversight of complex business projects and activities for CEO
Strategic Planning PHM	Planned care	Performance, quality, and improvement analytics	Emergency planning, resilience & response (ICS body and K&M)	Business and operational support function
Social care strategy	HCP facing teams	Corporate IT support (ICB body)	Environmental sustainability	ICB Strategy
Strategic change/ reconfiguration		Information Governance (inc SIRO role and DPO responsibilities)	Corporate compliance including risk, audit, FoI and complaints;	
		Address digital exclusion		

**The outcome of the further work on the
Divisional Improvement Projects**

Director of Strategy, Planning and Partnerships

The enclosed report provides information and updates on the outcome of the Trust Strategic Deployment Review process which includes the divisional contribution to delivery and the agreed list of divisional projects.

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 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

Strategy Deployment Review 2022/23 Update

Rachel Jones
Executive Director Strategy, Planning & Partnerships

October 2022

Board agreed vision goals and breakthrough objectives for 2022/23

Strategic Theme	Vision Goals	Strategic Theme Lead
Patient Experience	To reduce the overall number of complaints or concerns by 3 inpatient complaints by Datix each month	Joanna Haworth
Patient Safety and Clinical Effectiveness	Reduction in incidents resulting in harm by 7.5% by June 2023	Peter Maskell
Patient Access	Achieve the Trust RTT Trajectory by March 2023	Sean Briggs
Systems and Partnerships	Decrease the number of occupied bed days for patients identified as medically fit for discharge.	Rachel Jones
Sustainability	Delivery of financial plan, including operational delivery of capital investment plan	Steve Orpin
People	Reduce the Trust wide vacancy rate to 12% by the end of the financial year 2022-3	Sue Steen

Strategic Theme	Breakthrough Objectives	Project Lead
Patient Experience	To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience	Richard Gatune
Patient Safety and Clinical Effectiveness	Reduction in the rate of patient falls to 6.5 per 1000 occupied bed days by June 2023	Richard Gatune
Patient Access	To achieve the planned levels of new outpatients activity (shown as a % 19/20)	Sarah Davis
Systems and Partnerships	To increase the number of patients leaving our hospitals by noon on the day of discharge	Sarah Smith
Systems and Partnerships	No patient resides in an acute hospital bed who needs care that can be provided in another setting	Nick Baber
Sustainability	To reduce the amount of money the Trusts spends on premium workforce spend	Hannah Ferris
People	Reduce turnover to 12% by March 2023	Rob Henderson

Division agreed contribution to the Trust goals and objectives

Strategic Theme	Vision Goals	Medicine	Surgery	Cancer	WCSH	CCS	How many Divisions are driving ?
Patient Experience	To reduce the overall number of complaints or concerns by 3 inpatient complaints by Datix each month	Watch	Watch	Watch	Watch	Watch	0
Patient Safety and Clinical Effectiveness	Reduction in incidents resulting in harm by 7.5% by June 2023	Watch	Watch	Watch	Watch	Watch	0
Patient Access	Achieve the Trust RTT Trajectory by March 2023	Watch	Watch	Watch	Watch	n/a	0
Systems and Partnerships	Decrease the number of occupied bed days for patients identified as medically fit for discharge.	Watch	Watch	Watch	Watch	n/a	0
Sustainability	Delivery of financial plan, including operational delivery of capital investment plan	Watch	Watch	Watch	Watch	Watch	0
People	Reduce the Trust wide vacancy rate to 12% by the end of the financial year 2022-3	Watch	Watch	Watch	Watch	Watch	0
Strategic Theme	Breakthrough Objectives	Medicine	Surgery	Cancer	W&C	CCS	How many Divisions are driving ?
Patient Experience	To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience	Watch	Watch	Watch	Driver	Driver	2
Patient Safety and Clinical Effectiveness	Reduction in the rate of patient falls to 6.5 per 1000 occupied bed days by June 2023	Watch	Watch	Watch	Watch	n/a	0
Patient Access	To achieve the planned levels of new outpatients activity (shown as a % 19/20)	Watch	Watch	Driver	Watch	Driver	2
Systems and Partnerships	To increase the number of patients leaving our hospitals by noon on the day of discharge	Watch	Driver	Watch	Watch	n/a	1
Sustainability	To reduce the amount of money the Trusts spends on premium workforce spend	Driver	Watch	Driver	Driver	Driver	4
People	Reduce turnover to 12% by March 2023	Driver	Driver	Driver	Driver	Driver	5

Divisional Driver Metrics

Strategic Theme	Related Divisional Metrics	Driver/ Watch	Division
Patient Access	% initial assessment within 15 mins of arrival in department	Driver	Medicine and Emergency Care
Patient Access	Reducing Cancer 62 day backlog: Lung	Driver	
Sustainability	Realising Divisional CIP Target	Driver	
Patient Experience	Percentage of complaints responded to within target	Driver	Surgery
Patient Access	Improve outpatient utilisation in General surgery, T&O and Ophthalmology	Driver	
Patient Access	Reduce the DNA rate in OPA for General Surgery, ENT and Ophthalmology	Driver	
Sustainability	Realising Divisional CIP Target	Driver	
Patient Safety and Clinical Effectiveness	Radiotherapy treatment turnaround times – from signed EAS to start of treatment. Average turnaround for First Definitive Treatments	Driver	Cancer
Patient Safety and Clinical Effectiveness	Radiotherapy treatment turnaround times - from signed EAS to start of treatment. Average turnaround for Subsequent Treatments	Driver	
Patient Access	To achieve 80% completeness of data for 28 day faster diagnosis	Watch	
Patient Access	Reduction of Haematology Patient Backlog to 2 patients and maintain	Driver	
Sustainability	Realising Divisional CIP Target	Driver	
Patient Experience	Complaints TAT in maternity directorate	Driver	Women and Children's
Patient Safety and Clinical Effectiveness	Women waiting for Induction of Labour	Watch	
Patient Access	Paediatric directorate focus to achieve 85% outpatient utilisation.	Driver	
Sustainability	Realising Divisional CIP Target	Driver	
Patient Safety and Clinical Effectiveness	Histology Biopsy Turnaround Time - Reported within 7 days	Driver	Core Clinical Services
Patient Access	Radiology TAT (days) MRI and CT Scans – 2ww waits	Driver	
Patient Access	Radiology DM01 contribution achieved	Driver	
Sustainability	Realising Divisional CIP Target	Driver	

Agreed Corporate Projects

Corporate Projects 2022/23	Project Goal	Project Strategic Lead
Outstanding Care	Establish a robust quality framework across the trust aligned to the KLOEs and EPOC	Joanna Haworth
PFIS	Implementation of training in Continuous Improvement to front line teams	Joanna Haworth
EPMA	Ensure the Trust has a robust system that delivers safe, high quality and cost-effective system to order prescriptions across MTW (excluding chemotherapy) This project will target all inpatient adult wards and the ED across MTW	Peter Maskell
Safer Better Sooner	Ensure patient discharges are effective across 7 days, specifically focussing on weekend discharges	Sean Briggs
Outpatient pathways and procedures	Improve patient-provider communication through secure messaging, and increased patient participation in healthcare decisions Embed consistent delivery of new standard operating procedures for OP across all OP services	Sean Briggs
Workforce Supply	Develop the organisational policy and change management approach to create an adaptable and agile workforce designed for the health care needs of the future Identify alternative routes into health care with less reliance on overseas recruitment	Sue Steen
Leadership Development	Evolve the Exceptional Leadership programme to extend to all people leaders in the Trust (Band 3 upwards) Align all people development processes e.g. appraisals, training needs analysis, talent and succession planning Improve staff experience of being led and line managed	Sue Steen

Agreed Divisional Projects (1)

Strategic Theme	Divisional Projects 2022/23	Division
Patient Experience	Cardiology Reconfiguration of cardiology inpatients and cardiac catheter laboratory services on a single site	Medicine and Emergency Care
Patient Experience	Virtual Wards	
Patient Safety and Clinical Effectiveness	Digestive Diseases Unit (DDU) – Gastro Centralisation Reconfigure Gastroenterology services to Maidstone to provide 7 day service	
Patient Access	UTC	
Patient Access	7 Day Service Phase 3 of 3 year project	
Systems and Partnerships	Stroke Reconfiguration Delivery of Kent and Medway HASU	
Sustainability	Cardiology Renewal and Replacement Strategy Cardiology equipment to be procured under a managed service contract	
Patient Safety and Clinical Effectiveness	Surgical Robot A feasibility study of the effectiveness of a surgical robot on patient outcomes	Surgery
Patient Safety and Clinical Effectiveness	IPRO Digitised Anaesthetic System Fully digitised anaesthetic pathway through theatres	
Patient Access	Sunrise Surgical Care Systems To fully integrate Theatres EPR with scheduling to replace Theatreman system	
Systems and Partnerships	Maidstone Orthopaedic Unit Deliver a three-open-plan-Barn-theatre at Maidstone to provide capacity for 5030 Kent and Medway elective orthopaedic cases per annum	

Agreed Divisional Projects (2)

Strategic Theme	Divisional Projects 2022/23	Division
Patient Safety and Clinical Effectiveness	Same Day Emergency Care Haematology To provide specialist, quality, timely urgent care to Haematology patients	Cancer
Patient Access	Acute Oncology 6 Day Service Extend Acute Oncology service to operate 6 days per week from 9am – 6pm in ED clinical areas on both sites	
Patient Access	Acute Oncology 7 Day Service Full 7 days service to be implemented once suitable clinical space identified	
Systems and Partnerships	East Kent Oncology Development The provision of high quality, safe, compliant and reliable Oncology Service facilities for East Kent through design and co-location of the Oncology Service estate that leads to best practice and improved patient flow and service productivity	
Patient Safety and Clinical Effectiveness	Ockenden Review Maintain compliance with the additional compliance criteria identified by the Ockenden Phase 2 report and Kirkup report	Women and Children's
Patient Safety and Clinical Effectiveness	Gynaecology Improvement Project Implement a GP with Extended Role to support new referrals reducing wait times	
People	WC&SH Peoples Plan Workforce plan to improve staff health, wellbeing and overall satisfaction of working at MTW	
Patient Experience	Radiology Strategy Develop a robust and sustainable Community Diagnostic Centre for West Kent, repatriating outsourced cross-sectional radiology and MRI	Core Clinical Services
Patient Access	Demand and Capacity The development of reliable demand and capacity data across the division, initiating with Haematology and Blood Transfusion	
People	Therapies Service Developments Development of service improvements to improve flow, aligned to Safer Better Sooner	

The monitoring process has begun:

- The Executive Team Strategy Deployment Review meetings are in place monthly. These meetings provide a deep dive into the Corporate goals, objectives and projects with the Executive Leads and have a dual role of challenge and support.
- Divisional Strategy Deployment Review meetings take place monthly. This is where performance against the agreed scorecard is discussed and challenged. Where the metrics' performance is on a negative trajectory the Executive Team will discuss with the Division what countermeasures are in place. This will determine whether a verbal countermeasure summary or a full written countermeasure summary is required for the next meeting.
- The Patient First Improvement System 6 week training and coaching programme has begun. It has been designed to develop our people to solve problems and improve performance in line with the Trust Vision. The first cohort consisted of ward representation from all divisions who will graduate in October 2022.
- Divisional Driver meetings and Unit Leadership meetings to be set up to connect the strategy from board to floor as Patient First Units Graduate.

Medicine and Emergency Care Division Scorecard

	PF Domn.	Scope Division or Trust	Metric	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	People	Division	Reduce the Trust wide vacancy rate to 12% by the end of the financial year 2022-23	Watch			Verbal CMS
	Patient safety & Clinical Effectiveness	Division	Reduction in incidents resulting in harm by 7.5% by June 2023	Watch			Note Performance
	Patient Access	Division	Achieve the Trust RTT Trajectory by March 2023	Watch			Full CMS
	Patient Experience	Division	To reduce the overall number of complaints or concerns each month	Watch			Note Performance
	Systems	Division	Decrease the number of occupied bed days for patients identified as medically fit for discharge (shown as rate per 100 occupied beddays)	Watch			Verbal CMS
	Sustainability	Division	Delivery of financial plan, including operational delivery of capital investment plan.	Watch			Verbal CMS
Breakthrough Objectives	People	Division	Reduce turnover to 12% by March 2023	Driver			Full CMS
	Patient safety & Clinical Effectiveness	Division	Reduction in the rate of patient falls to 6.5 per 1000 occupied bed days by June 2023	Watch			Note Performance
	Patient Access	Division	To achieve the planned levels of new outpatients activity (shown as a % of 19/20)	Watch			Verbal CMS
	Patient Experience	Division	To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience.	Watch			
	Systems	Division	To increase the number of patients leaving our hospitals by noon on the day of discharge	Watch			Verbal CMS
	Sustainability	Division	To reduce the amount of money the Trusts spends on premium workforce spend - £000	Driver			Full CMS
Divisional Priority Metrics	Patient Access	Division	% Initial Assessment within 15 mins of Arrival in Department	Driver			Full CMS
	Patient Access	Division	Cancer 62 Day Standard Backlog : Lung	Driver			Full CMS
	Sustainability	Division	CIP Target	Driver			Full CMS

Surgery Division Scorecard

	PF Domn.	Scope Division or Trust	Metric	Watch / Driver/ Information	Variation	Assurance	CMS Actions
Vision Goals / Targets	People	Division	Reduce the Trust wide vacancy rate to 12% by the end of the financial year 2022-23	Watch			Note Performance
	Patient safety & Clinical Effectiveness	Division	Reduction in incidents resulting in harm by 8.2% by March 2023	Watch			Note Performance
	Patient Access	Division	Achieve the Trust RTT Trajectory by March 2023	Watch			Verbal CMS
	Patient Experience	Division	To reduce the overall number of complaints or concerns each month	Watch			Note Performance
	Systems	Division	Decrease the number of occupied bed days for patients identified as medically fit for discharge (shown as rate per 1000 occupied beddays)	Watch			
	Sustainability	Division	Delivery of financial plan, including operational delivery of capital investment plan - £000	Watch			Note Performance
Breakthrough Objectives	People	Division	Reduce Turnover Rate to 12% by March 2023	Driver			Verbal CMS
	Patient safety & Clinical Effectiveness	Division	Reduction in the rate of patient falls to 6.36 per 1000 occupied bed days by March 2023	Watch			Note Performance
	Patient Access	Division	To achieve the planned levels of new outpatients activity (shown as a % 19/20)	Watch			Note Performance
	Patient Experience	Division	To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience.	Watch			Verbal CMS
	Systems	Division	To increase the number of patients leaving our hospitals by noon on the day of discharge	Driver			Verbal CMS
	Sustainability	Division	Reduce the amount of money the Trusts spends on premium workforce spend - £000	Watch			Verbal CMS
Divisional Priority Metrics	Patient Access	Division	Outpatient New DNA Rate	Driver			Full CMS
	Patient Access	Division	OP Clinic Utilisation	Driver			Full CMS
	Patient Experience	Division	% complaints responded to within target - Division only	Driver			Verbal CMS
	Sustainability	Division	CIP Target - £000 (Monthly Target for first six months April to Sept)	Driver			Full CMS

Cancer Division Scorecard

	PF Domn.	Scope Division or Trust	Metric	Watch / Driver / Information	Variation	Assurance	CMS Actions
Vision Goals / Targets	People	Division	Reduce the vacancy rate to 12% by the end of the financial year 2022-3	Watch			Full CMS
	Patient safety & Clinical Effectiveness	Division	Reduction in incidents resulting in harm by 8.2% by March 2023	Watch			Note Performance
	Patient Access	Division	Achieve the Trust RTT Trajectory by March 2023	Watch			Note Performance
	Patient Experience	Division	To reduce the overall number of New complaints or concerns each month	Watch			Note Performance
	Systems	Division	Decrease the number of occupied bed days for patients identified as medically fit for discharge (shown as rate per 1000 occupied beddays)	Watch			Note Performance
	Sustainability	Division	Delivery of financial plan, including operational delivery of capital investment plan. £000	Watch			Note Performance
Breakthrough Objectives	People	Division	Reduce Turnover Rate to 12% by March 2023	Driver			Full CMS
	Patient safety & Clinical Effectiveness	Division	Reduction in the rate of patient falls to 6.36 per 1000 occupied bed days by March 2023	Watch			Note Performance
	Patient Access	Division	To achieve the planned levels of new outpatients activity (shown as a % 19/20)	Driver			Note Performance
	Patient Experience	Division	To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience (Cancer)	Watch			Verbal CMS
	Systems	Division	To increase the number of patients leaving our hospitals by noon on the day of discharge	Watch			Verbal CMS
	Sustainability	Division	Reduce the amount of money the Trusts spends on premium workforce spend - £000	Driver			Verbal CMS
Divisional Priorities	Patient safety & Clinical Effectiveness	Division	Radiotherapy treatment turnaround times - from signed EAS to start of treatment. Average turnaround for First Definitive Treatments	Driver			Verbal CMS
	Patient safety & Clinical Effectiveness	Division	Radiotherapy treatment turnaround times - from signed EAS to start of treatment. Average turnaround for Subsequent Treatments	Driver			Verbal CMS
	Patient Access	Division	28 day Faster diagnosis completeness of data - to achieve 80% completeness of data by end of October 2021.	Watch			Note Performance
	Patient Access	Division	Haematology Backlog - reduction of numbers of patients on the 62d backlog to 2 and maintain	Driver			Full CMS
	Sustainability	Division	CIP - Increase Private Patient income to 1 million by the end of March 2023	Watch			Verbal CMS

Exceptional people, outstanding care

Women's and Children Division Scorecard

	PF Domn.	Scope Division or Trust	Metric	Watch / Driver/ Information	Variation	Assurance	CMS Actions
Vision Goals / Targets	People	Division	Reduce the Trust wide vacancy rate to 12% by the end of the financial year 2022-3	Watch			Note Performance
	Patient safety & Clinical Effectiveness	Division	Reduction in incidents resulting in harm by 7.5% by June 2023	Watch			Note Performance
	Patient Access	Division	Achieve the Trust RTT Trajectory by March 2023	Watch			Full CMS
	Patient Experience	Division	To reduce the overall number of complaints or concerns	Watch			Note Performance
	Systems	Division	Decrease the number of occupied bed days for patients identified as medically fit for discharge - Gynae Only (LIMITED DATA)	Watch			
	Sustainability	Division	Delivery of financial plan, including operational delivery of capital investment plan - £000	Watch			Note Performance
Breakthrough Objectives	People	Division	Reduce Turnover Rate to 12% by March 2023	Driver			Full CMS
	Patient safety & Clinical Effectiveness	Division	Reduction in the rate of patient falls to 6.5 per 1000 occupied bed days by June 2023 - Gynae only.	Watch			Note Performance
	Patient Access	Division	To achieve the planned levels of new Gynae and Paediatric outpatients activity (shown as a % 19/20)	Watch			Verbal CMS
	Patient Experience	Division	To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience. (Gynae Only)	Driver			
	Systems		To increase the number of Gynae patients leaving our hospitals by noon on the day of discharge	Watch			Verbal CMS
	Sustainability	Division	Reduce the amount of money the Trusts spends on premium workforce spend - £000	Driver			Verbal CMS
Divisional Priority Metrics	Patient safety & Clinical Effectiveness	Division	Women waiting for Induction of Labour (Trust Target, 4hours and only those suitable)	Watch			
	Patient safety & Clinical Effectiveness	Division	Women waiting for induction of Labour (National Target, 2 hours and only those suitable)	Watch			
	Patient Experience	Division	Complaints % Responded to within target for Womens Services	Driver			Verbal CMS
	Patient Access	Division	Outpatient Utilisation - Paediatrics to achieve 85%	Driver			Full CMS
	Sustainability	Division	CIP Target - £000 (Monthly Target for first six months April to Sept)	Driver			Full CMS

Core Clinical Services Division Scorecard

	PF Domn.	Scope Division or Trust	Metric	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	People	Division	Reduce the Trust wide vacancy rate to 12% by the end of the financial year 2022-3	Watch			Note Performance
	Patient safety & Clinical Effectiveness	Division	Reduction in incidents resulting in harm by 8.2% by March 2023	Watch			Verbal CMS
	Patient Access	Division	Achieve the Trust RTT Trajectory by March 2023	N/A	N/A	N/A	N/A
	Patient Experience	Division	To reduce the overall number of complaints or concerns each month	Watch			Note Performance
	Systems	Division	Decrease the number of occupied bed days for patients identified as medically fit for discharge.	N/A	N/A	N/A	N/A
	Sustainability	Division	Delivery of financial plan, including operational delivery of capital investment plan (variance to plan)	Watch			Note Performance
Breakthrough Objectives	People	Division	Reduce Turnover Rate to 12% by March 2023	Driver			Full CMS
	Patient safety & Clinical Effectiveness	Division	Reduction in the rate of patient falls to 6.36 per 1000 occupied bed days by March 2023	N/A	N/A	N/A	N/A
	Patient Access	Division	To achieve the planned levels of new outpatients activity (shown as a % 19/20)	Watch			Note Performance
	Patient Experience	Division	To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience	Driver			
	Systems	Division	To increase the number of patients leaving our hospitals by noon on the day of discharge	N/A	N/A	N/A	N/A
	Sustainability	Division	Reduce the amount of money the Trusts spends on premium workforce spend - £000	Driver			Verbal CMS
Divisional Priority Metrics	Patient Access	Division	Radiology DM01 contribution achieved	Driver			Full CMS
	Patient safety & Clinical Effectiveness	Division	Histology Biopsy Turnround Time - Reported within 7 days	Driver			Full CMS
	Sustainability	Division	CIP Target - £000 (Monthly Target for first six months April to Sept)	Driver			Full CMS
	Patient Access	Division	Radiology TAT (days) 2WW only (MRI and CT Scans)	Driver			Verbal CMS

Trust Board meeting – October 2022

**Quarterly report from the 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 receipt at 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 Q2 (July – September 2022)

Action Requested / Recommendation

Discuss the content and recommendations outlined in the report.

Summary

This is the second quarter report for 2022 presented to the board by the Freedom To Speak Up Guardian (FTSUG). The purpose of this report is to identify trends, issues; and provide a progress report on the Freedom to Speak Up function.

An interim Deputy Freedom To Speak Up Guardian, Natalie Hayward, has been appointed as maternity cover for a period of one year commencing in April 2022.

The Freedom to Speak Up Guardian received **thirty-seven** concerns raised in the last quarter. The trend continues to be that the majority of concerns raised relate to staff who feel unfairly treated or harassed at work, with **eighteen** cases logged in the respect and dignity category. Concerns were received through various routes including: direct contact with the FTSUG, anonymous portal logs, safe space champions; and speaking up through the exit interview process.

Author: Natalie Hayward, Interim Deputy Freedom To Speak Up (FTSU) Guardian

Date: October 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
Deputy Freedom To Speak Up Guardian	Natalie Hayward (Maternity Cover for Ola Gbadebo-Saba)

The FTSU Agenda is to:

- Protect patient safety and quality are
- Improve experience of workers
- Promote learning and improvement

By ensuring that:

- Workers are supported in speaking up
- Barriers to speaking up are addressed
- Encourage a positive culture of speaking up
- Ensure issues raised are used as an opportunity for learning and development

2022/23 year to date data collection

Quarter	Month/Year	MGH	TWH	Satellite Sites	Unknown	No. of Contacts
Q1	April-June 2022	7	9	2	5	23
Q2	July – September 2022	7	13	8	9	37

In quarter two of 2022, **thirty-seven** cases were logged with FTSU. Of these, **seven** cases relate to Maidstone General Hospital and **thirteen** cases relate to Tunbridge Wells Hospital. There were **eight** cases received from satellite sites and **nine** further cases from an unknown location. We have seen a definite increase in cases from Tunbridge Wells hospital with the majority of cases being raised this quarter coming from staff working at Tunbridge Wells. In previous years it was felt that the number of cases being raised was disproportionately smaller at Tunbridge Wells than Maidstone Hospital. This increase demonstrates a greater understanding of the FTSU function and that it is reaching a wider group of staff at MTW.

Of the **sixty** total cases for the YTD; **eighteen** are currently open and **two** remain open from the previous year.

When reviewing the data submitted it shows that the majority of the concerns received in quarter two have been raised by staff working in Administration, Clerical, Maintenance and Ancillary. See appendix A.

A comparison analysis on data from the same quarter (Q2) in previous years shows a decrease of the total number of cases from **fifty-three** in 2021 to **thirty-seven** in 2022. However, this is a marked increase on twenty-three in 2020. The decrease in numbers between 2021 and 2022 can be partially explained by a drop in concerns from a particular area that raised **eighteen** concerns in 2021 and when the same was visited in 2022 by the deputy freedom to speak up guardian **eight** staff had concerns that were raised. See appendix B.

Themes/Issues

Theme	Number
Patient Safety	6
Bullying/ Harassment	18
Fraud	0
Health & Safety	5
*Other	8
Total	37

*Breakdown of 'Other' category	Number
Out of hours food available	1
Management visibility	1
TUPE Process	1
Workload, lack of support	1
Office Space	1
Infection Control	2
Staffing; annual leave	1
Total	8

The themes reported on in this paper, that were raised to FTSUG, continue to identify that a majority of staff concerns centre around respect and dignity issues. It is worth noting that **eight** of the **eighteen** concerns raised around dignity and respect pertain to a specific area which the Guardian has escalated and continues to work with the HRBP and staff concerned to resolve, a further **seven** cases raise similar concerns where staff feel undermined and unfairly treated at work by their management team. The individuals who have raised these concerns have all asked to remain anonymous

as they fear that they may suffer a detriment to their career for speaking up. The Guardian is working with colleagues to address these concerns without compromising confidentiality.

The cases that relate to patient safety concerns were all escalated to the appropriate channels. **Two** cases have been closed with the staff and guardian satisfied that the concerns raised were appropriately addressed. The remaining **four** cases have been escalated to senior leaders and remain open whilst we await assurances that the concerns have been addressed.

Exit interviews were conducted by the deputy freedom to speak up guardian which were requested by a number of staff in Q2. The staff raised similar reasons for leaving with issues around unsustainable workloads, a poor work life balance and lack of support from managers. There was also concerns around dignity and respect shown by managers and senior staff.

When comparing 2022 data with themes arising in Q2 in previous years, the data shows that the types of cases being reported are comparable between 2021 and 2022, considering the decrease in numbers mentioned above. It confirms the trend seen over the last three years showing respect and dignity as the main theme reported to FTSU. See appendix C.

Staff survey results

At the PODCO meeting in September FTSU guardians worked in collaboration with patient safety colleagues in presenting a deep dive report regarding the staff survey results on questions relating to speaking up. This included a comparison with better performing Trusts and the results of speaking up with fellow guardians working within these Trusts. The patient safety team provided their analysis of a survey undertaken on speaking up about patient safety concerns on Datix.

The guardians will continue to work closely with the patient safety team to improve the perception of speaking up and promote the speaking up agenda within the organisation.

Safe Space Champions

Safe Space Champions play a vital role in creating spaces for staff to raise concerns and help to promote a Speaking Up culture at MTW. There was a new cohort of training completed in September, recruiting an additional **five** Safe Space Champions from various areas across the Trust.

Speak Up Training

All the speak up training is now available on the online training platform, this includes;

- **Speak Up**; this is aimed at all staff working at MTW is gives an overview of the Freedom to Speak Up background and how staff can effectively speak up and raise concerns.
- **Listen Up**; this module is specifically aimed at managers and leaders within the organisation on how to listen effectively and ensure that when staff speak up they are adequately supported and their concerns are appropriately addressed.
- **Follow Up**; this new training is aimed at providing senior managers and boards on how to follow up on concerns that have been brought to their attention.

This training is complementary to the promotional work undertaken by the guardians such as the new value based inductions which provide new staff with an overview of the function and how staff can engage with the freedom to speak up guardians. The guardians regularly attend the preceptorship training programmes and give an in-depth talk on speaking up. We also regularly attend and give talks at the various network meetings, doctors stalls and junior doctors forums.

Appendix A: Staff Group who have raised concern

Staff Group	Number
Nursing & Midwifery	5
Medical	1
Unknown	9
AHP's	3
Corporate Services	1
Administration, Clerical & Maintenance/Ancillary	18
Total	37

Appendix B: Comparison of concerns logged and staff group

Total concerns logged	Q2 2020	Q2 2021	Q2 2022
Maidstone	9	11	7
Tunbridge Wells	3	13	13
Satellite Sites	0	18	8
Unknown	11	11	9
Total	23	53	37

Appendix C: Comparison of themes being reported

