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

Thu 22 December 2022, 09:45 - 13:00

Virtually, via Webconference

Maidstone and Tunbridge Wells NHS Trust

Agenda

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

12-1
To receive apologies for absence

David Highton

12-2
To declare interests relevant to agenda items

David Highton

12-3
To approve the minutes of the 'Part 1' Trust Board meeting of 24th November 2022

David Highton

Board minutes, 24.11.22 (Part 1).pdf (10 pages)

12-4
To note progress with previous actions

David Highton

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

12-5
Report from the Chair of the Trust Board

David Highton

N.B. This will be a verbal report.

12-6

Report from the Chief Executive

Miles Scott

Chief Executive's report December FINAL.pdf (3 pages)

Reports from Trust Board sub-committees

12-7
Quality Committee, 14/12/22

Maureen Choong

Summary of Quality C'ttee, 14.12.22.pdf (2 pages)

12-8
Finance and Performance Committee, 20/12/22

Neil Griffiths

Summary of Finance and Performance C'ttee 20.12.22.pdf (1 pages)

12-9
People and Organisational Development Committee, 16/12/22

Emma Pettitt-Mitchell

Summary of People and Organisational Development Cttee, 16.12.22.pdf (2 pages)

12-10
Patient Experience Committee, 01/12/22

Jo Webber

Summary of Patient Experience Committee 01.12.22.pdf (1 pages)

Integrated Performance Report

12-11
Integrated Performance Report (IPR) for November 2022

Miles Scott and colleagues

Integrated Performance Report for November 2022.pdf (37 pages)

Quality Items

12-12

Quarterly mortality data

Peter Maskell

Quarterly mortality data.pdf (19 pages)

12-13
To approve the NHS Resolution maternity incentive scheme submission

Sarah Flint and Rachel Thomas

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

To approve the NHS Resolution maternity incentive scheme submission.pdf (50 pages)

12-14
Review of the updated Infection prevention and control board assurance framework

Sara Mumford

Review of the updated Infection prevention and control board assurance framework.pdf (33 pages)

Systems and Place

12-15
Update on the social care discharge fund and the Trust's winter plan

Sean Briggs

N.B. This will be a verbal report.

12-16
Proposed Trust submission to the independent review of integrated care systems ('Hewitt review')

Rachel Jones and Miles Scott

Proposed Trust submission to the independent review of integrated care systems ('Hewitt review').pdf (6 pages)

Planning and strategy

12-17
Nursing and Midwifery staffing review (annual review)

Jo Haworth

Nursing and Midwifery staffing review (annual review).pdf (14 pages)

Annual Report and Accounts

12-18
To approve the Charitable Fund Annual Report and Accounts for 2021/22

Joanna Webber

To approve the Charitable Fund Annual Report and Accounts for 202122.pdf (40 pages)

12-19
To consider any other business

David Highton

12-20
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 individuals 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).

12-21
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 24TH NOVEMBER 2022, 9:45 AM, VIRTUALLY VIA WEBCONFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board (Chair)	(DH)
	Sean Briggs	Chief Operating Officer	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	Neil Griffiths	Non-Executive Director	(NG)
	Jo Haworth	Chief Nurse	(JH)
	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	(MS)
In attendance:	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)
	Kevin Rowan	Trust Secretary	(KR)
	Sarah Flint	Chief of Service, Women's, Children's and Sexual Health (for item 11-13)	(RP)
	Katie Goodwin	Divisional Director of Operations for Cancer Services and Core Clinical Services (for item 11-16)	(KG)
	Rachel Thomas	Acting Head of Midwifery and Gynaecology (for item 11-13)	(RT)
	Charlotte Wadey	Director of Nursing and Quality Cancer Services (for item 11-16)	(CW)
	Alison Wallington	Charity & Fundraising Manager, Cancer Services (for item 11-16)	(AW)
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]

11-1 To receive apologies for absence

Apologies were received from Wayne Wright (WW), Non-Executive Director. It was also noted that Karen Cox (KC), Associate Non-Executive Director would not be in attendance.

11-2 To declare interests relevant to agenda items

No interests were declared.

11-3 To approve the minutes of the meeting of 27th October 2022

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

11-4 To note progress with previous actions

The content of the submitted report was noted.

11-5 Report from the Chair of the Trust Board

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

- DH had been pleased to chair the Advisory Appointments Committee panel for the sole consultant appointment.
- It was a positive development that £3.3 billion that had not been previously allocated had been made available to the NHS in the government's autumn statement, and that circa £7 billion had been allocated to social care. It was not yet known how that funding would be applied, but DH

hoped that the funding for the 2022/23 winter would be invested in longer-term solutions, rather than short-term, spot purchases of care packages. The additional funding may mean that the Trust would need to adapt its winter plan, in conjunction with partner organisations.

11-6 Report from the Chief Executive

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

- The Trust had had some positive media coverage regarding patient flow, which had been supported by the TeleTracking system and the Care Coordination Centre, which had been formally opened. Other organisations had expressed an interest in the Trust's arrangements, and the Trust continued to be in the top five performing Trusts on the Emergency Department (ED) 4-hour waiting time target.
- The NHS-related aspect of the funding announced in the autumn statement would be very challenging, but the investment in social care had been significant, so it was important that the Trust worked with its partners to optimise the effectiveness of that investment. MS expected further details of the funding for the 2022/23 year to be available by the next Trust Board meeting.
- Industrial action had been announced by the Royal College of Nursing, but the ballot response rate at the Trust did not meet the required threshold for industrial action. The Trust however had a business continuity plan, which was led by SS, and understood the importance of actively engaging with the staff.
- MS wanted to congratulate all those involved, and PM in particular, in the successful deployment of the Electronic Prescribing and Medicines Administration (EPMA) system at Maidstone Hospital (MH). The Programme Director for EPR (Sunrise) and Digital Transformation and Director of IT and their teams should also be congratulated for the achievement.

Reports from Trust Board sub-committees

11-7 Quality Committee, 09/11/22

DH noted that JW chaired the meeting. JW therefore referred to the submitted report and highlighted the following points:

- It was a packed agenda, which included review of the Quality Committee's sub-committees.
- The most evident issue from the Divisional reports was the improvement in the Trust's vacancies position, and the associated benefits that resulted.
- A report had been considered on the quality failures at other NHS organisations, including the recent Independent Investigation into East Kent Maternity Services. Further details of the quality implications would be considered in the future.

DH acknowledged JW's first point and noted that JW and MC would review the format of future meetings, to make them slightly more manageable.

11-8 Finance and Performance Committee, 22/11/22

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

- Assurance had been given by the Surgery Division management team on their approach to financial recovery.
- SB had presented the month's performance regarding patient flow, but the meeting did not discuss the winter plan, so it would be helpful if SB could report on that at the Trust Board meeting.
- The meeting had focused on the pressures, including cancer referrals in urology, which had adversely affected the Trust's cancer access target performance.
- The Cost Improvement Programme (CIP) was discussed, and the further work required in advance of the 2023/24 CIP was noted.
- An interesting discussion had been held regarding the Trust's emerging financial strategy, which highlighted the complexity of the various factors, and further information would follow.
- The Committee reviewed the Business Case for the Trust's laundry services and recommended that the Trust Board approve the Business Case, which would be considered at the 'Part 2' Trust Board meeting scheduled for later that day.

11-9 People and Organisational Development Committee, 18/11/22

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

- The impact of the delays to the Objective Structured Clinical Examination (OSCE) for internationally-recruited nurses were acknowledged.
- A 'deep dive' was undertaken, with a robust discussion held, on flexible working, and SS and SO had agreed to discuss the issues at the Executive Team Meeting (ETM), as some decisions were required.

11-10 Audit and Governance Committee, 02/11/22 (incl. approval of the revised Terms of Reference)

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

- The meeting was a relatively routine meeting, given the date within the year, so the risk register had been the primary focus of the meeting. One of the older risks, "Staff shortages Out of Hours Haematology/Transfusion", had been referred to the People and Organisational Development Committee for a more detailed review, and if that process worked well, the Audit and Governance Committee intended to undertake a 'deep dive' on certain risks itself. The intention was to ensure that the management of a risk went beyond the process of recording the risk.
- Updated Terms of Reference had been agreed, which reflected the Committee's role in security, and DM's role as the Security management NED champion, and the Terms of Reference had been submitted to the Trust Board for approval.

The revised Terms of Reference for the Audit and Governance Committee were approved as submitted.

11-11 Charitable Funds Committee, 17/11/22 (incl. approval of the revised Terms of Reference)

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

- A new fundraising manager had been appointed, and they had started to make a difference, despite only being at the Trust for a few weeks.
- A proposed approach to fundraising had been discussed, but it was acknowledged that some executive-led focus was required, to ensure the clinical areas that had been proposed for fundraising represented the areas of highest priority.
- Updated Terms of Reference had been agreed and these had been submitted for approval.

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

Integrated Performance Report

11-12 Integrated Performance Report (IPR) for September 2022

SS referred to the "People" Strategic Theme and reported the following points:

- The vacancy rate was experiencing special cause variation of an improving nature, and the rate was now 11.22% against the target of 12%.
- 60 Whole Time Equivalent (WTE) staff had been added to the establishment, which would have a positive effect.
- The staff turnover rate was at 13.55%, which was above the 12% target.
- The A3 work on retention had been completed, and five projects had now been established. One of the projects was to identify the end-to-end processes in recruitment, while another related to the 'onboarding' of new staff. A values-based induction programme had also been launched, and circa 100 new appointees had attended a recent face-to-face/in-person induction course.
- Retention was a key issue, and it was acknowledged that that was affected by the flexibility issues EPM had referred to under item 11-9.
- Work was also continuing on the Trust's attraction strategy.

DH noted that the Trust was explicitly seeking recruitment to Bank posts, in addition to substantive posts, and asked for further details of the decision-making criteria. SS explained that whenever a substantive member of staff joined the Trust, they were encouraged to also join the Staff Bank and

the decision had been based on the fact that the pool of Bank staff in some areas had reduced, as well as on the Trust's need to reduce agency staff usage and expenditure. DH asked for confirmation that the Bank Staff recruitment was therefore supplementary to substantive recruitment, and SS confirmed that was the case.

RF then commended the work that SS and her team had done over the past few months, that had now started to have a positive impact on the workforce metrics. SS confirmed she would relay RF's comments to her team.

SS then continued and reported the following points:

- Sickness absence levels continued to fluctuate at circa 4.5%, which was the Trust's overall target.
- Seasonal flu and respiratory illness had now started to be experienced by staff, so the normal sickness absence monitoring process would be applied. Staff continued to be prompted to obtain a flu and COVID-19 vaccination.
- Appraisal compliance continued to improve, and was currently at 90.38%, which was below the 95% target. SS' team were pursuing compliance with the relevant areas, but SS would likely have to escalate the issue to the ETM.
- Vacancy rates had continued to improve in nursing, which was a significant achievement.

JW noted that NHS England (NHSE) had recently published guidance to increase understanding of the menopause, so asked whether that would have an impact on how wellbeing would be discussed with staff. SS noted that the Trust had a menopause support group, and had some in-house expertise among the Chiefs of Service for Women's Children's and Sexual Health and Core Clinical Services. SS also acknowledged that 70% of the NHS workforce were women, so the issue would continue to be a priority area for the Trust.

PM then referred to the "Patient Safety & Clinical Effectiveness" Strategic Theme and highlighted the following points:

- Falls were experiencing common cause variation but had started to vary from the trajectory, which would see a reduction in the patients being harmed, which was the objective.
- The increase in falls may be affected by an increase in reporting, so a 'deep dive' had been undertaken, to explore what the data had identified. JH was leading the other 'deep dives' into various areas regarding the harm rate.
- The EPMA system had been implemented at MH two weekends ago, while the implementation at Tunbridge Wells Hospital (TWH) would commence on the forthcoming weekend. There had been relatively few quality incidents thus far, which was a testament to the work of the Chief Pharmacist / Clinical Director of Pharmacy & Medicines Optimisation and her pharmacy team.

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

- The *Clostridiodes difficile* rate had reduced for the second consecutive month, which was testament to the work of the Infection Prevention and Control team. It was hoped that the trend would continue.
- There had been a decrease in the number of inpatients with COVID-19, which was currently circa 20, and the ability to isolate patients had now increased, which would reduce the occurrence of hospital-acquired infections, of which there had been very few.
- There had been many patients attending the ED with influenza, and although the admission rate for such patients had been low, that rate was likely to increase.

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

- Performance on the Diagnostics Waiting Times and Activity (DM01) standard had been static, but most of the modalities had improved, so the main limiting factor was the access to echocardiograms, which had been adversely affected by the staffing position. An improvement plan was however in place.
- The 40-week waiting time position had improved markedly in the month. There were now 575 patients waiting more than 40 weeks for treatment, and the Trust was on track to deliver its target of having no such patients by the end of 2022/23.
- There had been a long conversation at the Finance and Performance Committee meeting on 22/11/22 regarding the cancer access standards, which had been achieved for a record 37 consecutive months, but not achieved for the 38th month. The achievement had however been

very significant and the staff had been thanked for their efforts over the last three years. The performance for the latest month had been adversely affected by the position in urology and RJ would work with SB's team to undertake short-, medium- and long-term 'deep dives' into that speciality. However, the backlog waiting position had improved and the ETM had reviewed the cancer recovery plan. If the Trust performed well for another week the target would be delivered in November, but that outcome was not certain.

- At the date of the Trust Board meeting, the Trust the second-best performer in the NHS on the ED 4-hour waiting time target, and only Sheffield Children's NHS Foundation Trust had performed better. The Trust's current performance was circa 85%. SB believed that the Trust had made the correct decision to retain the 4-hour target, which had now been confirmed as a continued area of national focus.
- There had been a further record number of attendances at the Trust's EDs, and such increased attendances were one of the key challenges for the winter period.
- In terms of winter planning, the Trust had been asked to submit an urgent bid for funding by the end of that day, so that bid was being prepared. The Trust was also prioritising the provision of GPs within the EDs, and also focusing on Same Day Emergency Care (SDEC) services. The aforementioned additional funding would enable the purchase of additional Pathway 3 capacity.

MC referred to the impact of the escalation wards, and asked how often the Trust placed additional patients on wards. SB explained that the Trust had, for the past few years, had a policy called 'plus one', which meant if the EDs had 20 patients where a 'decision to admit' had been made, a balance would be struck with the wards, to consider whether a low-complex patient, or a patient who was expected to be discharged, could be moved from their bed, to accommodate a patient from ED. SB then gave assurance that the Trust had no plans to change its approach, and was not considering applying the 'Bristol policy', whereby extra patients were just admitted to wards to be managed. MC welcomed that assurance and asked that the Trust Board be notified should the approach be considered for change. JH added further details of the 'plus one'/boarding policy and confirmed that the number of patients that had been 'boarded' was closely monitored.

JH referred to the "Patient Experience" Strategic Theme and reported the following points:

- The breakthrough Counter Measure Summary now included data on complaints that related to poor communication. A 'deep dive' had been undertaken on such complaints, and the two key themes had been found to be a lack of compassion from staff; and patient and families not being involved in treatment and care. The former theme was not unique to the Trust, and may be affected by factors such as exhaustion. However, plans to address the issue had been developed, although the Trust was committed to understanding the matter more.
- Complaints response performance continued to be erratic, which was related to the volume of complaints received, although JH confirmed that the position would improve for November 2022. JH continued to provide weekly oversight and address any identified constraints.
- There had been continued work to reduce the number of overdue complaints, but such work was not recognised in the reported performance.
- The complaints team was feeling more positive and two substantive staff had been appointed that week. A new Complaints Manager had also been appointed, as the current manager would leave the Trust in January 2023.
- The Friends and Family Test (FFT) response rate performance had declined significantly over the past month, but that was related to the provider's ability to upload the relevant data. The Trust was discussing the situation with the provider, Netcall. A text messaging service had been introduced in July 2022, but some glitches had now been identified in the process, so the Business Intelligence team was working with the provider to resolve these.

RJ then referred to the "Systems" Strategic Theme and reported the following points:

- Performance on the "Discharge before Noon" metric was static, at circa 20%, although performance had been able to reach 24% during the month. The national standard, which reflected the Trust's target, was 33%.
- The Trust was working with Hilton Nursing Partners Limited to optimise the use of Pathway 1 capacity.
- Work was also underway to increase the number of discharges between 12pm and 3pm, particularly in relation to nurse-led and criteria-led discharges.

- Work was taking place with the Therapies department to consider the use of checklists, seeing patients as quickly as possible, and improving the therapies referral process, which had been identified during the recent Emergency Care Improvement Support Team (ECIST) visit. The work was being supported by the Chief of Service for Core Clinical Services.
- The implementation of the EPMA system had had the expected adverse impact on discharges, but once the Electronic Discharge Notification (eDN) aspects were implemented, RJ was confident that the position would improve.

RF noted that the winter plan had explored several options regarding discharge but RF was not sure what the plans were regarding such options. RF continued and referred to the options that pertained to therapies, which had been constrained by staffing issues, so RF now expected some positive steps, given the improvement in recruitment that SS had reported earlier in the meeting. RJ noted that the Trust would be purchasing additional capacity with the aforementioned increased funding, and had obtained an agreement regarding the opening of Pathway 1 capacity. RJ also stated that the Trust was working with another provider to try and counteract the staffing problems that Hilton Nursing Partners Limited had experienced the previous winter. SB added that any option that had not required additional funding, or only involved low cost had been implemented, such as the Trauma & Orthopaedics SDEC, and ED additional hours.

DH then noted that the Trust had previously had issues with discharging patients before the 4pm deadline imposed by the patient transport provider, so asked what the deadline would be for the new Pathway 1 provider. SB explained that the new provider was expected to be more flexible, although Hilton Nursing Partners Limited had been flexible, and the problem was with the patient transport provider's inconsistent performance, which had led the Trust to procure and operate its own transport service at great cost. DH stated that he presumed such issues would inform the patient transport contract discussions that would be held with the Kent and Medway Integrated Care Board (KM ICB). SO confirmed he would add the issue to the list. DH also stated that the position emphasised that the discharge process involved many different parts. The point was acknowledged.

SO then concluded the item by referring to the "Sustainability" Strategic Theme and reporting the following points:

- The Trust's financial performance was on plan for months 1 to 7, but the delivery of the month 7 plan had only been achieved by the release of non-recurrent contingency funding.
- The delivery of the plan continued to be challenging and SO's team were working closely with SB and his team.
- The CIP position had improved, but not to the level required. Consideration was also being given to learn the lessons from 2022/23 when developing the 2023/24 CIP.
- The key Breakthrough Objective was to reduce premium agency expenditure and SO was pleased to see the improvement in workforce metrics that SS had reported earlier in the meeting. However, that improvement had not had a positive impact on the agency expenditure, and a review of the data had identified that although vacancies were the main factor in the premium agency expenditure for medical staff, the same relationship did not seem to be in place for nursing staff. The use of temporary staffing for the Trust's escalation capacity was also affecting the situation, as was roster management, so work was taking place on both.

Quality Items

11-13 <u>The findings of, and response to, the "Reading the Signals; Maternity and Neonatal Services in East Kent – the Report of the Independent Investigation report"</u>

DH firstly noted that it had been mandated that all Trust Boards consider the "Reading the Signals…" report. SF then pointed out that the Divisional Director of Operations for Women's, Children's and Sexual Health had also planned to attend, to demonstrate that the report was being taken seriously by the entire Divisional management team, but that individual then had to deal with an acute paediatrics issue. RT then referred to the submitted report and gave a presentation that highlighted the following points:

- 202 death cases had been analysed by the Independent Investigation panel, and it had been concluded that nearly half of the cases analysed could have been avoided had national guidance been adhered to.
- The themes discussed in the report included the importance of listening to families; lack of kindness and compassion demonstrated by staff; unprofessional conduct and poor working relationships; and inadequate communication with women regarding their care.
- The report identified four key areas for action: “Monitoring safe performance - find signals amongst the noise”; “Standards of Clinical Behaviour”; “Flawed Teamworking…”; and “Organisational behaviour – looking good while doing badly”.

RT then elaborated on the Trust’s response under action 1. DH referred to the Robson Group metrics and asked whether these were used by other neighbouring Trusts. SF explained that the Trust had developed the metrics, following the work undertaken by Mike Robson circa 20 years ago, and although it had been shared with others, it was not mandated for use by other organisations.

RT then continued and elaborated on the Trust’s responses under actions 2 and 3, which included the Exceptional Leaders course; exit interview data analysis; listening events and feedback development; the introduction of Midwifery Engagement meetings; Multidisciplinary Clinical Governance sessions; the commitment to the personalised care agenda; and the establishment of an informed choice forum to discuss complex cases.

DH noted that the “Reading the Signals…” report referred to cliques within midwifery staffing and asked whether any specific actions would address that potential problem. RT replied that the maternity engagement meetings had that objective, to enable people to understand the pressures on the different services and encourage mutual respect. SF added that the multidisciplinary group that would discuss complex cases would also support that aim.

RT then continued and elaborated on action 4, which included recommendations to the government to consider placing a bill for public bodies not to deny, deflect and conceal information from families and other bodies; to ensure appropriate maternity representation on the board; and for NHSE to examine the approach to poorly performing Trusts and leadership. RT also elaborated on the actions being taken by the Trust, which included the ‘Voice Box’ Initiative for listening to staff, and the active engagement the Trust undertook with the Healthcare Safety Investigation Branch and their recommendations. RT then also explained the issues that had affected the Maternity Voices Partnership.

EPM noted that many actions were being undertaken so asked how the work, including the listening events, aligned with the Trust’s Breakthrough Objectives. RT explained the approach to overseeing the action plan while SF acknowledged that further work was required to align the Division’s work to the Trust’s priorities, although the listening events had been established before the “Reading the Signals…” report had been published. EPM encouraged the Trust to carefully consider the volume of work involved, given the pressures on staff. The point was acknowledged.

RT then concluded by highlighting the need to address the current gap in the service’s Patient Experience post, although RT understood that an individual within the service’s governance team would be able to address that gap.

MS referred back to action 2, and noted that parts of the pathway/service where there was more of an issue/theme for the Trust, so asked for further details on the themes that would be focused on. SF replied that the themes that emerged was the integration of staff working between different areas of the service; the induction given to new staff members; kindness at handover; and helping the senior people within teams to do their best under significant pressure, as well as being clear about what ‘doing their best’ actually involved when the pressure was significant. RT added that there was often something lacking or misunderstood in written complaints responses, so work was being done to hold more face-to-face/in-person local resolution meetings, which although took more time, were ultimately more beneficial.

DH then confirmed that it had been an important item for the Trust Board to consider and thanked RT and SF for their professional report. DH also noted that he understood the East Kent review

would likely lead to a further national response. DH also noted that the Trust Board supported the actions being taken by SF and RT, and the Trust Board took maternity matters very seriously.

11-14 Care Quality Commission (CQC) State of Care 2021/22 – Key findings and implications for the Trust

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

- The State of Care report was based on the findings from the CQC's inspections, and the key headlines were related to 'gridlocked' care i.e. patients waiting in ambulances outside hospitals, and waiting in hospitals to be discharged. The issue was also affected by the number of staffing vacancies, which totalled 300,000 across health and social care.
- There was also a focus on access to care, and there were huge variations in such access across the country. The report identified some areas of innovation to help reduce inequalities.
- There were currently 500,000 patients awaiting assessments for adult social care.
- The constrained access to primary care also explained some of the increased ED attendances.
- The "Areas of Specific Concern" included maternity care and mental health services.
- The next steps including discussing the briefing at the Trust's key committees linked to organisational strategy i.e. the People and Organisational Development Committee, Digital Transformation Board and Quality Committee; as well as considering the national care priorities when reviewing the Trust's 2023/24 strategic priorities. The Trust's 2023/34 quality priorities would also reflect the issues raised by the State of Care report.

DH noted that the content of the State of Care report would influence the CQC's inspection regime, but it was now five years since the Trust's last CQC inspection, so asked JH whether there had been any clarity on the timing of the next inspection. JH replied that she met with the CQC's relationship manager for the Trust each month, and there had been five such relationship managers in the last 12 months i.e. there had been high levels of turnover. JH continued that the Trust was not aware of a date for a future inspection, but the CQC was inspecting local maternity services, and Dartford and Gravesham NHS Trust had been inspected recently at short notice, so the Trust's service could expect a visit by the CQC at some point.

Systems and Place

11-15 Update on the West Kent and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)

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

- The 'Together We Can' symposium, which RJ, MC and NG had attended, had been a major opportunity for networking, and the initial output from the event was expected in December 2022.
- An 'away day' had been held on 20/10/22, and HCP Development Board had agreed that the 'neighbourhoods' within West Kent should be co-aligned with the four Primary Care Networks (PCNs), so there would be nine neighbourhoods within the HCP footprint.
- The process of delegation to the HCP was proceeding, and discussion was taking place regarding the decisions that would be retained by the ICB. Such discussions were complex but good progress had been made.
- The Trust Board 'Away Day' in December would explore system partnerships and working in more detail.

JW noted that third sector providers had attended the aforementioned symposium, but asked if commercial providers had also been present. RJ confirmed that had been the case, although there had been some issues regarding data sharing, and other partners, such as the Police, had also been present.

DH noted that RJ had mentioned the funding for the Integrated Care Team parts of the ICB were moving from the ICB to the HCP, and asked whether the staff would likely transfer with the funding. RJ confirmed that would be the case and the current focus was on such staff. DH asked whether it was intended to complete the change by 01/04/23. RJ confirmed that was the plan, and although the ICB wanted the change to take place sooner, RJ, supported by MS and SS, wanted more time to be taken, to ensure the process was conducted properly.

Planning and strategy

11-16 <u>To approve the Heads of Terms for the development of a Maggie's Centre at Maidstone Hospital</u>

DH introduced the item by noting that the Trust Board had previously supported the principle of a Maggie's Centre, but asked that a Maggie's Centre be explained, for the benefit of any members of the public observing the meeting. CW duly described the purpose of a Maggie's Centre, which included the fact that the Centre was available for staff support. SS asked CW to elaborate on the staff support function and CW explained that the specific details of such support would need to be agreed, but it related to staff being involved in the provision of holistic support.

KG then referred to the submitted report and highlighted the following points:

- Since the Trust Board last considered the issue, in May 2021, work had taken place with the Estates team and the Director of Emergency Planning & Response, and a location for the Centre had now been identified, which would require the relocation of the current Occupational Health department.
- The timeframe for the project was five to seven years, depending on the success of the associated fundraising, and AW would be integral to the fundraising efforts, although Maggie's would lead on the fundraising.
- The Heads of Terms were included in the report, and although these were not legally binding, if they were approved, more detailed agreements, which would be legally binding, would be developed.

DM referred to the location of the Centre and asked whether the opportunity cost of using that site, in terms of future potential alternative development, had been considered. KT gave assurance to that effect and stated that it was unlikely that the identified location would be used for any future clinical services, although there would be a cost to re-locate the Occupational Health department.

DH asked whether it was important for the Occupational Health department to operate from a separate building, or could be incorporated within the existing hospital buildings. MC pointed out that the Occupational Health service was already located within TWH, while the building at the MH site was cold in the winter, so a new location could have additional benefits. SS agreed but highlighted that the only request she had made was that the department's new location remained within the main MH site. DH commented that the plans could therefore be a double benefit and would not be a barrier. MS agreed and noted that the timescale of the project would allow sufficient time for a solution for the Occupational Health re-location issue to be identified and agreed.

DH invited queries or comments on the content of Heads of Terms. None were raised. The Heads of Terms for the development of a Maggie's Centre at Maidstone Hospital were approved as submitted.

RF then opined that the decision that the Trust Board had just made was very important, given the Trust's status as the Cancer Centre for Kent. RF also noted that Maggie's provided ongoing support for cancer patients, which would enable the Trust to provide much better long-term healthcare to cancer patients. DH agreed.

KR asked about future updates on progress and whether these should be considered by the Charitable Funds Committee or Trust Board. DH proposed that a six-monthly update be considered at the Trust Board. This was agreed.

Action: Add a "Six-monthly update on the project to develop a Maggie's Centre at Maidstone Hospital to the Trust Board's forward programme (Trust Secretary, November 2022 onwards)

Corporate governance

11-17 <u>Briefing on the latest national corporate governance developments (including the new "Code of governance for NHS providers")</u>

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

- The new Code of Governance, which would apply from April 2023, did not represent mandatory guidance, so the long-established 'comply or explain' principle would apply, whereby Trusts must either comply with each of the Code's provisions or explain why it had departed from the Code.
- KR's initial assessment had identified that some actions were required to enable the Trust to claim full compliance, but a detailed gap analysis would be undertaken to refine/confirm such actions in advance of April 2023.
- An initial assessment of the "Guidance on good governance and collaboration" had not identified any concerns in relation to compliance, but KR would work with RJ and her team to undertake a detailed gap analysis, to identify whether any action was required. KR would also discuss the guidance with the Executive Director of Corporate Governance at NHS Kent and Medway and KR's counterparts at the other providers within the Integrated Care System.
- Any recommended actions from both assessments would be discussed with DH, MS and the whole Trust Board, as required.
- The full documents were accessible on Admincontrol.

DH noted that one of the provisions in the Code of Governance was to seek to align Board positions between NHS Trusts and NHS Foundation Trusts, in relation to the length of appointments for Non-Executive Directors, as most Foundation Trust Non-Executive Directors were appointed on three-year terms, whereas NHS Trusts tended to have four-year terms. DH continued that it was therefore likely that Non-Executive Directors in NHS Trusts would, in the future, be appointed on two- or three-year teams, with NHS Trusts asked to justify any proposed extensions beyond a six-year period, so DH and KR should consider the potential implications for the Trust's Non-Executive Directors. KR confirmed he would liaise with DH as required.

11-18 To consider any other business

KR asked the Trust Board to delegate the authority to the 'Part 2' Trust Board meeting scheduled for later that day to approve a Business Case for the Trust's laundry services, which NG had referred to under item 11-8; and also approve the appointment of the Trust's external auditor. The requested authority was duly granted.

11-19 To respond to questions from members of the public

KR confirmed that no questions had been received.

11-20 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'
11-16	Add a "Six-monthly update on the project to develop a Maggie's Centre at Maidstone Hospital to the Trust Board's forward programme.	Trust Secretary	November 2022	The item was scheduled for May and November 2023 (and every six months thereafter).

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
10-14	Ensure that the appendices relevant to the "Perinatal Quality & Safety Dashboard" were included in the next "Quarterly Maternity Services report" to the Trust Board.	Acting Head of Midwifery and Gynaecology	January 2023	The information will be included in the next scheduled quarterly report, in January 2023.
10-17	Ensure that the next "Quarterly report from the Freedom to Speak Up Guardian" to the Trust Board contained further analysis in relation to "Staff Group who have raised concern".	Deputy Freedom to Speak Up Guardian	January 2023	The information will be ncluded in the next scheduled quarterly report, in January 2023.

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

Report from the Chief Executive **Chief Executive**

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

- The Trust is pleased that a compensation scheme has now been agreed and approved by the Department of Health and Social Care for the families of the victims of David Fuller's mortuary crimes. We are grateful to the families for the input they have provided into the design of the scheme and apologise once again for the hurt Fuller's horrendous crimes have caused the families. We understand that no amount of compensation can lessen the pain they have suffered as a result of his actions but hope the agreed compensation scheme will provide a fair and swift process for victims' families and ensure they are able to access any additional support they may need. Earlier this month, Fuller appeared at the Old Bailey and was sentenced for further mortuary offences. Fuller previously received two whole life sentences in December 2021 after pleading guilty to the murders of two women. At the same time, he was given concurrent sentences totalling 12 years following offences he committed in the mortuaries at Tunbridge Wells Hospital and the former Kent and Sussex Hospital. On December 7 Fuller received a four-year sentence (to be served concurrently) after pleading guilty to 16 further mortuary offences. These offences relate to the final 23 mortuary victims and means that all 101 victims have now been reflected in the charges. No further charges are expected and the work of the independent inquiry into Fuller's crimes is ongoing. The inquiry team expect to publish their findings in the first half of 2023.

- In recent weeks, we've seen record breaking levels of attendances in our Emergency Departments. These have included a high number of young children and their parents with concerns about Strep A. This has resulted in a significant rise in attendances for under 16's, and double the forecasted number. The most affected age range has been amongst four to seven years old, which is more than three times higher than normal for this time of year. To manage these patients, we have put on additional GP and ED registrar shifts and increased paediatric nursing shifts. We've also expanded the hours of our Riverbank Children's Unit to 24/7 and are using two additional outpatient rooms on each of our sites. In addition to the fantastic commitment shown by colleagues, we're supporting this demand through different and new ways of working. These include:

  - Implementing a new Criteria-Led Discharge (CLD) process within our Safer, Better, Sooner programme. CLD is a process to discharge a patient when they meet pre-agreed clinical criteria for discharge without the need for further doctor or therapy review.
  - The introduction of virtual wards which will initially provide 20 virtual respiratory beds by the end of December and will then focus on other specialties. The Trust has NHSE/I resourcing in place to increase the number of virtual ward patients to 187 by December 2023.
  - The NHSE winter improvement collaborative programme between SECAmb, community services and Same Day Emergency Care (SDEC) units in acute trusts.
  - A scheme to support patients requiring large packages of care and additional care home beds following the extra funding announced through the Social Care Discharge Fund.

- After EPMA (Electronic Prescribing and Medicines Administration) and EDN (Electronic Discharge Notification) successfully went live at Maidstone Hospital in mid-November, the system has now gone live at Tunbridge Wells Hospital. I want to thank colleagues for

completing their training, and the team whose hard work was behind the successful launch, while also managing the current challenges across our services.

- Digital improvements are also planned in other areas of the Trust, including our Outpatients Department – a service which sees nearly half a million patients a year. A key development in this area is enhancing patient experience and to support this we are planning to introduce a Patient Portal. Patient Portals enable patients to play an active role in their care which leads to improved clinical outcomes, better patient-provider communication, and higher levels of patient satisfaction. Patient Portals also have the benefit of enabling patients to 'self-manage' areas of their care pathway which have previously been managed solely by care teams and administrators. This enables better digital communications with patients, driven by SMS and/or email notifications which include:

  - new appointment details
  - changes to hospital appointments
  - appointment reminders
  - the ability to view letters from their GP

  This portal will free up the time of the care teams, which is essential given the increasing demands on the workforce. We are currently evaluating different patient portals with a view to start rolling out the platform in the spring next year.

- Our work to fully establish our workforce also continues. Recent progress includes:

  - Reducing our turnover towards our target of 12% by March 2023
  - Increasing our overall Trust whole time equivalents (WTE)
  - Maintaining high levels of recruitment activity - over 900WTE in the pipeline, including 528WTE who are going through pre-employment checks or have start dates booked
  - Increasing the number of registered nurses in post, up to 1782.29 WTE - a steady increase over the last 18 months
  - The resumption of face to face inductions - over 100 new starters at one of our most recent events.

- To support this ongoing rise in demand on our services, in 2023 we will progress a number of infrastructure developments and welcome additional investments which will further improve the care we offer our patients. Projects and investments include:

  - Building our new elective orthopaedic theatre complex at Maidstone Hospital
  - The roll out of phase two of our Community Diagnostic Centre (CDC) near Maidstone Hospital which will see additional services introduced in April.
  - Progress on the Digestive Disease Unit (DDU) strategy continuing with the start of the Gastroenterologist of the Week model now in operation at Tunbridge Wells Hospital (TWH). This facilitates daily consultant gastroenterologist input for patients with gastrointestinal complaints, providing a truly consultant delivered service. The pathway is now in place to enable patients with gastrointestinal illnesses presenting at Maidstone Hospital to transfer across to the DDU at TWH. The Gastroenterology team continue to collaborate with the surgical team on delivering the DDU strategy and look forward to developing the Bariatric service at TWH.
  - Completing work on our Hyper Acute Stroke Unit (HASU)/Acute Stroke Unit (ASU) at Maidstone Hospital in line with the agreed development of the system wide stroke services in Kent and Medway. Once the whole unit is finished we will have an 18 bed HASU and 35 bed ASU to support stroke care for our communities
  - Developing our medical student accommodation building at Tunbridge Wells Hospital which will be completed next year.
  - Within cancer services, a second £2m Halcyon radiotherapy machine at the Kent Oncology Centre, which treated its first patients this month and will support the reduction of treatment times.

- Following the tragic news of a migrant boat capsizing in the English Channel earlier this month, our Trust plans were escalated quickly to care for those who died during the incident. A thank you to all our teams who stepped up to put these plans into action with professionalism and care, including colleagues in Emergency Planning, Radiology, our Mortuary and Security.

- Dr Derek Harrington will take over from Dr Garth Sommerville as MTW's Director of Medical Education in January 2023. Garth has been MTW's Director of Medical Education for over 15 years and has provided unwavering leadership in both under and post graduate education, more recently in his work in readying the Trust for its first influx of Kent and Medway Medical School (KMMS) students. Derek brings experience from a range of senior educational roles as we continue to educate and develop our clinicians for the future. We are grateful to both Derek and Garth for their commitment to their work in their respective fields of appraisal and education, and wish them both well with their ongoing roles within MTW.

- On Friday 16 December, we welcomed the new Patient Safety Commissioner, Dr Henrietta Hughes, to Tunbridge Wells Hospital. During her visit, Dr Hughes talked to patients in one of our clinics about their experiences with the Trust. She also met members of the Trust Board, including Chief Nurse Jo Haworth, and heard about the work we are doing to improve patient safety.

- The NHS Staff Survey for 2022 has now closed and we saw a response rate of 42%. I want to thank colleagues for taking the time to complete the survey and work is now underway to collate the responses which will be shared in the spring.

- Congratulations to the winner of the Trust's Employee of the Month award for November – Trainee Anatomical Pathology Technologist, Jenni Old. Since taking on this new role alongside her training, Jenni has helped bring in a number of innovations and ideas helping to make a positive impact on service delivery.

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, 14/12/22 Committee Chair (Non-Exec. Director)

The Quality Committee met (virtually, via webconference) on 14th December 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.
- The Clinical Director of Pharmacy and Medicines Optimisation and Medical Director presented an **update on the implementation of the Electronic Prescribing and Medicines Administration (EPMA) module** wherein the Committee were provided with a detailed overview of the issues which had been encountered during the 'go-live' period, the interventions which had been developed, and the patient safety incidents which had been addressed and it was agreed that the Patient Safety Manager should liaise with the Chief Pharmacist / Clinical Director of Pharmacy and Medicines Optimisation to investigate what, if any, support was required from the Patient Safety Team in response to the Electronic Prescribing and Medicines Administration (EPMA) module related patient safety incidents. It was also agreed that the Chief Pharmacist / Clinical Director of Pharmacy and Medicines Optimisation should provide Committee members with details of the feedback received from the Transcribing Team regarding the implementation of the Electronic Prescribing and Medicines Administration (EPMA) module. The Committee commended the EPMA Team on the success of the EPMA 'go-live'.
- The Director of Strategy, Planning and Partnerships attended for a **further review of the health inequalities and equality of access to services on patient outcomes** which provided Committee members with details of the draft West Kent Health Needs Assessment and the key findings therein and it was agreed that the Director of Strategy, Planning and Partnerships should ensure that the Trust's health inequalities programme of work considered what, if any, actions could be implemented in response the adverse patient outcomes associated with the method by which clinical trials were conducted. It was also agreed that the Director of Strategy, Planning and Partnerships should circulate the final West Kent Health Needs Assessment to Committee members, once available.
- The Chief of Service for Women's, Children's and Sexual Health and the Acting Head of Midwifery and Gynaecology presented an **update on Maternity Services**, which included a focus on the Trust's response to the Ockenden review of maternity services and Kirkup review of maternity services, wherein the Committee were informed of the key priorities for the Trust's Maternity Services, the initiatives which had been implemented to support kindness and compassion, and the Committee commended the depth of data that was available which was available; however, a discussion was held regarding how to optimise the assurance provided by such data and it was agreed that the Chief of Service, Women's, Children's and Sexual Health should investigate the development of an overarching Maternity Services assurance dashboard in response to the various assurance requirements.
- The Committee reviewed the **items scheduled for scrutiny at future Quality Committee 'deep dive' meetings**, wherein a comprehensive discussion on the scope of the future "In-depth review of the Trust's mortality rate" item was held. It was agreed that the Medical Director should ensure that either the Deputy Chief of Service for Medicine and Emergency Care (Chair of the Sepsis Committee) or the Deputy Chief of Service for Surgery (Co-Vice Chair of the Sepsis Committee) were available to attend the April 2022 Quality Committee 'deep dive' meeting for the "Further review of the management of Sepsis at the Trust" item. It was also agreed that the Director of Quality Governance should provide Committee members with details of the key themes from assurance requests which had been received from external partner organisations such as the West Kent Health and Care Partnership Board and the Care Quality Commission (CQC).

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

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

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

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

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

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the Finance and Performance Committee, 20/12/22	**Committee Chair (Non-Exec. Director)**

The Committee met on 20th December 2022, via a webconference.

1. **The key matters considered at the meeting were as follows:**
   - The **actions from previous meetings** were reviewed.
   - The Programme Director for EPR (Sunrise) attended to provide an **update on the implementation of the Electronic Patient Record (EPR)**, which included the latest position on the implementation of the Electronic Prescribing and Medicines Administration (EPMA) system at both main hospital sites (which was commended by the Committee).
   - The Programme Director and Clinical Lead for Cardiology attended to give an update on the **cardiology strategic business case**, which included the details of the three options for the co-located service at Maidstone Hospital. It was noted that the Executive Team Meeting had approved the release of £350k to further develop the options, which would enable the Outline Business Case (which was intended to be completed in May 2023) to be clear on the costs of each option.
   - The **Patient Access strategic theme metrics for month 8** were reviewed, which acknowledged the extreme pressures being faced by the Trust, and the resulting reduced performance on the Emergency Department (ED) 4-hour waiting time target. A discussion was also held on the current challenges with the Pathway 1 provider and it was agreed that the Chief Operating Officer should liaise with the Director of Strategy, Planning and Partnerships and submit an "Update on the Social Care Discharge Fund and out of hospital care capacity for the 2022/23 winter period" to the Committee's meeting in January 2023. It was however confirmed that the 62-day cancer waiting time target had been met again for October, and the Chief Operating Officer expected the target to be met for November and December 2022.
   - The Deputy Chief Executive/Chief Finance Officer reported on the **financial performance for month 8,** which included the latest position on the Cost Improvement Programme (CIP). It was agreed that details of the emerging CIP for 2023/24, which was noted to be very challenging, would be submitted to the Committee's meeting in January 2023.
   - The Chief Operating Officer gave an **update on the response to the external Estates and Facilities review,** although it was agreed that future reports should include the financial values of the associated benefits. It was also agreed that the future quarterly updates on the response to the review should be scheduled as two separate items/reports (one covering Estates and one covering Facilities), to reflect the separation of responsibilities within the Trust's structure.
   - The **findings from relevant Internal Audit reviews** were noted, which included the 'reasonable assurance' conclusion that had been given for the "Processes for Dealing with Data Quality Issues" review.
   - 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]
Information and assurance

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

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the People and Organisational Development Committee, 16/12/22 | **Committee Chair (Non-Exec. Director)**

The People and Organisational Development Committee met (virtually, via webconference) on 16th December 2022 (a 'main' meeting).

The key matters considered at the meeting were as follows:

- The **actions from previous 'main' meetings** were noted.
- The Chief People Officer presented the latest **review of the "Strategic Theme: People" section of the Integrated Performance Report (IPR)** which included details of turnover rate and bank and agency spend which resulted in the Chief People Officer agreeing to update the Committee on the interim measures in place to track and reduce the use of agency staff. It was also agreed that a review of the deep dive into high vacancy rates within the Trust's lower banded support roles and an update on the initiatives introduced to support Internationally Educated Nurses should be scheduled at future committee meetings. Furthermore, the Chief People Officer and Interim Deputy Chief People Officer, People and Systems assured that the next "Monthly review of the "Strategic Theme: People" section of the IPR" would include an analysis of the reasons provided when requesting bank shifts and the Chief People Officer would provide Committee members with a summary of the areas of the Trust that are non-compliant in terms of appraisal completion.
- The Deputy Chief People Office, Organisational Development updated the Committee **on the plans to extend the Exceptional Leaders programme to all People Leaders and the continued evaluation of Exceptional Leaders Programme participants** which included the scheduling of a "Further update on the plans to extend the Exceptional Leaders programme to all People Leaders with particular focus on data from the bands that have attended the programme (incl. the purpose of the "Affina Team Journey" assessment and development tool)" item at a future Committee meeting.
- The Deputy Chief People Officer, Organisational Development then provided an **update on the Trust's Equality, Diversity and Inclusion (EDI) strategy and any further support that was required** in which it was agreed that the comments raised at the People and Organisational Development Committee meeting in December 2022 should be incorporated into the Trust's Equality, Diversity and Inclusion (EDI) strategy prior to submission to the Executive Team Meeting in January 2023.
- The Deputy Chief People Officer, Organisational Development then provided an **update on Divisional Development Plans,** which included the measures to improve the Trust's culture.
- The Deputy Chief People Officer, People and Systems updated the Committee **on the plans to support flexible working arrangements for retiring staff and those staff returning from retirement,** in which it was decided that the Chief Nurse should confirm to the Trust Secretary's Office the scheduling of an "Update on the progress made introducing retired Nursing and Midwifery staff into pastoral roles at the Trust" item at a future Committee meeting.
- The **organisational development aspects of the Care Quality Commission (CQC) State of Care 2021/22 report** was then noted.
- The Committee then noted the **forward programme**.
- The Committee conducted an **evaluation of the meeting** wherein it was suggested that a regular update from the Health and Wellbeing Committee be added to the forward programme.

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

- The Administration Assistant, Trust Secretary's Office should schedule a "Brief update on the data received from exit interviews conducted at the Trust" at the Committee's meeting in March 2023 and an "In-depth review of the data received from exit interviews conducted at the Trust" at the Committee's meeting in June 2023.

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

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

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

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the Patient Experience Committee, 01/12/22	**Committee Chair (Non-Executive Director)**

The Patient Experience Committee (PEC) met on 1st December 2022, virtually, via webconference

The key matters considered at the meeting were as follows:

- The Chief Nurse **reviewed the findings from the national inpatient survey 2021** and highlighted the areas in which the Trust had done well with patient experience, where it could be improved and how this improvement could be achieved.
- The Chief Nurse and Deputy Chief Nurse for Quality and Experience provided a **review of the "Patient Experience" Strategic Theme** in which it was agreed that the Interim Patient Experience Lead should investigate and report back to the Committee what, if any, feedback had been received by the volunteers responsible for distributing the leaflets to patients on discharge.
- The Deputy Chief Nurse for Quality and Experience then provided an **update on the development of the Trust's new Patient Experience Strategy** in which it was agreed that the Deputy Chief Nurse for Quality and Experience should ensure that the Patient Experience and Engagement Strategy reflected the feedback from the Patient Experience Committee meeting in December 2022 regarding an enhanced focus on health and equality in alignment with the new Parliamentary and Health Service Ombudsman framework; and the Administration Assistant, Trust Secretary's Office should schedule a "review of the National Institute for Health Research patient research involvement for the Trust" item at the committee's meeting in March 2023.
- The representative from **Healthwatch Kent gave a brief update** on the patient experience themes, positive feedback and the engagement activity currently being undertaken by Healthwatch.
- The Complaints and PALS Manager tabled a **review of complaints and PALS performance and key themes** report which covered the complaints and PALS activity for August to October 2022, as the report had not been circulated prior to the meeting it was agreed that the Administration Assistant, Trust Secretary's Office would circulate the complaints report to committee members.
- The Interim Patient Experience Lead gave an **update on voluntary services** in which it was agreed that the Interim Patient Experience Lead would liaise with the Chair of League of Friends, Maidstone Hospital and Voluntary Service Manager to produce a proposal to encourage those undertaking the Duke of Edinburgh Award programme to volunteer with the Trust. It was also agreed that the Interim Patient Experience Lead should investigate ways in which youths from a wide range of backgrounds within the community could be encouraged to volunteer with the Trust.
- The Chair of the Patient Experience Committee led a **discussion regarding the future of the Patient Experience Committee** where it was agreed that committee members would email any feedback, ideas and views on the future of the Patient Experience Committee to the Administration Assistant, Trust Secretary's Office by 15/01/2023.

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

- The Administration Assistant, Trust Secretary's Office should liaise with the Chief Nurse to schedule a "Review of the Maternity Survey 2022" at a future committee meeting.
- The Administration Assistant, Trust Secretary's Office should ensure the PALS Team Leader was invited to future Patient Experience Committee meetings.

The issues that need to be drawn to the attention of the Board: N/A

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

NHS
Maidstone and Tunbridge Wells NHS Trust

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

The IPR for month 8, 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, 20/12/22, Finance and Performance Committee, 20/12/22

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report

November 2022

MTW
exceptional people, outstanding care

Contents

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

Key to KPI Variation and Assurance Icons

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

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

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

Maidstone and Tunbridge Wells NHS Trust

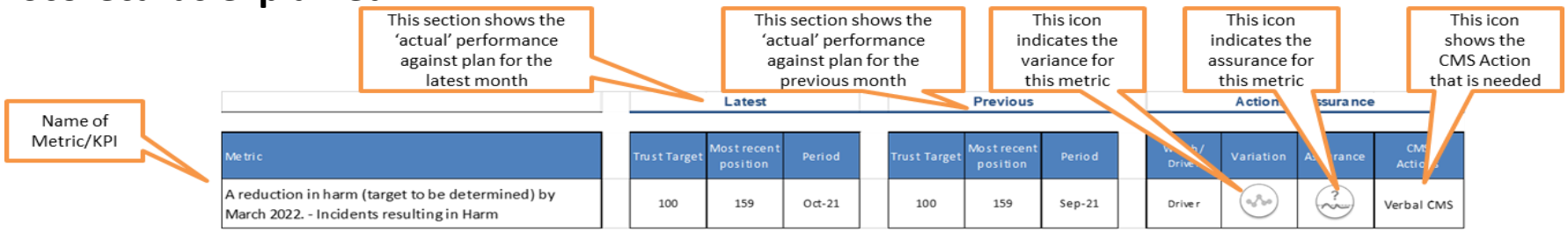
Escalation Rules:

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

Escalation Pages:

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

Scorecards explained



Further Reading / other resources

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

MTW exceptional people, outstanding care

Executive Summary

Executive Summary

Vacancy Rate continues to experience special cause variation of an improving nature and variable achievement of the target with the nursing vacancy rate also improving. The Trust Turnover Rate has failed the target for more than six months and continues to be in special cause variation of a concerning nature. Agency spend continues to fail the target for more than six months and is in common cause variation. Sickness levels are in variable achievement of the target and common cause variation. The Trust Appraisal rate remains in escalation as is not achieving the target. The Trust Financial Plan was on plan, generating a £5.9m deficit year to date.

Following the improvement in the vacancy rate the Nursing Safe Staffing Levels also improved to 93.4% in November and are now experiencing special cause variation of an improving nature. The rate of inpatient falls also improved in November, to bellow the maximum limit, and 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 November and is now experiencing special cause variation of an improving nature and consistently failing the target at 88.3%, driven mainly by the continued low performance for Echocardiography. RTT performance is experiencing common cause variation 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, September, October and November with November only slightly below plan. Diagnostic Activity levels have not achieved the target for more than six months but remain consistently above 1920 levels. Elective activity is now experiencing special cause variation of an improving nature as has achieved the plan for more than six consecutive months. It is therefore above plan Year to date (YTD).

A&E 4hr performance is experiencing common cause variation at 83.2% 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 has once again achieved the Cancer Waiting Times 62 Day standard for the month of October and has continued to achieve the national 2 Week Wait (2WW) Standard (96.7%). 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)*

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)

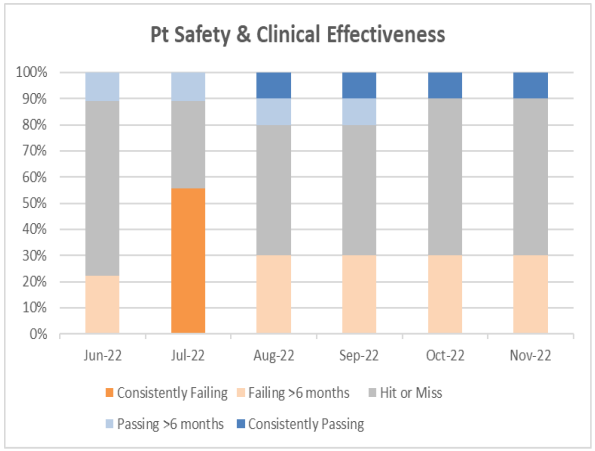
*Escalated due to the *rule* for being in Hit or Miss for more than six months being applied

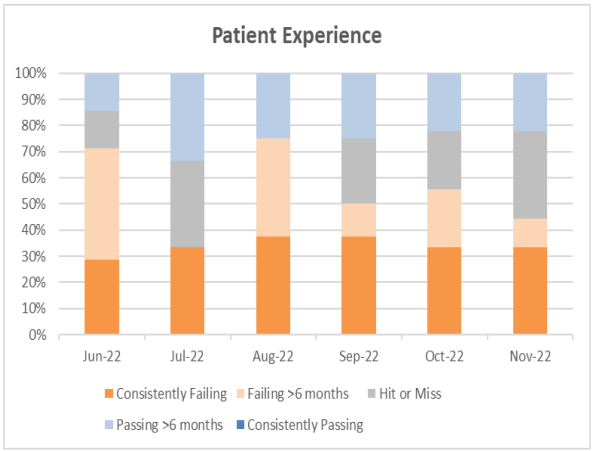
Patient Experience:
- Communication Complaints (P.20)
- Complaints responded within target (P.21)
- FFT Response Rates - all areas (P.22)

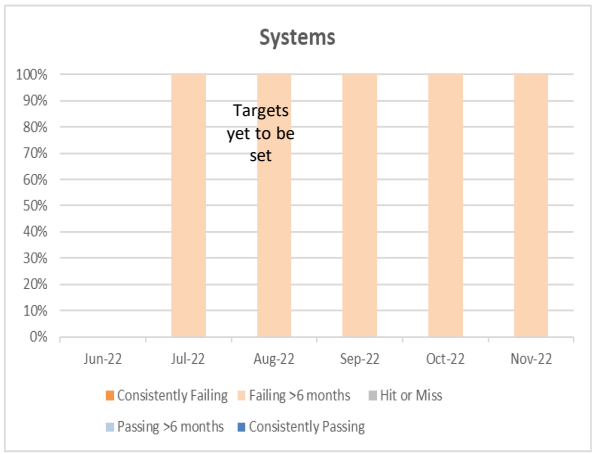
Systems:
- Discharges before Noon (P.24)

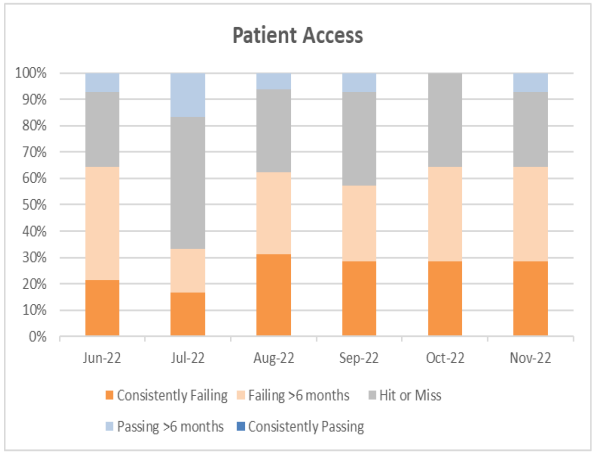
Sustainability
- Agency Spend (P.26)

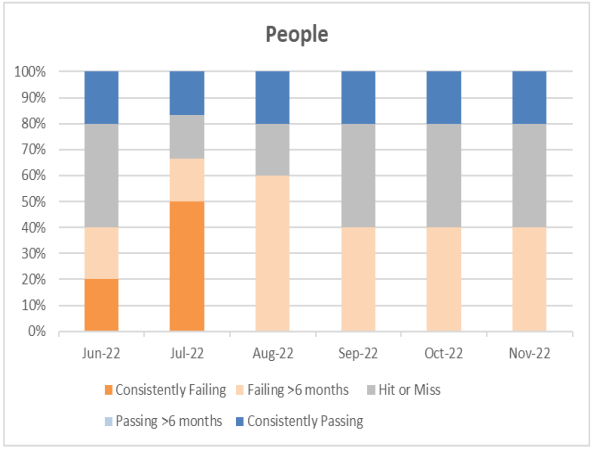
Assurance Stacked Bar Charts by Strategic Theme

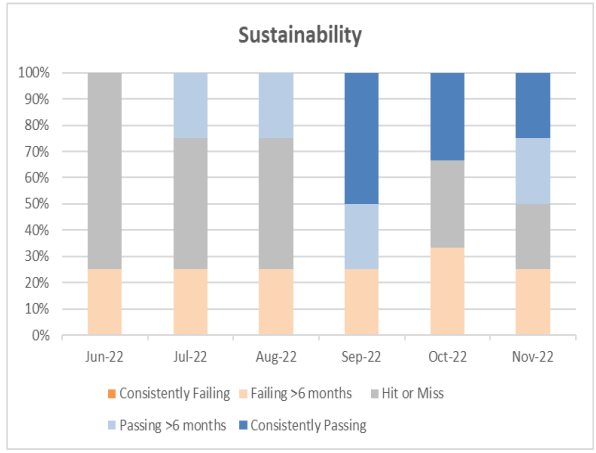












Matrix Summary

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

Strategic Theme: People

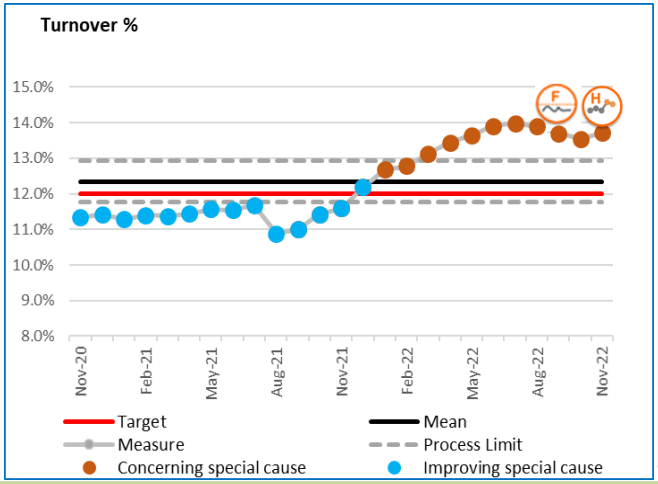
	CQC Domain	Metric	Latest: Trust Target	Latest: Most recent position	Latest: Period	Previous: Trust Target	Previous: Most recent position	Previous: Period	Actions & Assurance: Watch / Driver	Actions & Assurance: Variation	Actions & Assurance: Assurance	Actions & Assurance: CMS Actions
Vision Goals / Targets	Well Led	Reduce the Trust wide vacancy rate to 12% by the end of the financial year 2022-3	12%	10.7%	Nov-22	12%	11.2%	Oct-22	Driver			Note Performance
Breakthrough Objectives	Well Led	Reduce Turnover Rate to 12% by March 2023	12%	13.7%	Nov-22	12%	13.5%	Oct-22	Driver			Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Well Led	Sickness Absence	4.5%	4.9%	Oct-22	4.5%	4.4%	Sep-22	Driver			Not Escalated
	Well Led	Appraisal Completeness	95.0%	90.0%	Nov-22	95.0%	90.4%	Oct-22	Driver			Escalation
	Well Led	Statutory and Mandatory Training	85.0%	85.8%	Nov-22	85.0%	86.8%	Oct-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

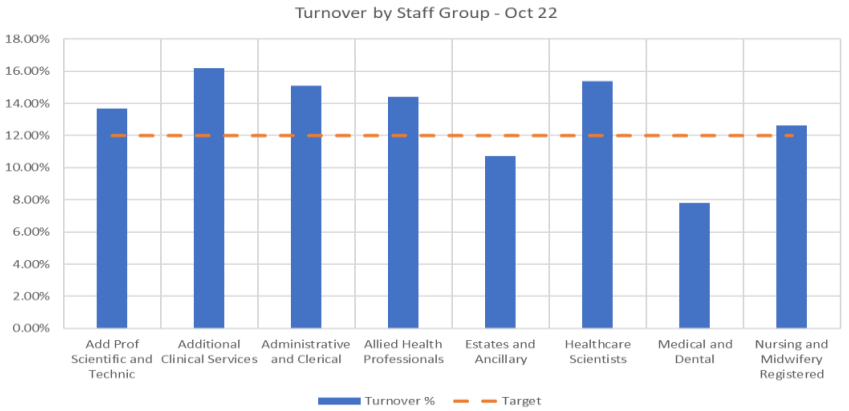
1. Historic Trend Data



Nov-22
13.70%
Variance / Assurance
Metric is currently experiencing special cause variation of a concerning nature and has not achieved the target for more than 6 months
Max Target (Internal)
12%
Business Rule
Full CMS as not achieved target for 6+ months

2. Stratified Data

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



3. Top Contributors

A3 Stakeholder engagement workshop to identify contributors and subsequent countermeasure sessions have taken place in October

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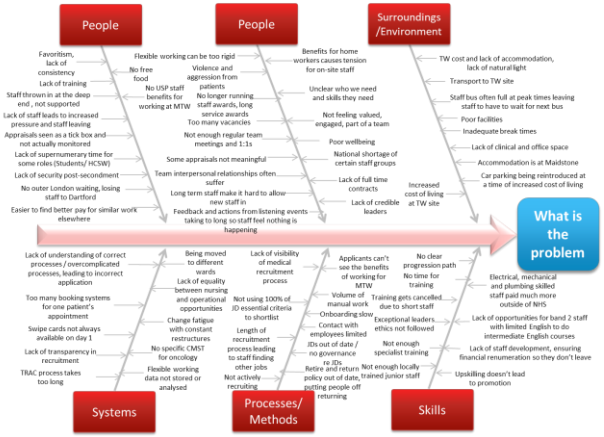
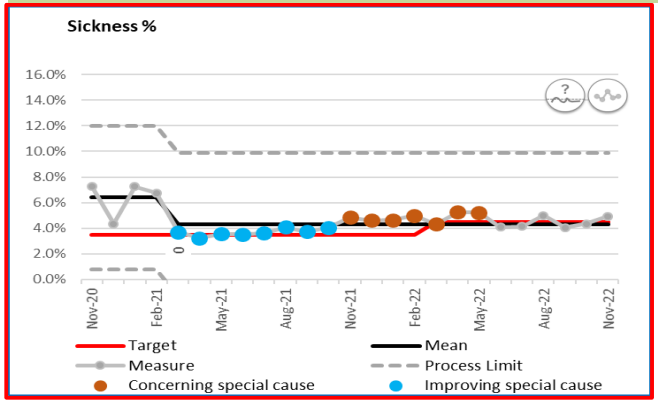


4. Action Plan

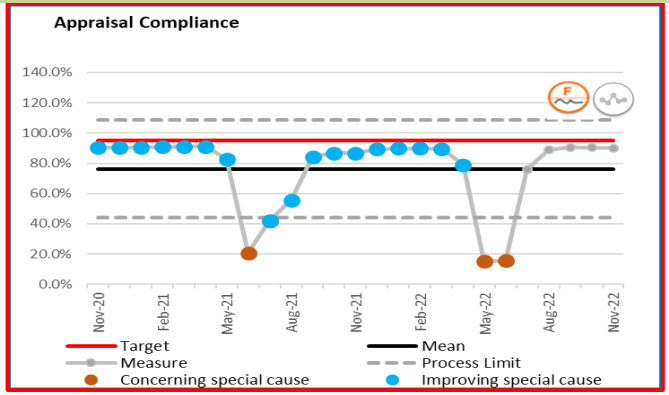
The A3 continues to be developed, with countermeasures identified and to be implemented.

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 now set up and running

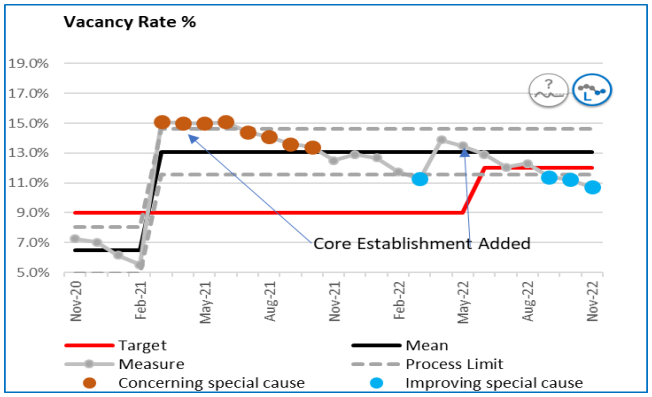
People – Workforce: CQC: Well-Led



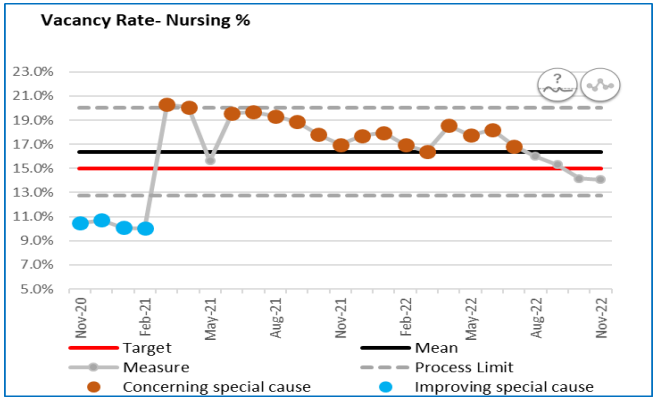
Oct-22
4.9%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Max Target (Internal)
4.5%
Business Rule
Escalated as in Hit & Miss for >6months



Nov-22
90.01%
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



Nov-22
10.71%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and variable achievement of the target
Max Limit (Internal)
12%
Business Rule
Not Escalated - Shown for Information



Nov-22
14.06%
Variance / Assurance
Metric is currently experiencing common cause Variation and variable achievement of 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 October) and variable achievement of the new target..

Nursing Vacancy Rate: Shown for information as is linked to Vacancy Rate. Metric is now experiencing common cause variation and variable achievement of the target..

Actions:

Sickness: Has increased for October, with the spike mainly being attributed to cold/flu reasons. This is to be expected for this time of year.

Vacancy Rate: The vacancy rate continues to improve, with high levels of recruitment activity across the Trust. The pipeline is strong and we would expect the rate to continue to improve over the coming months. We now have fewer actual vacancies than the end of FY21/22 (when Trust budget increased and automatically created over 200 new vacancies)

Vacancy rate - Nursing: continued improvement in the rate, with a strong pipeline to further this.

Turnover: not reported here, however a breakthrough objective with a target of 12% by 31 March 2023. November rate shows a slight increase, however, we expect this to decrease next month (last year saw a lot of leavers in December 2021, which informs this metric)

Assurance & Timescales for Improvement:

Sickness: Continued monitoring of any spikes for non-seasonal reasons for absence

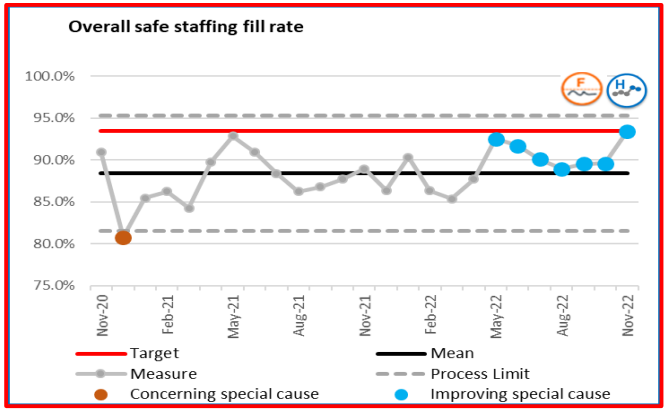
Vacancy Rate % - Recruitment pipeline shows high level of recruitment activity and due to the increase of recruitment activity with international recruitment, marketing campaign and events etc we expect this metric will continue to improve.

Turnover: Workforce Supply programme working groups now running to build on existing interventions regarding this target

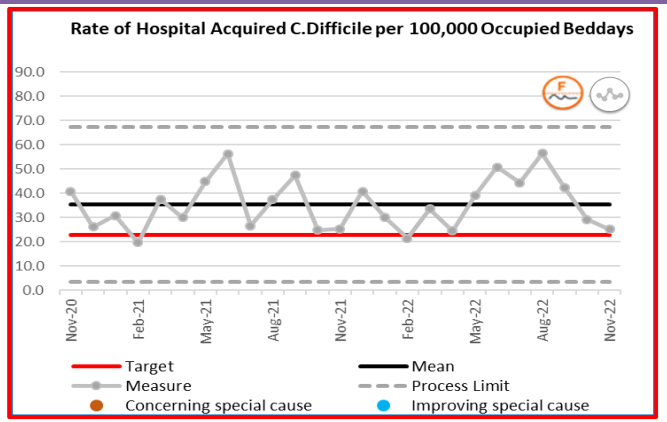
Strategic Theme: Patient Safety & Clinical Effectiveness

			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Safe	Reduction in incidents resulting in harm by 8.2% by March 2023	127	188	Nov-22	128	193	Oct-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	6.65	5.38	Nov-22	6.72	7.45	Oct-22	Driver			Verbal CMS
Constitutional Standards and Key Metrics (not in SDR)	Safe	Number of New SIs in month	11	10	Nov-22	11	13	Oct-22	Driver			Not Escalated
	Safe	Standardised Mortality HSMR	100.0	101.5	Jul-22	100.0	101.7	Jun-22	Driver	H		Not Escalated
	Safe	Summary Hospital-level Mortality Indicator (SHMI)	100.0	93.0	Jul-22	100.0	97.0	Jun-22	Driver		P	Not Escalated
	Safe	Never Events	0	0	Nov-22	0	0	Oct-22	Driver			Not Escalated
	Safe	Safe Staffing Levels	93.5%	93.4%	Nov-22	93.5%	89.6%	Oct-22	Driver	H	F	Escalation
	Safe	Infection Control - Hospital Acquired Covid	0	10	Nov-22	0	30	Oct-22	Driver		F	Escalation
	Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays	22.7	25.1	Nov-22	22.7	29.2	Oct-22	Driver		F	Escalation
	Safe	IC - Number of Hospital acquired MRSA	0	0	Nov-22	0	0	Oct-22	Driver			Not Escalated

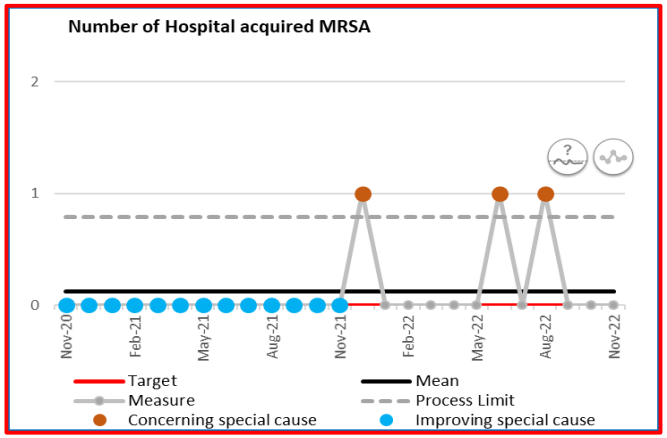
Patient Safety and Clinical Effectiveness: CQC: Safe



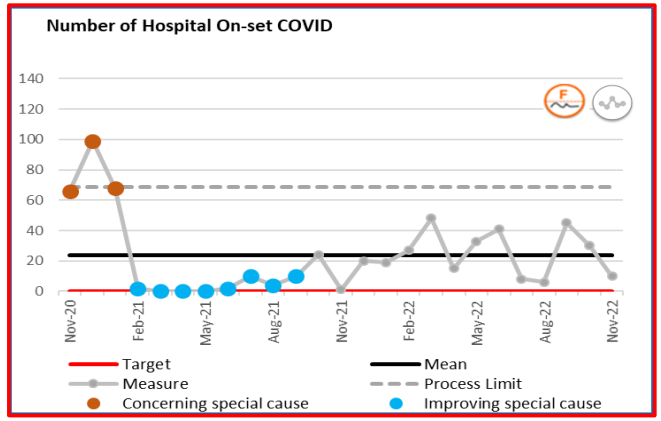
Nov-22
93.4%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature but has not achieved the target for >6months
Target (Internal)
93.5%
Business Rule
Full Escalation as has not achieved the target for > 6 months



Nov-22
25.1
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has not achieved the target for >6months
Max Target (Internal)
22.7
Business Rule
Full Escalation as Hit or Miss > 6 months



Nov-22
0
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Max Target
0
Business Rule
Full Escalation as Hit or Miss > 6 months



Nov-22
10
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 has moved to special Cause Variation of an improving nature, but 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. The Deputy Chief Nurse and HON for Safe Staffing are now included in the risk assessments for non framework agency requests. This give Corporate Nursing oversight in line with the new Safe Staffing Policy. Nursing establishment reviews were completed in November, with the Workforce Board Report currently being finalised. Retention of Registered Nurses/Midwives and Healthcare Clinical Support Workers (HCSWs) 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 ControlA further Trust wide C diff incident meeting was held on the 4th Nov to monitor progress against the previous actions and identify any further areas for improvement. IPC, PPE and antimicrobial audits continue to be undertaken, with the findings fed back at the time and reported to the IPCC. Weekly C diff round are being undertaken with the Consultant Microbiologist, IPC team and antimicrobial pharmacist to support the management of patients with CDI . The Trust has seen 62 cases to the end of November against a year end limit of 62. The Trust continues to see a small number of Covid outbreaks which are mainly associated with Covid positive patients being identified on asymptomatic discharge screening. All Covid contacts are identified and quarantined. Point of care respiratory screening has detected an increasing number of patients with flu, a small number who have required admission

Assurance & Timescales for Improvement:

Safe Staffing Fill Rate: Real time daily staffing data has been developed by the Senior Corporate Nursing and ICC team. A new procedure for the raising of red flags is now live, with additional training provided for the matron teams. This will ensure that safe staffing processes align with the new Safe Staffing policy which is being presented at January 2023 PRC. The Trust continues to roll out SafeCare, with 27 clinical areas now live. Recruitment activity continues to move at pace with local recruitment events ongoing. An increase in HCSW vacancies was seen owing to the implementation of funded escalation wards. Due to increase in HCSW recruitment activity, monthly induction capacity will be increased to 30 in the new year. The aim is to reduce the Nursing and Midwifery vacancy rate to 10% by December 2022.

Infection Control: The IPC team have supported the further development of respiratory pathways to meet the increasing winter demand. We continue to provide 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*
Weekly Covid-19 outbreak management meetings are held and we continue with

Strategic Theme: Patient Access

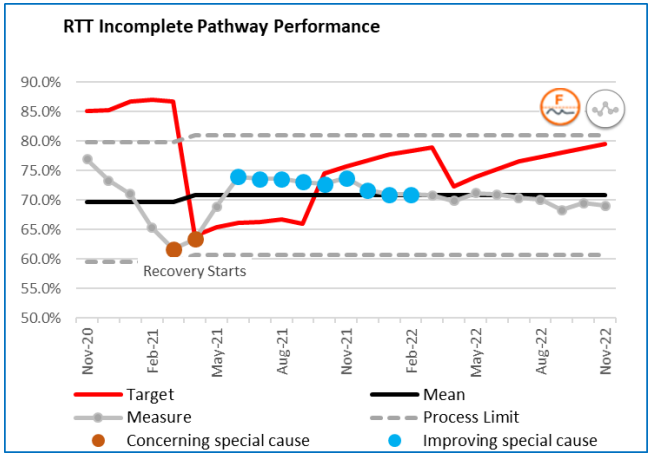
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Responsive	Achieve the Trust RTT Trajectory by March 2023	79.5%	69.0%	Nov-22	78.8%	69.5%	Oct-22	Driver		F	Full CMS
Breakthrough Objectives	Responsive	To achieve the planned levels of new outpatients activity (shown as a % 19/20)	121.2%	116.4%	Nov-22	107.2%	101.5%	Oct-22	Driver	H	F	Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Responsive	RTT Patients waiting longer than 40 weeks for treatment	473	489	Nov-22	481	631	Oct-22	Driver		F	Escalation
	Responsive	Access to Diagnostics (<6weeks standard)	98.5%	88.3%	Nov-22	98.9%	89.9%	Oct-22	Driver	H	F	Escalation
	Responsive	A&E 4 hr Performance	91.3%	83.3%	Nov-22	93.1%	84.1%	Oct-22	Driver		F	Escalation
	Responsive	Cancer - 2 Week Wait	93.0%	96.7%	Oct-22	93.0%	94.0%	Sep-22	Driver		?	Not Escalated
	Responsive	Cancer - 62 Day	85.0%	85.0%	Oct-22	85.0%	73.6%	Sep-22	Driver		?	Not Escalated
	Effective	Transformation: % OP Clinics Utilised (slots)	85.0%	61.7%	Nov-22	85.0%	60.7%	Oct-22	Driver		F	Escalation
	Effective	Transformation: % of Patients Discharged to a PIFU Pathways	1.5%	3.4%	Nov-22	1.5%	3.5%	Oct-22	Driver	No SPC	No SPC	Not Escalated
	Effective	Transformation: CAU Calls answered <1 minute	90.0%	62.9%	Nov-22	90.0%	62.6%	Oct-22	Driver	H	F	Escalation
	Effective	Flow: Ambulance Handover Delays >30mins	5.0%	9.3%	Nov-22	5.0%	8.7%	Oct-22	Driver		F	Escalation
	Effective	Flow: % of Emergency Admissions into Assessment Areas	65.0%	60.3%	Nov-22	65.0%	61.0%	Oct-22	Driver	H	?	Not Escalated
	Responsive	To achieve the planned levels of elective (DC and IP cobined) activity (shown as a % 19/20)	104.4%	113.9%	Nov-22	97.2%	103.8%	Oct-22	Driver		P	Not Escalated
	Responsive	To achieve the planned levels of outpatients follow up activity (shown as a % 19/20)	99.5%	106.7%	Nov-22	90.1%	93.3%	Oct-22	Driver		?	Not Escalated
	Responsive	To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20)	210.7%	126.2%	Nov-22	200.4%	119.4%	Oct-22	Driver	H	F	Escalation

Vision: Counter Measure Summary

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

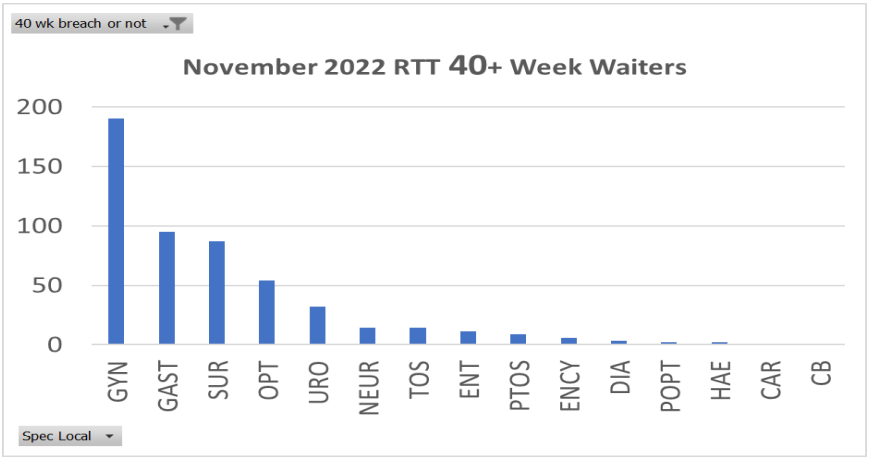
Owner: Sean Briggs
Metric: Referral to Treatment time Standard
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Nov-22
69.0%
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
79.5%
Target Achievement
Metric has failed the target for >6 months

2. Stratified Data



3. Top Contributors

- Underperformance for Outpatients YTD affecting overall position
- Highest number of long waiting patients is mainly in Gynaecology, Gastroenterology and Gen Surgery
- Due to increase in overall waiting list size 75% of patients over 26 weeks are being validated in comparison to 90% in August

Risk

- Neurology increased referrals (284) from Medway in backlog – awaiting agreement from ICB to return patients to local trust

4. Action Plan

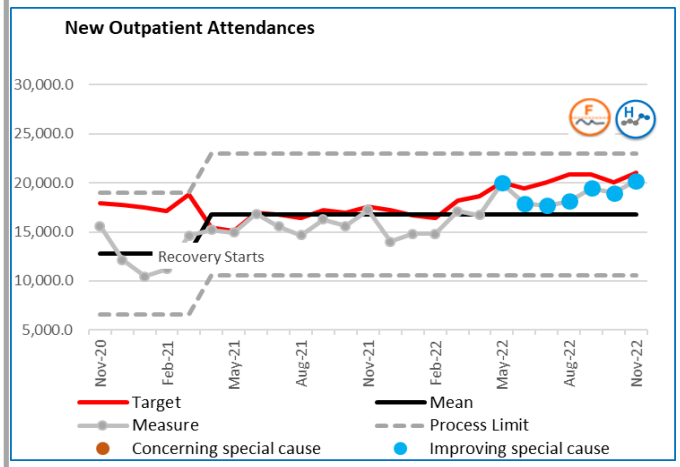
Countermeasures	Action	Who / By when	Complete (Y/N)
Improved New Outpatient Activity	Focussed work on the Breakthrough Objective to Increase New Outpatient Activity	Steph Parrick	Ongoing
Validation	Recovery plan developed to be agreed at Execs	CAU & PAT team	Nov
Daily PTL	Gynae team	Gynae & PAT team	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	RTT recovery plan presented to Execs – awaiting outcome	RTT Lead, BI Team	Complete
	Implementation of RTT recovery plan	RTT Lead/GM's	Ongoing

Breakthrough Objective: Counter Measure Summary

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

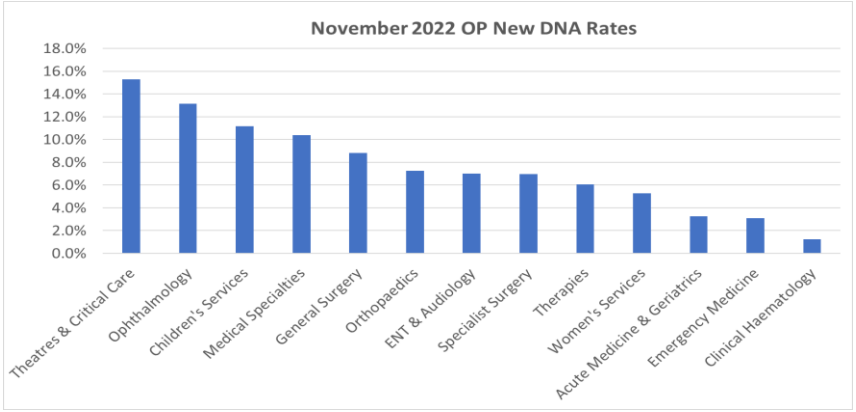
Owner: Sean Briggs
Metric: Elective Activity: New Outpatients
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



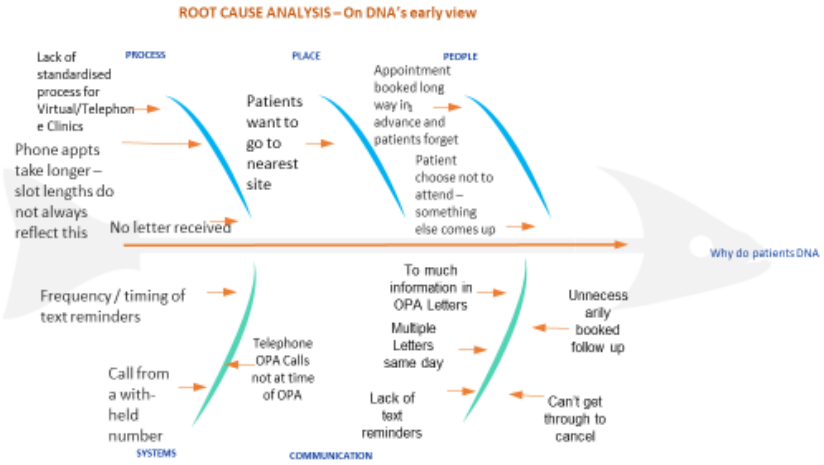
Nov-22
20,212
Variance Type
Metric is currently experiencing Special Cause Variation of an improving nature
Target
21,049
Target Achievement
Metric has failed the target >6months

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

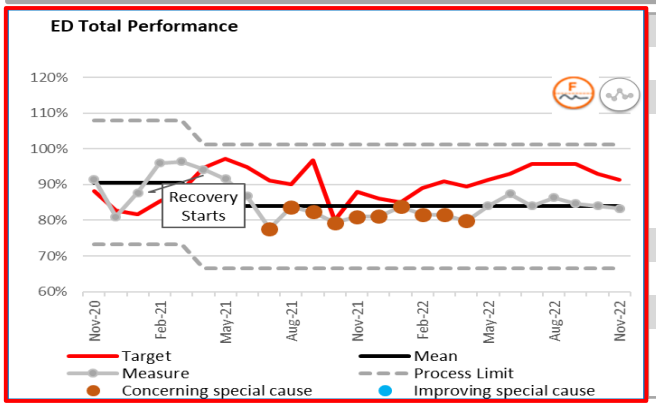
3. Top Contributors



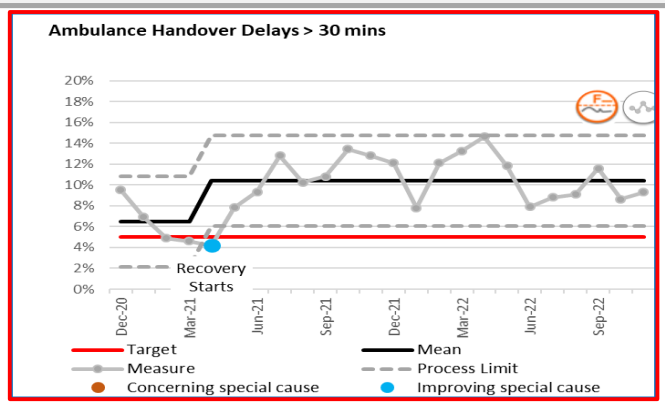
4. Action Plan

Countermeasures	Action	Who / By when	Complete (Y/N)
Two way text	Implementation plan developed	Project Team	Complete
	Operational process flows for CAU to be agreed	Project team	December
	IT Load balancers installed	IT	January 2023
	Go live	Project Team	January 2023
Switch on Paediatric Text reminders (agreed for Ophth)	Awaiting agreement from IG and Safeguarding teams	Steph Parrick	December 2022
Telephone Clinics – review of letter re working for Private Number/time of call	Monitor Telephone Clinic DNA's to see improvement	Project Team	In progress

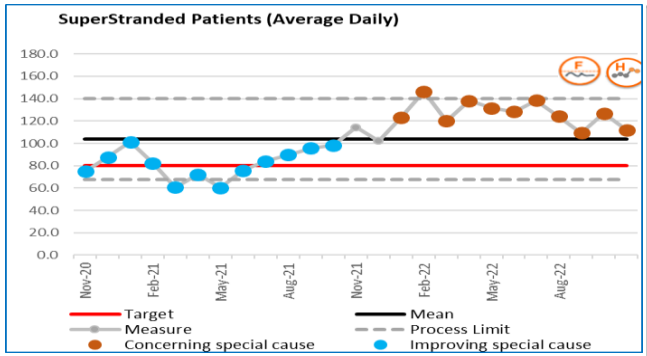
Patient Access – Hospital Flow: CQC: Responsive



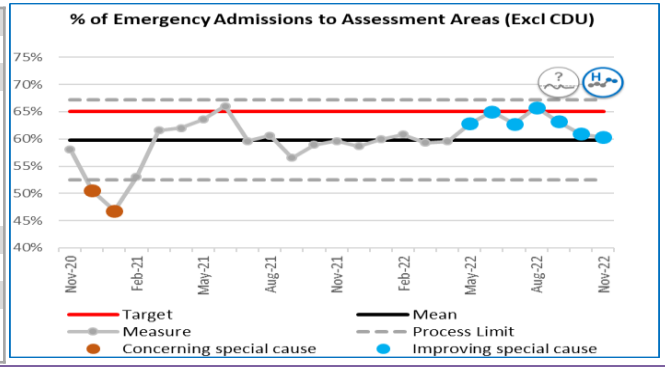
Nov-22
83.25%
Variance / Assurance
Metric is currently experiencing Common Cause variation and has failed the target for >6 months
Target (Internal)
93.1%
Business Rule
Full Escalation as has failed the target for > 6 months



Nov-22
9.3%
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



Nov-22
112
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
Not Escalated



Nov-22
60.3%
Variance / Assurance
Metric is currently experiencing special cause variation of an improving nature
Target
65%
Business Rule
Shown for Info as related to A&E Performance

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. Ambulance window works commenced at TW

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:

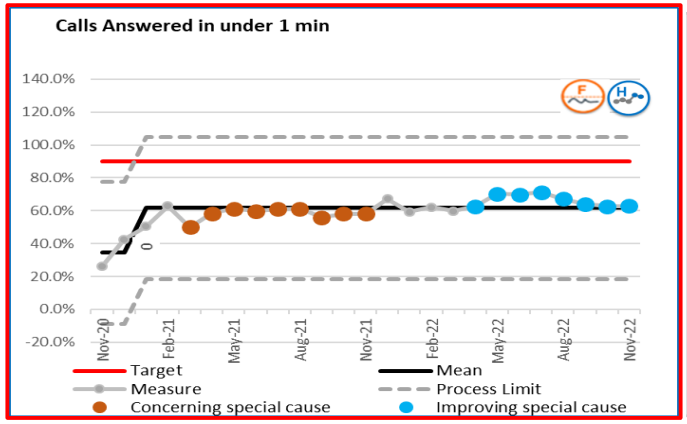
ED 4hr performance (inc MIU): Continue with ED improvement huddles. Daily monitoring of UTC utilisation to increase use of available resource. Review of medical staffing to meet demand.

Ambulance handovers delays: Maidstone performed at 94.6% and TW 90% 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. 60 minute breaches has also reduced from 0.78% to 0.47%

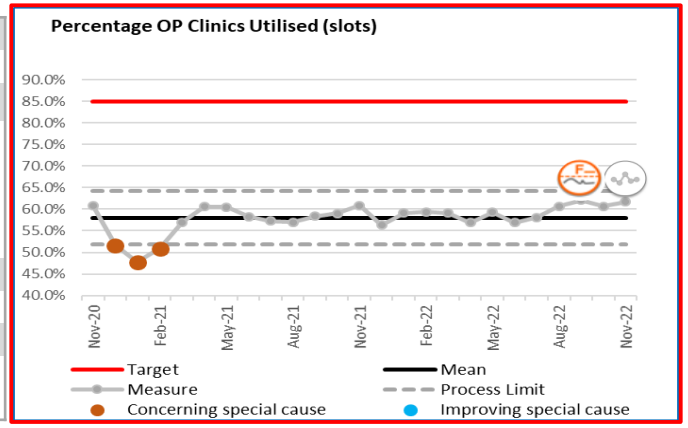
Super stranded patients:
Monthly MADE events to bring an MDT approach. Improved understanding of pathways and introduction of resource packages.

% 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 ward beds before being assessed by the SAU team.

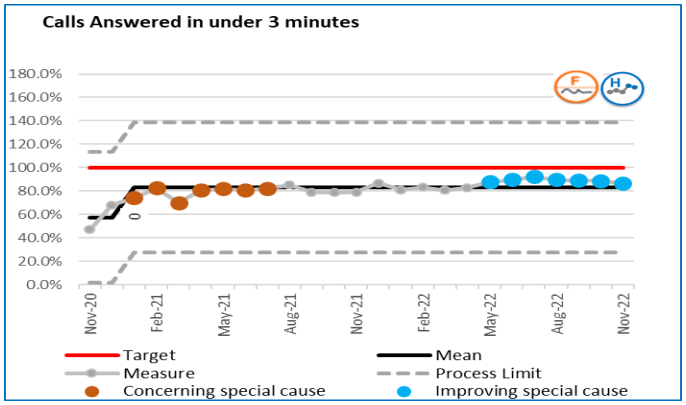
Patient Access – Transformation: Outpatients: CQC: Responsive



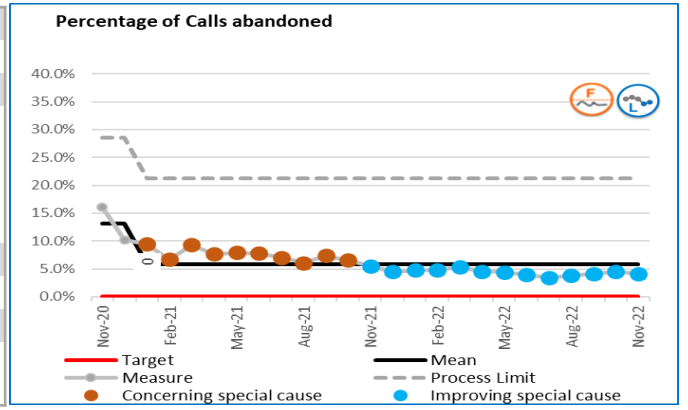
Nov-22
62.9%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target
Target (Internal)
90%
Business Rule
Full Escalation



Nov-22
61.7%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and consistently failing the target
Target (Internal)
85%
Business Rule
Full Escalation



Nov-22
86.4%
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



Nov-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: Screens have been installed in the Ophthalmology CAU office and are on order for T&O. These screens display call performance on the day in real time.

Haematology have now gone live on netcall, the team are monitoring call performance closely.

Recruitment has now been completed for call operatives for the outpatient communication centre pilot. Initially we will be offering support to CAUs to help manage call volumes.

Outpatient appointment re-booking/cancelling web page form has been developed and is due to go live.

Outpatient Utilisation: Introduction of SOAP and Focal to the outpatient team to support management of utilisation of clinic templates

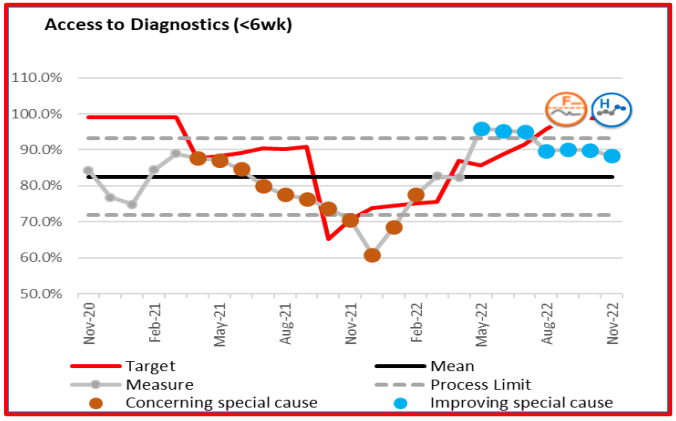
Assurance & Timescales for Improvement:

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.

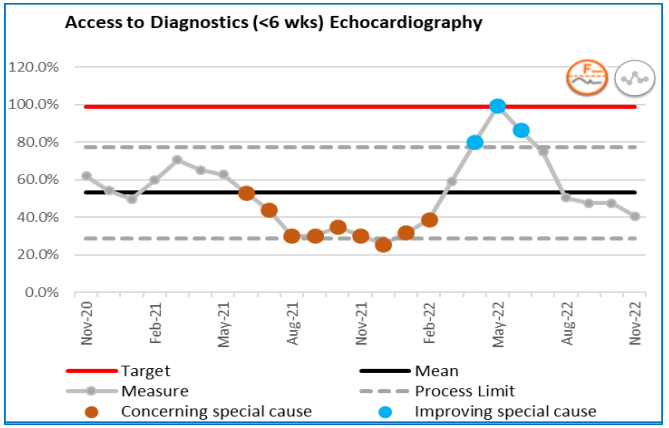
Call performance dashboard is being developed by BI to show call data at weekly performance meetings.

Outpatient Utilisation: Corporate Project on clinic templates

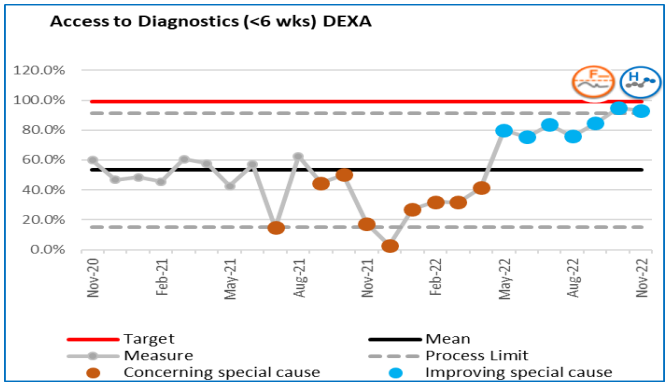
Patient Access – Diagnostics Waiting Times: CQC Responsive



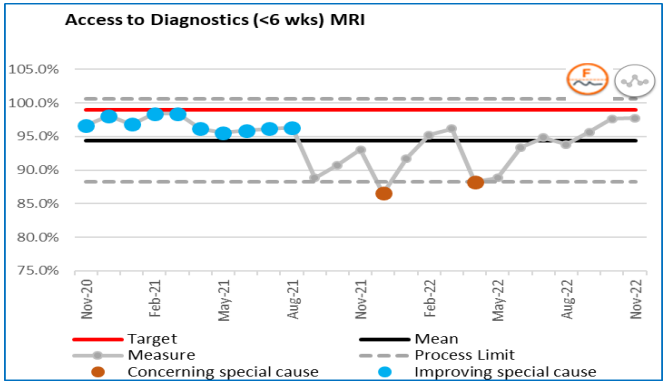
Nov-22
88.3%
Variance / Assurance
Metric is currently experiencing common cause variation and is consistently failing the target
Target (Internal)
88.6%
Business Rule
Full Escalation



Nov-22
40.6%
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



Nov-22
93.2%
Variance / Assurance
Metric is currently experiencing special cause variation of an improving nature and consistently failing the target
Max Limit (Internal)
99%
Business Rule
For Information as Contributor to Overall



Nov-22
97.4%
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

Summary:

Diagnostic Waiting Times: Performance (measured via DM01) is experiencing common cause variation and consistently failing the target. The main contributor to this underperformance is Echocardiography.

Echocardiography: is experiencing common cause variation and consistently failing the target.

DEXA: is experiencing special cause variation of an improving nature and consistently failing the target but this is now showing an improving trend.

MRI: is experiencing common cause variation and has failed the target for more than six months (showing signs of recovery).

Actions:

Echocardiography: The cardiology team have implemented an improvement plan.

DEXA: New DEXA in place at TWH and activity commenced.
Additional outsourcing agreement is agreed.
Additional staff training to ensure a more robust service

MRI: Monitoring equipment has arrived and paediatric backlog now cleared.

Assurance & Timescales for Improvement:

Echocardiography: The procurement of an Echocardiogram machine and repairs on two others is in progress. New starters joining team in November. New clinical space identified and having works carried out to enable use for additional Echo clinics. Review of Direct Access referral process.

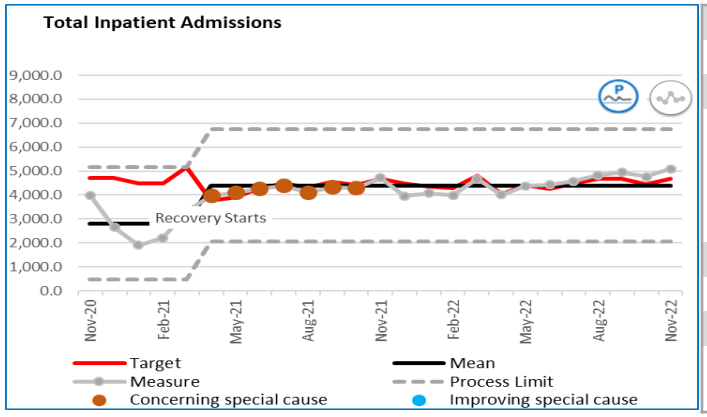
DEXA: Recovery plan in progress and is monitored weekly with DCOO. The plan is on track to be DM01 compliant by the end of October 22 and show in Nov / Dec 22

9.8% improvement made in month

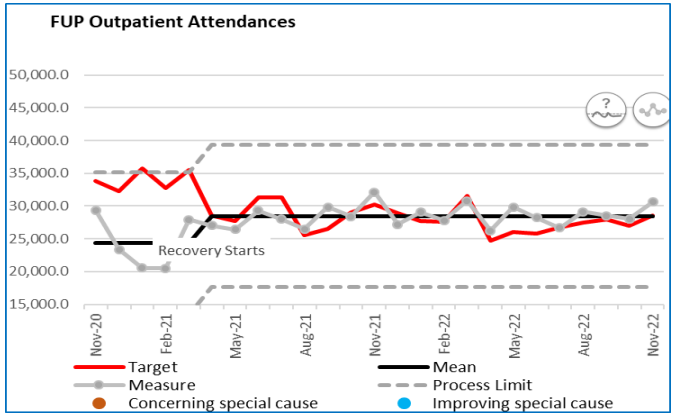
MRI: Paediatric backlog now cleared. Ongoing discussions with Anaesthetics re: cover aligned with managed service

Overall DM01 Recovery Plan in progress.

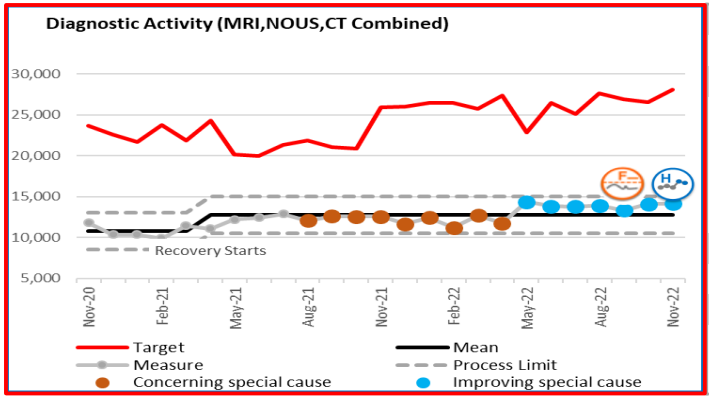
Patient Access –Activity Levels: CQC Responsive



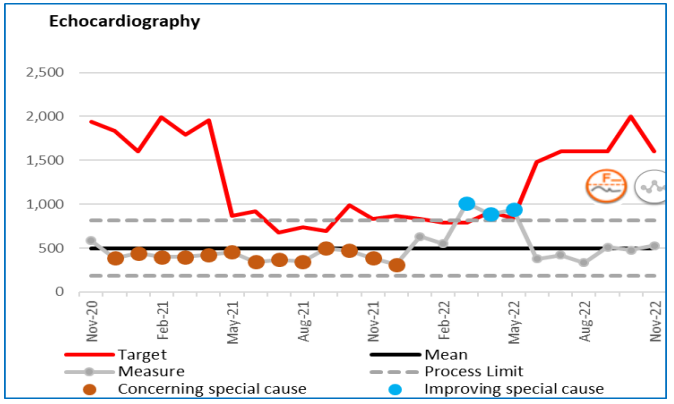
Nov-22
5093
Variance / Assurance
Metric is currently experiencing Common Cause Variation and has passed the target for >6 consecutive months
Target
4667
Business Rule
Not Escalated



Nov-22
30,617
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Target
28,556
Business Rule
Not Escalated



Nov-22
14,153
Variance / Assurance
Metric is currently experiencing special cause variation of an improving nature and consistently failing the target
Target
28,090
Business Rule
Full Escalation as consistently failing the target



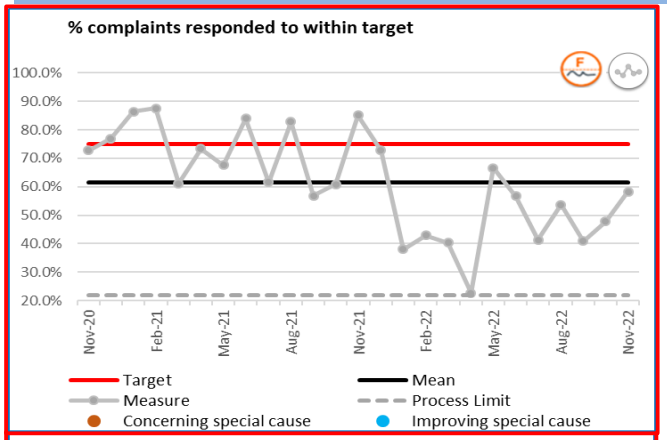
Nov-22
528
Variance / Assurance
Metric is currently experiencing common cause variation and is consistently failing the target
Target
1600
Business Rule
For Information as Contributor to Overall

Summary:	Actions:	Assurance & Timescales for Improvement:
Elective Activity (DC/EL): This indicator is now experiencing common cause variation and has passed the target for >6 consecutive months. Performance has been above plan for June, July , August, September, October and November 2022. Performance is therefore above both plan and 1920 levels YTD. **OP Follow Up Activity:** The activity is experiencing common cause variation and variable achievement of the target. Activity levels for October 2022 were slightly higher than plan and 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. **Echocardiography:** is experiencing common cause variation and consistently failing the target.	**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.	**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.

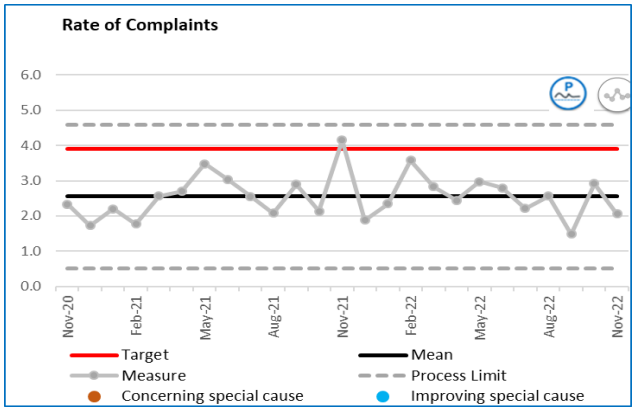
Strategic Theme: Patient Experience

			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Caring	To reduce the overall number of complaints or concerns each month	36	41	Nov-22	36	60	Oct-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	19	Nov-22	24	29	Oct-22	Driver			Verbal CMS
Constitutional Standards and Key Metrics (not in SDR)	Caring	Complaints Rate	3.9	2.1	Nov-22	3.9	3	Oct-22	Driver			Not Escalated
	Caring	% complaints responded to within target	75.0%	58.3%	Nov-22	75.0%	47.8%	Oct-22	Driver			Escalation
	Caring	% VTE Risk Assessment (one month behind)	95.0%	95.7%	Oct-22	95.0%	95.8%	Sep-22	Driver			Not Escalated
	Caring	Friends and Family (FFT) % Response Rate: Inpatients	25.0%	14.1%	Nov-22	25.0%	16.6%	Oct-22	Driver			Not Escalated
	Caring	Friends and Family (FFT) % Response Rate: A&E	15.0%	1.5%	Nov-22	15.0%	0.9%	Oct-22	Driver			Escalation
	Caring	Friends and Family (FFT) % Response Rate: Maternity	25.0%	11.8%	Nov-22	25.0%	10.8%	Oct-22	Driver			Escalation
	Caring	Friends and Family (FFT) % Response Rate: Outpatients	20.0%	5.8%	Nov-22	20.0%	4.7%	Oct-22	Driver			Escalation

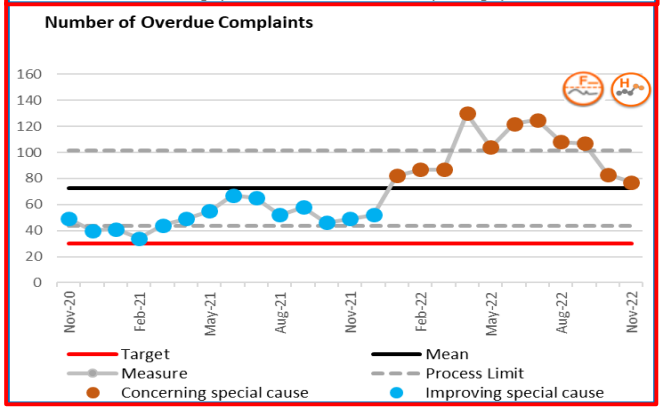
Patient Experience: CQC: Caring (Hit or Miss >6 months)



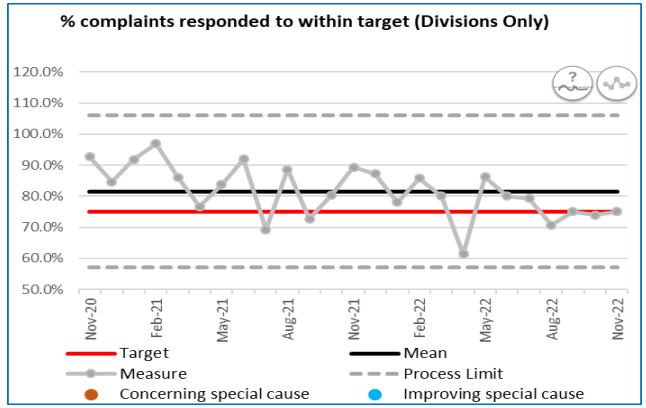
Nov-22
59.3%
Variance / Assurance
Metric is common cause variation and failing the target for 6+ months
Target (Internal)
75%
Business Rule
Full Escalation failed the target 6+ months



Nov-22
2.06
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



Nov-22
77
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



Nov-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

Summary:

% 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

Number of Overdue Complaints: This indicator is experiencing special cause variation of a concerning nature and is consistently failing the target since October 2020.

Actions:

% Complaints responded to within Target:
Complaints performance recovery and stabilisation actions include;

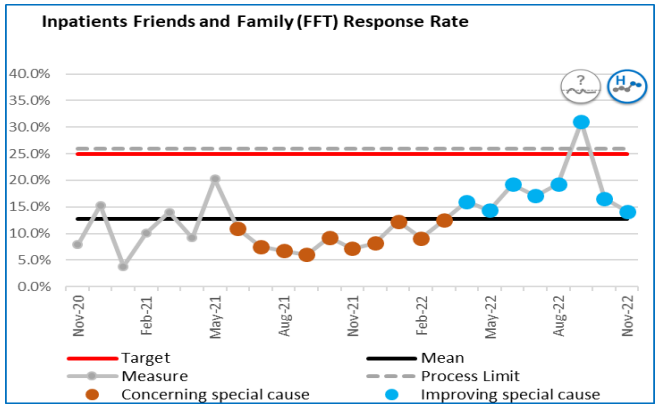
- Interim performance monitoring reported weekly to CN
- Weekly oversight meetings led by CN and DQG
- Additional temporary resource in place up to Jan 2023
- Successful recruitment to x2 12 month Complaint Lead posts
- Business case for revised complaints model (meeting new 2022 National framework) 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

Assurance & Timescales for Improvement:

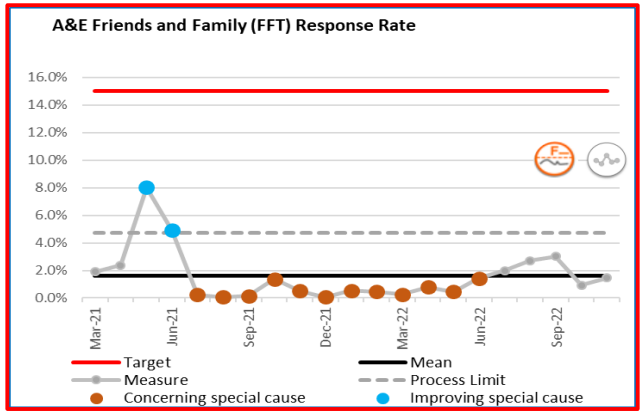
% Complaints responded to within Target:

- Sustained reduction in overall number of open complaints
- No complaints breached due to issues relating to CCT in October
- Expect to see continued improvement in % compliance in November as a result of new 40-day timeframe

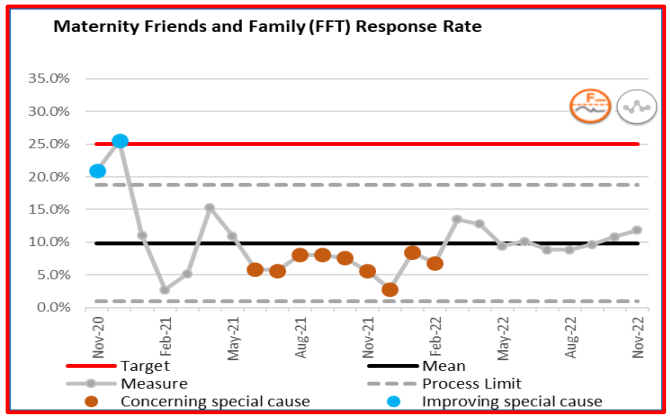
Patient Experience: CQC: Caring



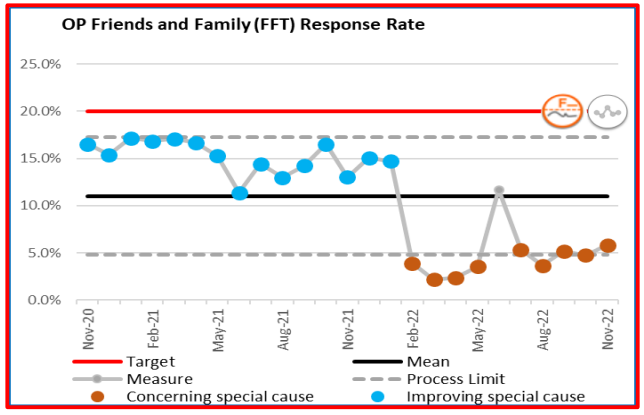
Nov-22
14.1%
Variance / Assurance
Metric is currently experiencing Common cause variation and is consistently failing the target
Target (Internal)
25%
Business Rule
Not Escalated



Nov-22
1.5%
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



Nov-22
11.8%
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



Nov-22
5.8%
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 currently experiencing Common cause variation and has failed the target for >6 months. ***Responses that are positive – 96.5%***

FFT Response Rate A&E: Metric is currently experiencing Common Cause Variation and is consistently failing the target. ***Responses that are positive – 84.0%***

FTT Response Rate Maternity: Metric is currently experiencing common cause variation and is consistently failing the target. ***Responses that are positive – 98.3%***

FFT Response Rate Outpatients: Metric is currently Special Cause Variation of a concerning nature and is consistently failing the target. ***Responses that are positive – 94.2%***

Actions:

FFT Response Rate Inpatients: this is an improving picture.

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

FFT Response Rate Maternity: Assurance requested

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

FFT Response All: In October there was an issue with IQVIA not uploading paper cards onto the FFT platform.

Assurance & Timescales for Improvement:

FFT Response Rate Inpatients: Continue to monitor

FFT Response Rate A&E: Continue to monitor

FFT Response Rate Maternity: Assurance they will continue to promote FFT in clinical areas. Continue to monitor.

FFT Response Rate Outpatients: Assurance requested from Netcall /BI SMS data and a deep dive into all elements of the campaign upload to ensure full capture of all OPD patients. Meeting with BI and Netcall in November. Deep dive ongoing. Outpatient FFT responses in November increased.

FFT Response All: Meetings with IQVIA in November and December for assurance around paper uploads. FFT responses increased in November - we will continue to monitor all aspects of FFT.

Strategic Theme: Systems

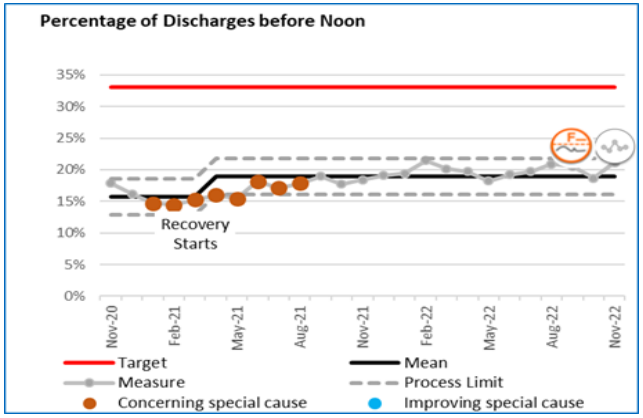
			Latest			Previous			Actions & Assurance			
	CQC Domain	Metric	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions
Vision Goals / Targets	Effective	Decrease the number of occupied bed days for patients identified as medically fit for discharge (shown as rate per 100 occupied beddays)	3.5	6.3	Nov-22	3.5	4.8	Oct-22	Driver	No SPC	No SPC	-
Breakthrough Objectives	Effective	To increase the number of patients leaving our hospitals by noon on the day of discharge	33.0%	21.1%	Nov-22	33.0%	18.6%	Oct-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

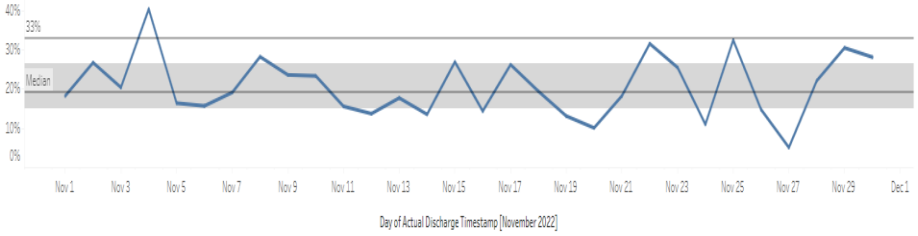


Recent agreement to use TT for more accurate and timely data – data being migrated to Europe Nov, expect usage and integration in Dec

Current Data Source: Allscripts
Nov-22
21.1%
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
33%
Target Achievement
Metric is consistently failing the target

2. Stratified Data

TT Data 30/11/22: 28% DBN There is a clear dip at the weekends reducing our overall average - requiring some focus work



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 EDN Project Group is focussing on this – including providing digital solutions and CoS support for EDNs being completed during ward rounds. Representation from this group attends the Flow Improvement Programme Board chaired by the Director of Operational Nursing.
Pharmacy TAT for Dossett's and TTOs / sent by couriers	Yes however EDN completion seems to be root cause for delays in this area. Post EPMA implementation, pharmacy will continue to make improvements in this area.
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 and improve the current estate.

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

4. Action Plan

Counter-measure	Action	Who	When	Complete
Data Source imprvms.	• Teletracking is a more timely and accurate source of data for DBN with performance. Data migration postponed to 14.12.22 - this enable BI to access the data warehouse for onwards performance tracking. Performance on TT on 30.11.22 was 28%	NS/ RS	12.12..22	In Progress
Hilton Pathway	• Further roll out to all wards of pre-booked (day before) Hilton max. of 5 patients/ day. • New rolling waiting list agreed for up to 5 pts. • New RAG'd referral form displayed around all wards to help with referral rejections rates due to incomplete information. • Focus on patients being wrongly flagged as medically fit – causing process inefficiencies.	Hilton/NP/AG/FR / OT	Start 4.10.22	In Progress
Criteria Led Discharge	• CLD being presented at the Nursing and Midwifery Board in February. • Communications of CLD across organisation. • Engagement with clinical leads from orthopaedics and medicine to aid with implementation of CLD across services. • CLD flag now on Teletracking enabling ward managers to monitor and facilitate at board rounds.	KC/ FR / NP	7.11.22	In Progress

Strategic Theme: Sustainability

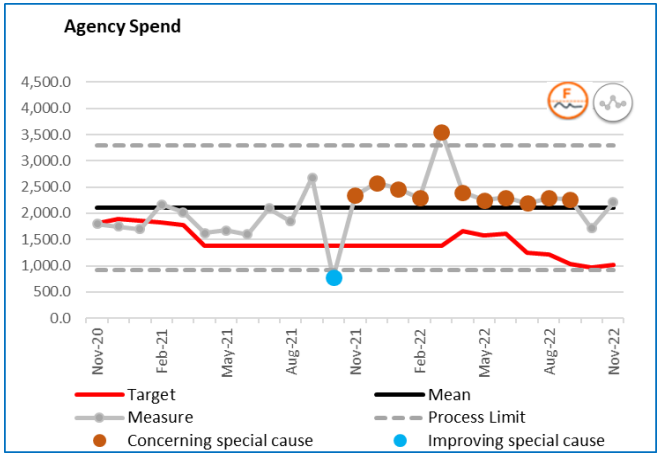
	CQC Domain	Metric	Latest: Trust Target	Latest: Most recent position	Latest: Period	Previous: Trust Target	Previous: Most recent position	Previous: Period	Actions & Assurance: Watch / Driver	Actions & Assurance: Variation	Actions & Assurance: Assurance	Actions & Assurance: CMS Actions
Vision Goals / Targets	Well Led	Delivery of financial plan, including operational delivery of capital investment plan (net surplus(+)/net deficit (-) £000)	1,177	1,178	Nov-22	1,205	1205	Oct-22	Driver			Verbal CMS
Breakthrough Objectives	Well Led	Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000	1019	2212	Nov-22	972	1716	Oct-22	Driver			Full CMS
Constitutional Standards and Key Metrics (not in SDR)	Well Led	CIP	4094	1158	Nov-22	4094	1651	Oct-22	Driver			Not Escalated
	Well Led	Cash Balance (£k)	10620	18319	Nov-22	11403	25051	Oct-22	Driver			Not Escalated
	Well Led	Capital Expenditure (£k)	8402	1607	Nov-22	4388	531	Oct-22	Driver			Not Escalated

Breakthrough: 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

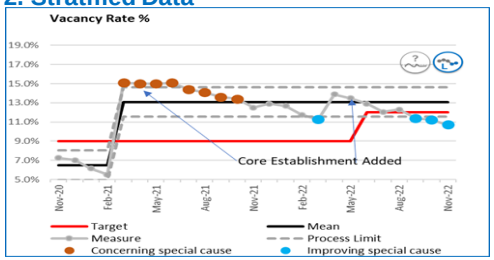
1. Historic Trend Data



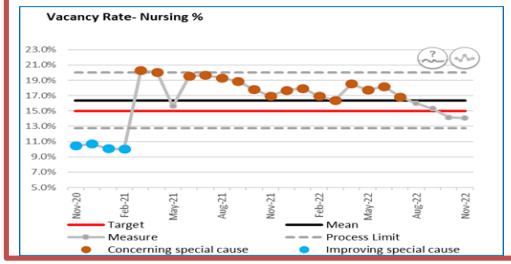
Nov-22
2212
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
1,019
Target Achievement
Metric has not achieved the target for >6 months

Note the Oct 22 value is low due to a release of accruals from previous months

2. Stratified Data



Vacancy Rate: Is now experiencing special cause variation of an improving nature.



Nursing Vacancy Rate: Metric is now experiencing common cause variation and variable achievement of the target..

3. Top Contributors

Vacancy rates are improving and sickness is fairly stable according to reporting figures but our premium workforce spend is not coming down:

Next steps to triangulate the following data against the Top 10 agency spends:

- Healthroster Performance
- Turnover
- Sickness
- Activity

4. Action Plan

The “reason for booking” is inconsistently completed which makes it difficult to determine the top contributors.”

Continued work to balance ESR with the finance ledger	Ongoing
Review of top 25 agency workers	Dec
Review of top 25 high cost locums	Dec
Triangulation of top 10 agency spend areas with sickness, turnover, roster performance and activity	Dec
Identify a high spend area and observe their booking processes form an area perspective and staff bank to understand the data flow	Dec
Review of agency booking controls/authorisation processes	Dec

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Appendices

MTW
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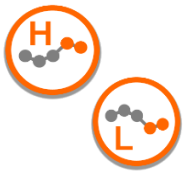
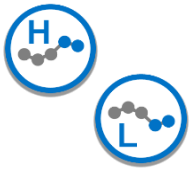
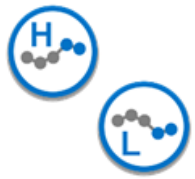
SDR Business Rules Driven by the SPC Icons

Assurance: Failing

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

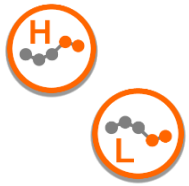
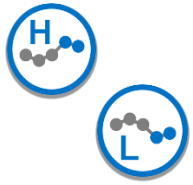
SDR Business Rules Driven by the SPC Icons

Assurance: Hit & Miss

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

SDR Business Rules Driven by the SPC Icons

Assurance: Passing

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

Passing, Failing and Hit & Miss Examples

Metrics that consistently **pass** have:

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

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

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

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

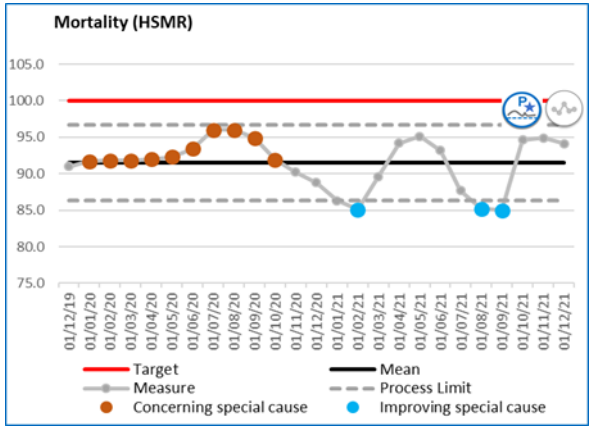
The **target** line **between** the **upper** and **lower** control limit for all metric types

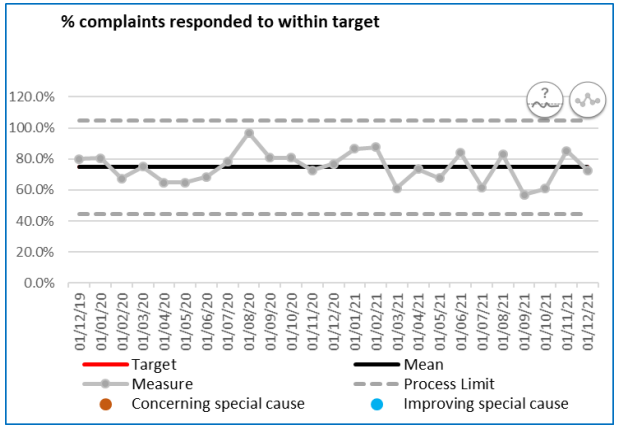
Metrics that consistently **fail** have:

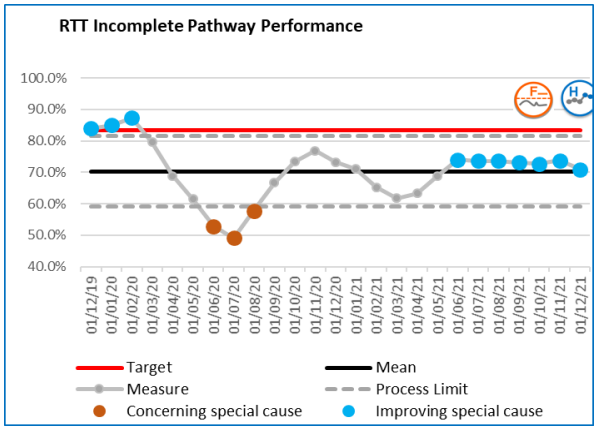
The **lower** control limit **above** the target line for metrics that need to be **below the target**

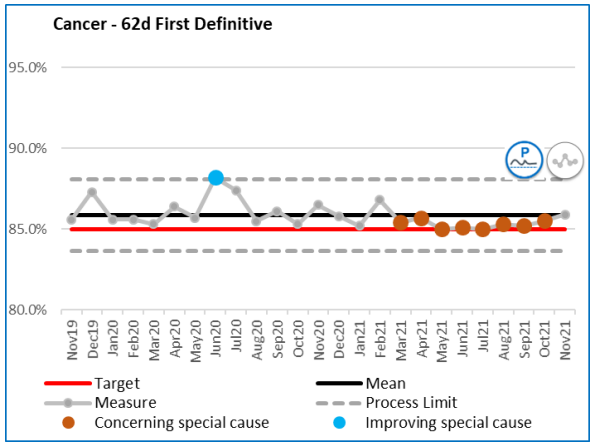
The **upper** control limit **below** the target line for metrics that need to be **above the target**

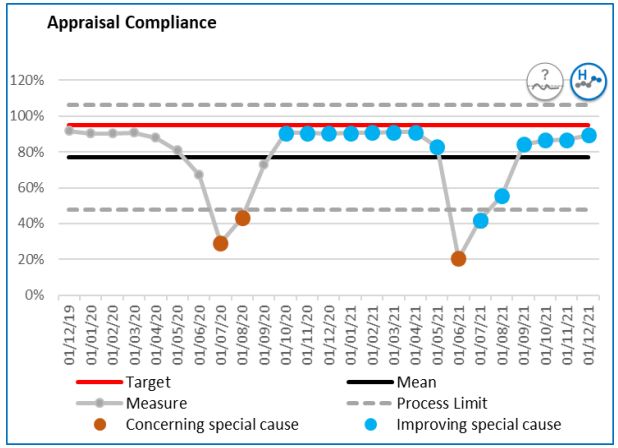
A metric not achieving the target for 6 months or more will be flagged as failing

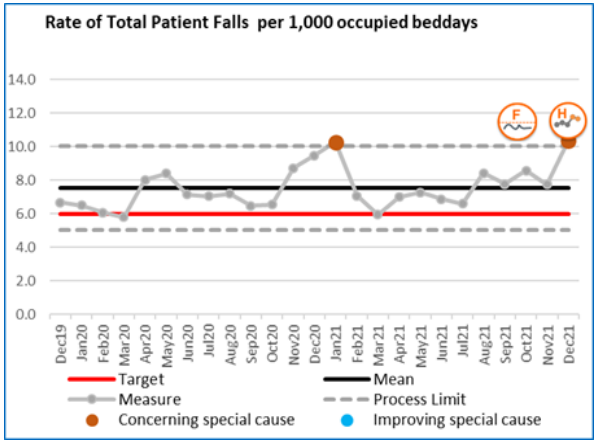












Executive Summary

- The Trust has delivered the November Plan and the Year to Date plan by delivering a surplus of £1.2m in month and a £4.7m deficit year to date.
- The key pressure is within pay budgets which are adverse to plan by £2m. The main pressures continue to be within Emergency Medicine medical staffing (£3.9m) and facilities staffing (£1.3m). These pressures were partly offset by underspends within Nursing (£2.6m) and support to clinical staff (£0.7m).
- Cost Improvement Plans (CIP) are behind of plan with a year to date adverse position of £5.9m. The Trust is forecasting £16.1m slippage to the year end target, a recovery plan has been developed which mainly mitigates this risk with non recurrent measures
- There is a risk of £7.5m associated with Elective Recovery Fund (ERF) clawback as the Elective Activity in April to November was 9% 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 have been indications that no clawback will be applied to systems in H2. There is however a risk that the Trusts other Commissioners may choose to clawback funds including Specialised Commissioning, the YTD financial risk for all the out of area Commissioners equates to circa £2.8m.
- The Trust is forecasting to deliver a breakeven position however this includes mitigations/improvements which are detailed further in the main finance report but there remains a £2.6m risk.

Year to Date Financial Position

- The Trust was on plan, generating a £4.7m deficit.
- The key year to date variances is as follows:
    - **Adverse Variances**
        - CIP Slippage (£5.9m)
        - Pay budgets overspent by £2m. The main pressures continue to be within Emergency Medicine medical staffing (£3.9m) and facilities staffing (£1.3m). These pressures were partly offset by underspends within Nursing (£2.6m) and support to clinical staff (£0.7m).
        - Printing, postage and telephone pressures (£0.4m) which includes a 15% inflation increase for hybrid mail.
        - Additional security costs (£0.2m)
    - **Favourable Variances**
        - Release of £5m from reserves. The following reserves have been released: £1.9m from growth reserve to offset unfunded waiting list initiatives incurred, £1.6m from service developments and £1.5m from contingency to part offset some of the YTD pay pressures and CIP slippage
        - Underspends within Elective outsourcing due to Elective activity below budget (£0.7m) and depreciation underspend (£0.5m)

Risks

- CIP delivery (£16.1m). The Trust is forecasting £16.4m slippage against the CIP target, a recovery plan has been developed which mainly mitigates this risk with non recurrent measures.
- There has been confirmation that the H1 ESRF clawback will not be applied at the System level and there have been indications that no clawback will be applied to systems in H2. However there is a risk that the Trusts other Commissioners may choose to clawback funds including Specialised Commissioning, the YTD financial risk for all the out of area Commissioners equates to circa £2.5m There is also a specific ESRF financial risk included within the £2.8m relating to Radiotherapy commissioned by NHSE Specialised Commissioning that equates to a clawback of £1m, this is being challenged by the Trust due to objections of the inclusion of Radiotherapy in the scope of the ESRF.

Current Month Financial Position

- The Trust was on plan generating a £1.2m surplus in the month.
- The key current month variances are as follows:
  - CIP slippage of £2.9m in the month.
  - Reduction in provisions to reflect latest assessment (£2.3m)
  - Cardiology consumable rebate (£0.7m)

Cashflow:

- The closing cash balance for November was £18.3m reducing down the cash balance from October's position of £25m. The Trust has repaid the £1m to K&M ICB which related to the 21/22 SLA overpayment of income. The Trust has also benefited from the in-year settlement of KMMS development costs which were raised as debtors at year-end 21/22 (c.£6m).
- Forecast levels of expenditure within the cash flow are matched to the I&E position – therefore the underlying performance on I&E and CIPs will materialise as cash pressures or opportunities.
- Part of the carried forward cash balance of £11.8m relates to c£5.8m capital creditors where invoices were not received in March. The capital plan for the year was £41.3m (including c£1.95m System PDC for HASU and National Funding of £29m for the Barn theatre); the majority of the capital spend with the cash flow forecast is within Qtr4 c£20m. The phasing of the capital spend is back ended but will be revised when projects are confirmed, in particular the Barn Theatre project: the precise funding available to the Trust for 22/23 will be determined following the NHSE Joint Investment Committee meeting on the 12th December. The balance sheet is assuming a reduction in capital creditors carried forward from c£5.8m to closing creditors of £3.8m within the cash flow - therefore the capital cash spend overall in the cash flow is currently c.£30.6m.
- The Trust is working with Suppliers, Procurement Department and budget holders/authorised signatories to ensure invoices are receipted, approved and paid as promptly as possible, this is to assist with the Trust adhering to the BPPC (Better Payment Practice Code) target of 95%. Currently the Trust is meeting this in two of the four aspects:

  1. Trade suppliers by value 96.1%
  2. Trade suppliers by volume 96.4%
  3. NHS suppliers by value 94.9%
  4. NHS suppliers by volume 86.7%

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 (OBC to be reviewed/approved on 12/12/2022 by NHSE)

- 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), MoU received and returned. In addition, funding has also been confirmed for Digital Diagnostics (PACS and Home Reporting) of £382k and Endoscopy Decontamination of £58k.

- £4.3m was spent in M8 against the Plan of £20.6m. The variance relates mostly to spend on the Barn and Stroke projects: The Barn project has been delayed pending the OBC approval - preparatory design and other fees have continued at risk. The OBC is being considered at the NHSE Joint Investment Sub-Committee on 12th December. The Stroke business case capital resource was approved in year by the ICB. MTW has applied through NHSE for PDC cash.

Year-end Forecast

- The Trust is currently forecasting to deliver a breakeven position but has unmitigated risks of £2.6m which if materialised would mean the Trust would be overspent by £2.6m
- The forecast already assumes the full release of central held reserves (contingency, service developments and growth reserve) and includes mitigations and actions highlighted within the main report.

Maidstone and Tunbridge Wells NHS Trust

Finance Report

Month 8
2022/23

Maidstone and Tunbridge Wells NHS Trust

November 2022/23

	Current Month					Year to Date					Annual Forecast / Plan		
	Actual	*Plan*	*Variance*	Pass-through	*Revised Variance*	*Actual*	*Plan*	*Variance*	Pass-through	*Revised Variance*	*Forecast*	*Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income	53.8	53.0	0.8	0.2	0.6	426.6	423.0	3.6	(0.4)	4.0	648.9	636.1	12.7
Expenditure	(48.9)	(47.8)	(1.1)	(0.2)	(0.9)	(401.6)	(396.8)	(4.8)	0.4	(5.2)	(602.9)	(588.7)	(14.2)
EBITDA (Income less Expenditure)	4.9	5.2	(0.3)	0.0	(0.3)	25.1	26.2	(1.1)	0.0	(1.1)	46.0	47.5	(1.4)
Financing Costs	(3.8)	(4.1)	0.3	0.0	0.3	(30.2)	(31.4)	1.2	0.0	1.2	(47.2)	(48.7)	1.5
Technical Adjustments	0.0	0.0	0.0	0.0	0.0	0.4	0.4	(0.0)	0.0	(0.0)	1.2	1.2	0.0
Net Surplus / Deficit (Incl Top Up funding support)	**1.2**	**1.2**	**0.0**	**0.0**	**0.0**	**(4.7)**	**(4.7)**	**0.0**	**0.0**	**0.0**	**0.0**	**(0.0)**	**0.0**
Cash Balance	18.3	10.6	7.7		7.7	18.3	10.6	7.7		7.7	2.0	5.0	(3.0)
Capital Expenditure (Incl Donated Assets)	1.6	8.4	6.8		6.8	4.2	20.6	(16.4)		(16.4)	51.6	41.3	(10.3)
Cost Improvement Plan (Internal £30m target)	1.2	4.1	(2.9)		(2.9)	7.8	13.6	(5.9)		(5.9)	13.9	30.0	-16.1

Summary Current Month:
- The Trust was on plan generating a £1.2m surplus in the month.

The Trusts key variances to the plan are:
- CIP slippage of £2.9m in the month.
- The CIP slippage was offset by reduction in provisions to reflect latest assessment (£2.3m) and a Cardiology consumable rebat e (£0.7m)

Year to date overview:
- The Trust was on plan generating a £4.7m deficit year to date.
- The Trusts key variances to the plan are:

Adverse Variances:
- CIP Slippage (£5.9m)
- Pay budgets overspent by £2m. The main pressures continue to be within Emergency Medicine medical staffing (£3.9m) and facili ties staffing (£1.3m). These pressures were partly offset by underspends within Nursing (£2.6m) and support to clinical staff (£0.7m).
- Printing, postage and telephone pressures (£0.4m) which includes 15% inflation pressure associated with Hybrid mail and addit ional security costs (£0.2m)
- **Favourable Variances:**
- Release of £5m from reserves. The following reserves have been released: £1.9m from growth reserve to offset unfunded waiting list initiatives incurred, £1.6m from service developments and £1.5m from contingency to part offset some of the YTD pay pressures and CIP slippage.
- Reduction in provisions to reflect latest assessment (£2.3m)

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 £7.8m savings year to date which is £5.9m adverse to plan.

Risks
- **CIP delivery.** The Trust is forecasting £16.1m slippage against the CIP target, a recovery plan has been developed which mainly mitigates this risk with non recurrent measures.
- **ESRF Clawback**. There has been confirmation that the H1 ESRF clawback will not be applied at the System level and there have been indications that no clawback will be applied to systems in H2. However there is a risk that the Trusts other Commissioners may choose to clawback funds including Specialised Commissioning, the YTD financial risk for all t he out of area Commissioners equates to circa £2.8m There is also a specific ESRF financial risk included within the £2.8m relating to Radiotherapy commissioned by NHSE Specialised Commissioning that equates to a clawback of £1m, t his 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 there is currently a risk of £2.6m unmitigated risks to the forecast.

Nov-22		DAY				NIGHT				TEMPORARY STAFFING						Nurse Sensitive Indicators				Financial review		
Hospital Site name	Health Roster Name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Bank/Agency Usage	Agency as a % of Temporary Staffing	Bank / Agency Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand Unfilled -RM/N (number of shifts)	Overall Care Hours per pt day	FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Stroke Unit (M) - NK551	90.0%	95.7%	-	100.0%	115.0%	134.9%	-	-	43.5%	42.7%	287	20.16	61	7.1	6.5%	100.0%	11	2	447,760	322,744	125,016
MAIDSTONE	Cornwallis (M) - NS959	93.0%	64.3%	-	-	101.1%	173.3%	-	-	47.7%	21.0%	102	7.17	14	5.9	0.0%	-	2	1	106,091	106,445	(354)
MAIDSTONE	Culpepper Ward (M) - NS551	106.9%	77.2%	-	100.0%	111.6%	103.3%	-	-	24.7%	31.5%	40	2.84	10	4.9	10.0%	100.0%	1	0	135,378	130,634	4,744
MAIDSTONE	Foster Clark - NS251	92.5%	67.7%	-	100.0%	104.2%	87.8%	-	-	23.2%	25.2%	92	5.71	27	7.5	17.7%	100.0%	3	1	159,109	153,035	6,074
MAIDSTONE	John Day Respiratory Ward (M) - NT151	90.2%	97.4%	-	-	108.7%	111.7%	-	-	34.5%	40.1%	159	11.11	29	6.2	65.6%	95.2%	1	0	148,686	172,615	(23,929)
MAIDSTONE	Intensive Care (M) - NA251	94.6%	76.2%	-	-	89.9%	77.0%	-	-	9.7%	0.0%	85	5.07	19	57.8	200.0%	83.3%	0	1	264,486	220,980	43,506
MAIDSTONE	Pye Oliver (Medical) - NK259	92.3%	107.7%	-	-	107.8%	130.0%	-	-	40.3%	52.2%	89	6.28	17	6.3	-	-	0	1	129,560	142,431	(12,871)
MAIDSTONE	Whatman Ward - NK959	80.5%	102.2%	-	100.0%	102.0%	276.5%	-	-	72.6%	42.9%	122	8.54	11	6.5	10.4%	100.0%	6	0	100,051	154,455	(54,404)
MAIDSTONE	Lord North Ward (M) - NF651	104.1%	104.6%	-	100.0%	100.0%	100.6%	-	-	5.9%	5.5%	17	1.22	6	8.0	-	-	3	0	113,978	109,880	4,098
MAIDSTONE	Mercer Ward (M) - NJ251	95.9%	103.6%	-	100.0%	106.6%	138.9%	-	-	28.9%	52.1%	68	4.74	10	6.1	-	-	5	1	111,630	126,383	(14,753)
MAIDSTONE	Edith Cavell - NS459	104.9%	89.6%	-	100.0%	113.3%	111.7%	-	-	47.7%	33.0%	99	6.98	15	7.1	9.8%	100.0%	4	1	115,314	126,685	(11,371)
MAIDSTONE	Short Stay Surgical Unit (M) - NE751	105.3%	103.2%	-	-	91.7%	-	-	-	15.1%	3.5%	15	0.99	0	20.3	-	-	0	0	55,664	59,186	(3,522)
MAIDSTONE	Acute Medical Unit (M) - NG551	94.5%	84.5%	-	-	112.7%	196.7%	-	-	24.1%	22.8%	64	4.42	26	7.9	2.3%	100.0%	1	0	167,876	178,007	(10,131)
TWH	Ward 22 (TW) - NG332	71.9%	72.4%	-	100.0%	98.9%	134.8%	-	-	48.0%	51.9%	136	9.58	61	5.3	33.3%	94.1%	5	1	143,120	150,509	(7,389)
TWH	Coronary Care Unit (TW) - NP301	80.9%	49.7%	-	-	83.3%	-	-	-	20.3%	27.2%	58	4.20	26	10.4	100.0%	96.9%	0	0	72,344	73,294	(950)
TWH	Ward 33 (Gynae) (TW) - ND302	95.3%	99.4%	-	-	98.4%	99.7%	-	-	24.6%	6.8%	42	2.72	4	7.1	17.2%	100.0%	0	0	98,025	99,107	(1,082)
TWH	Intensive Care (TW) - NA201	119.1%	119.5%	-	-	112.8%	103.6%	-	-	16.8%	0.0%	132	8.80	0	31.9	900.0%	100.0%	0	0	387,399	364,963	22,436
TWH	Acute Medical Unit (TW) - NA901	88.0%	65.0%	-	100.0%	98.8%	74.4%	-	100.0%	23.2%	27.4%	148	10.90	72	7.4	13.1%	93.8%	3	0	240,445	205,423	35,022
TWH	Surgical Assessment Unit (TW) - NE701	116.5%	139.3%	-	-	93.3%	93.3%	-	-	41.4%	7.9%	69	4.77	8	21.3	-	-	0	0	75,005	82,768	(7,763)
TWH	Ward 32 (TW) - NG130	68.6%	81.6%	-	100.0%	72.5%	86.7%	-	-	21.5%	24.7%	149	10.42	69	7.8	11.4%	100.0%	3	0	144,071	138,858	5,213
TWH	Ward 10 (TW) - NG131	106.2%	77.1%	-	-	98.4%	133.3%	-	-	27.3%	29.4%	100	6.89	14	6.0	2.9%	100.0%	10	0	142,984	154,907	(11,923)
TWH	Ward 11 (TW) Winter Escalation 2019 - NG144	73.9%	80.1%	-	-	124.5%	87.8%	-	-	64.7%	34.8%	207	14.65	51	5.5	-	-	5	4	151060	148943.92	2116.08
TWH	Ward 12 (TW) - NG132	80.9%	86.6%	-	100.0%	98.9%	80.7%	-	-	31.4%	26.2%	132	8.59	59	5.5	10.8%	100.0%	2	0	142,848	147,951	(5,103)
TWH	Ward 20 (TW) - NG230	79.9%	91.1%	-	-	116.7%	98.9%	-	-	33.7%	51.1%	138	9.78	62	5.8	46.7%	90.5%	14	1	168,317	141,362	26,955
TWH	Ward 21 (TW) - NG231	92.3%	86.7%	-	100.0%	108.4%	110.0%	-	-	42.8%	61.4%	225	15.10	60	6.4	1.6%	100.0%	3	1	145,279	153,946	(8,667)
TWH	Ward 2 (TW) - NG442	75.4%	84.3%	-	100.0%	114.8%	155.6%	-	-	50.1%	52.4%	152	10.90	75	6.7	84.4%	74.1%	8	0	177,009	186,383	(9,374)
TWH	Ward 30 (TW) - NG330	91.5%	83.1%	-	100.0%	114.3%	146.3%	-	-	53.4%	48.5%	197	12.84	49	6.4	19.6%	100.0%	7	1	122,390	182,591	(60,201)
TWH	Ward 31 (TW) - NG331	88.4%	116.1%	-	-	124.4%	99.2%	-	-	31.0%	33.2%	147	9.64	49	6.7	74.4%	96.9%	7	5	136,506	190,925	(54,419)
Crowborough	Crowborough Birth Centre (CBC) - NP775	69.1%	92.7%	-	-	60.0%	96.7%	-	-	15.9%	0.0%	60	3.36	5	161.5	85.7%	100.0%	0	0	142,044	96,876	45,168
	Midwifery (multiple rosters)	78.9%	63.2%	-	100.0%	86.2%	85.0%	-	-	17.2%	6.1%	782	43.87	189	10.5	24.2%	95.9%	0	0	781,365	861,117	(79,752)
	Hedgehog Ward (TW) - ND702	118.9%	46.8%	-	-	145.7%	46.8%	-	-	47.7%	63.4%	270	19.15	62	9.5	1.3%	100.0%	0	0	147,273	208,496	(61,223)
MAIDSTONE	Maidstone Birth Centre - NP751	107.3%	90.1%	-	-	100.0%	94.9%	-	-	16.9%	0.0%	48	2.17	1	55.6	79.4%	100.0%	0	0	73,878	87,835	(13,957)
TWH	SCBU (TW) - NA102	95.8%	51.0%	-	-	101.7%	66.8%	-	-	24.4%	4.4%	143	8.59	15	10.6	7.1%	100.0%	0	0	207,587	203,777	3,810
TWH	Short Stay Surgical Unit (TW) - NE901	90.9%	61.3%	-	100.0%	93.0%	103.3%	-	-	17.5%	15.1%	53	3.63	7	10.8	-	-	1	0	79,831	93,079	(13,248)
MAIDSTONE	Accident & Emergency (M) - NA351	95.1%	105.4%	-	100.0%	97.8%	91.4%	-	-	28.9%	26.8%	328	23.07	49		1.9%	87.6%	1	0	374,574	450,119	(75,545)
TWH	Accident & Emergency (TW) - NA301	95.0%	84.4%	-	100.0%	98.1%	86.9%	-	100.0%	39.3%	48.8%	450	31.34	42		1.0%	77.0%	5	0	403,226	490,892	(87,666)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	94.5%	97.5%	-	100.0%	95.0%	-	-	-	14.6%	3.5%	16	1.11	1	17.0	32.6%	100.0%	0	0	57,536	60,071	-2,535
MAIDSTONE	Peale Ward COVID - ND451	66.3%	84.8%	-	100.0%	96.6%	100.0%	-	-	18.8%	14.4%	44	3.18	17	9.0	32.4%	100.0%	2	0	122,523	95,838	26,685
TWH	Private Patient Unit (TW) - NR702	109.5%	73.0%	-	100.0%	68.3%	100.0%	-	-	19.3%	2.2%	52	3.69	26	8.6	108.6%	100.0%	0	0	75,053	24,454	50,599
																Total Established Wards				6,867,275	7,097,961	(230,686)
																Additional Capacity beds	Cath Labs			55,152	40,719	14,433
																	Crowborough Birth Centre (CBC)					
																Other associated nursing costs				4,969,407	4,521,640	447,767
																				11,891,834	11,660,320	231,514

Under fill

Overfill

Green: equal to or greater than 90% but less than 110%
Amber Less than 90% OR equal to or greater than 110%
Red equal to or less than 80% OR equal to or greater than 130%

NHS Maidstone and Tunbridge Wells NHS Trust

Quarterly mortality data **Medical Director**

This report is submitted in line with guidance from the National Quality Board, March 2017. This stipulates that Trusts are required to collect and publish on a quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public board meeting in each quarter to set out the Trust's policy and approach and publication of the data and learning points.

Which Committees have reviewed the information prior to Board submission?
- 'Main' Quality Committee, 09/11/22

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

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Mortality Surveillance Group Report

October 2022

MTW
exceptional people, outstanding care

Contents

Note: Detailed analysis and a deep dive into specific areas are available on request - mtw-tr.informationdepartment@nhs.net

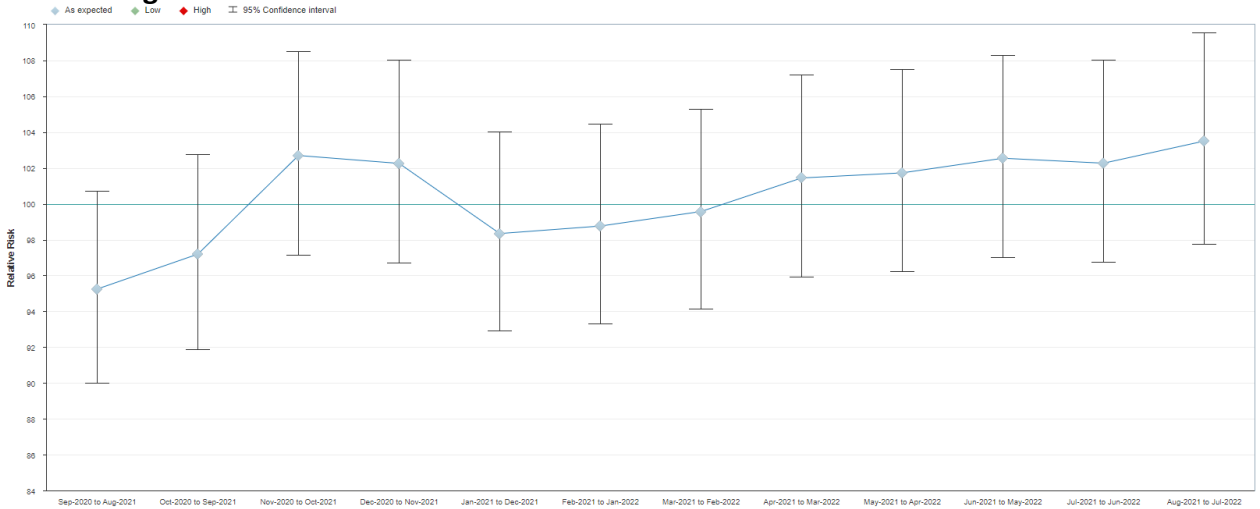
Executive Summary

- T Health (Dr Foster) have updated on schedule. Published data is up to **July 2022**.
- HSMR has risen from the previous period– Rolling HSMR currently at **103.5**. We are in the "as expected" bracket.
- **Due to flex coding in the most recent month when reporting is pulled, it is recommended that the HSMR figure reported is 4 months in arrears (so the 2nd to last datapoint on the charts).** Report from T-Health explains recommendation further (appendix 1).
- Monthly HSMR shows an increase in Jun 22 (88.8), in the "as expected" bracket
- The latest reporting month saw two CUSUM alerts – Pneumonia & Residual Codes, Unclassified
- Weekend and Weekday HSMR are above the national average, but is in the "as expected" bracket. Further analysis suggests case mix and coding around Covid episodes are influencing the expected rate, as well as flex coding in the most recent month of a dataset. Crude mortality is consistently below the national average.
- Deaths with no comorbidities on a rolling 12 month basis have remained fairly static in the latest published dataset. Those deaths with no comorbidities focussed on Geriatric and Respiratory Medicine
- Trust SHMI continues to perform in the green.

HSMR Overview

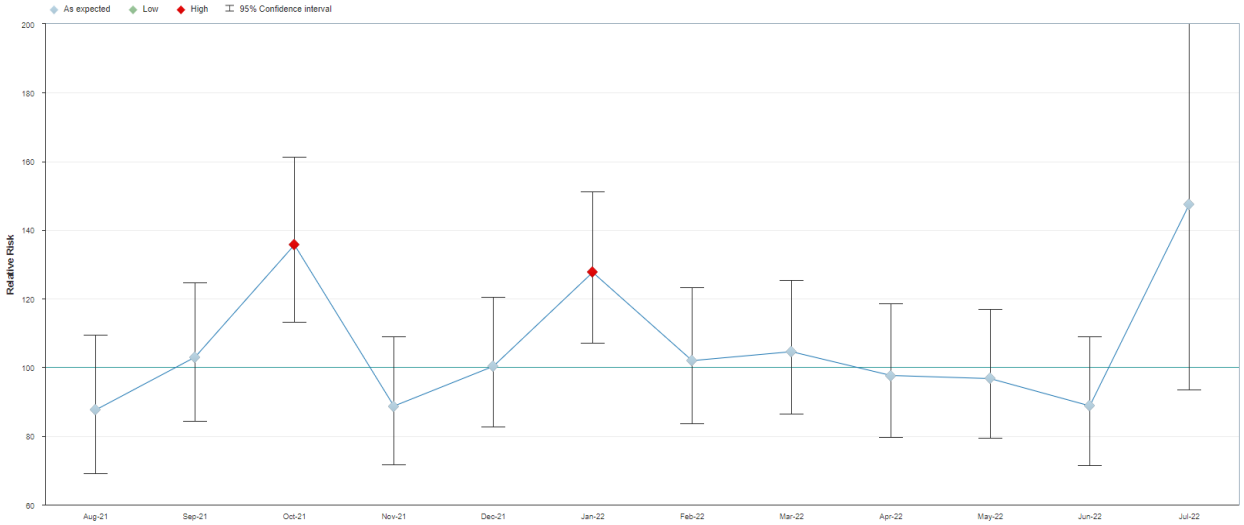
Maidstone and Tunbridge Wells NHS Trust

Rolling 12 Months



The 12 months **Aug 2021 to Jul 2022** show our HSMR to be **103.5**, an increase on last month's figure of **102.3**. The This places the Trust in the "as expected" bracket

Monthly View



The latest month should be viewed with caution as this often shows a false position due to the lag in coding activity. Viewing the previous month, so **June 2022** in this case, shows that the Trust's position has decreased to **88.8** from **96.7** in May 2022. The monthly view should be taken with caution, however, with a the rolling 12 month view a much more robust view of HSMR

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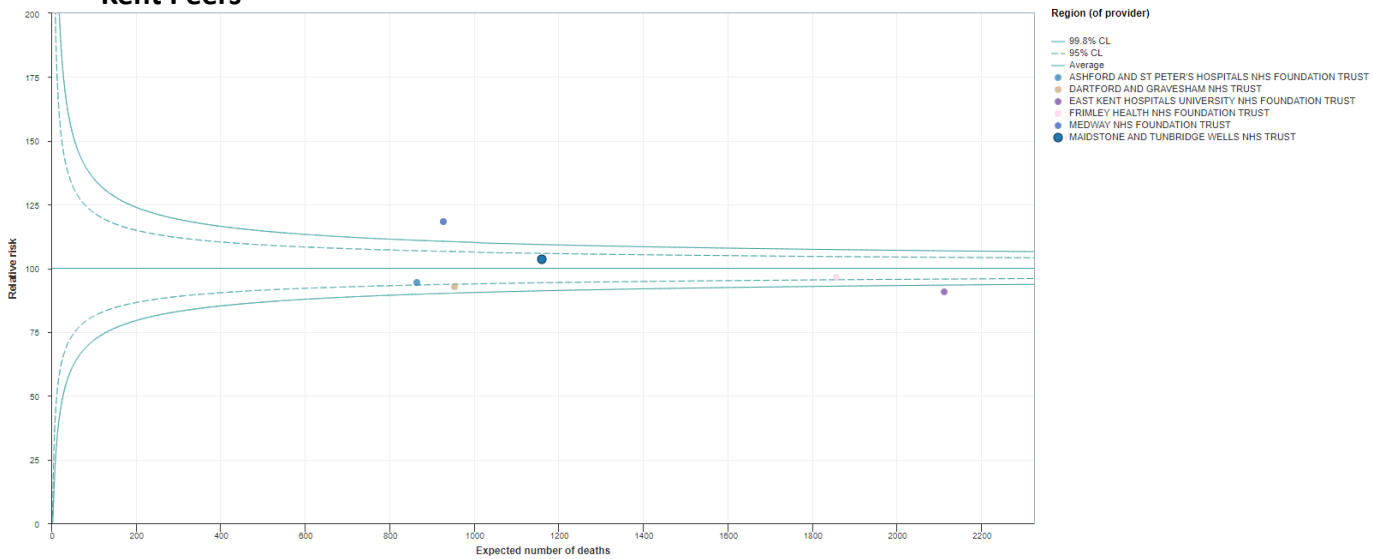
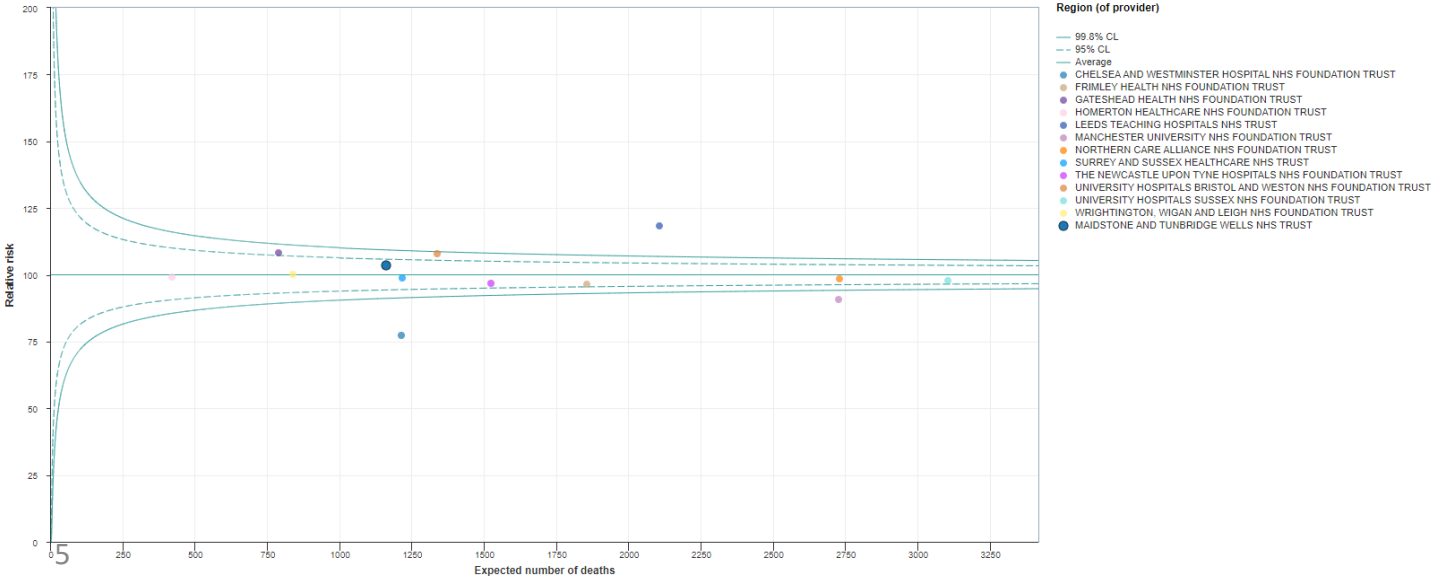
HSMR – Benchmarking

Maidstone and Tunbridge Wells NHS Trust

Kent Peers



Good & Outstanding Trusts



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CUSUM Alerts - Overview

NHS
Maidstone and Tunbridge Wells
NHS Trust

Relative risk & CUSUM alerts

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
All Diagnoses	1 8	128148	1636	1575.4	1.3	103.8				
HSMR (56 diagnosis groups)	1	39429	1201	1160.6	3.0	103.5				
Congestive heart failure, nonhypertensive	1	701	88	66.8	12.6	131.7				
Intestinal infection	1	1016	15	9.4	1.5	160.2				
Multiple sclerosis	1	29	1	0.7	3.4	148.2				
Occlusion or stenosis of precerebral arteries	1	5	1	0.1	20.0	1459.3				
Other upper respiratory infections	1	479	2	0.4	0.4	567.0				
Pneumonia		1621	243	202.7	15.0	119.9				
Residual codes, unclassified	2 4	8309	111	65.8	1.3	168.7				
Septicemia (except in labour)	1	716	130	98.9	18.2	131.5				
All Procedures	1	76808	1094	1065.1	1.4	102.7				
Chemotherapy		320	6	2.0	1.9	303.8				
Diagnostic imaging of heart		1058	49	34.5	4.6	142.2				
Other destruction of haemorrhoid	1	41	1	0.0	2.4	5904.1				

Highest observed exceeding expected

Title	Rel. risk	Vol	Obs	Exp	O-E
Residual codes, unclassified	168.7	8309	111	65.8	45.2
Pneumonia	119.9	1621	243	202.7	40.3
Septicemia (except in labour)	131.5	716	130	98.9	31.1
Congestive heart failure, nonhypertensive	131.7	701	88	66.8	21.2
Rest of Upper GI	109.3	1189	185	169.2	15.8

Highest crude rates

Title	Rel. risk	Vol	Obs	%
Cardiac arrest and ventricular fibrillation	84.2	34	14	41.2
Aspiration pneumonitis, food/vomitus	109.7	239	68	28.5
Respiratory failure, insufficiency, arrest (adult)	112.7	70	16	22.9
Occlusion or stenosis of precerebral arteries	1459.3	5	1	20.0
Septicemia (except in labour)	131.5	716	130	18.2

CUSUM alerts for Pneumonia and Residual Codes, Unclassified for latest month

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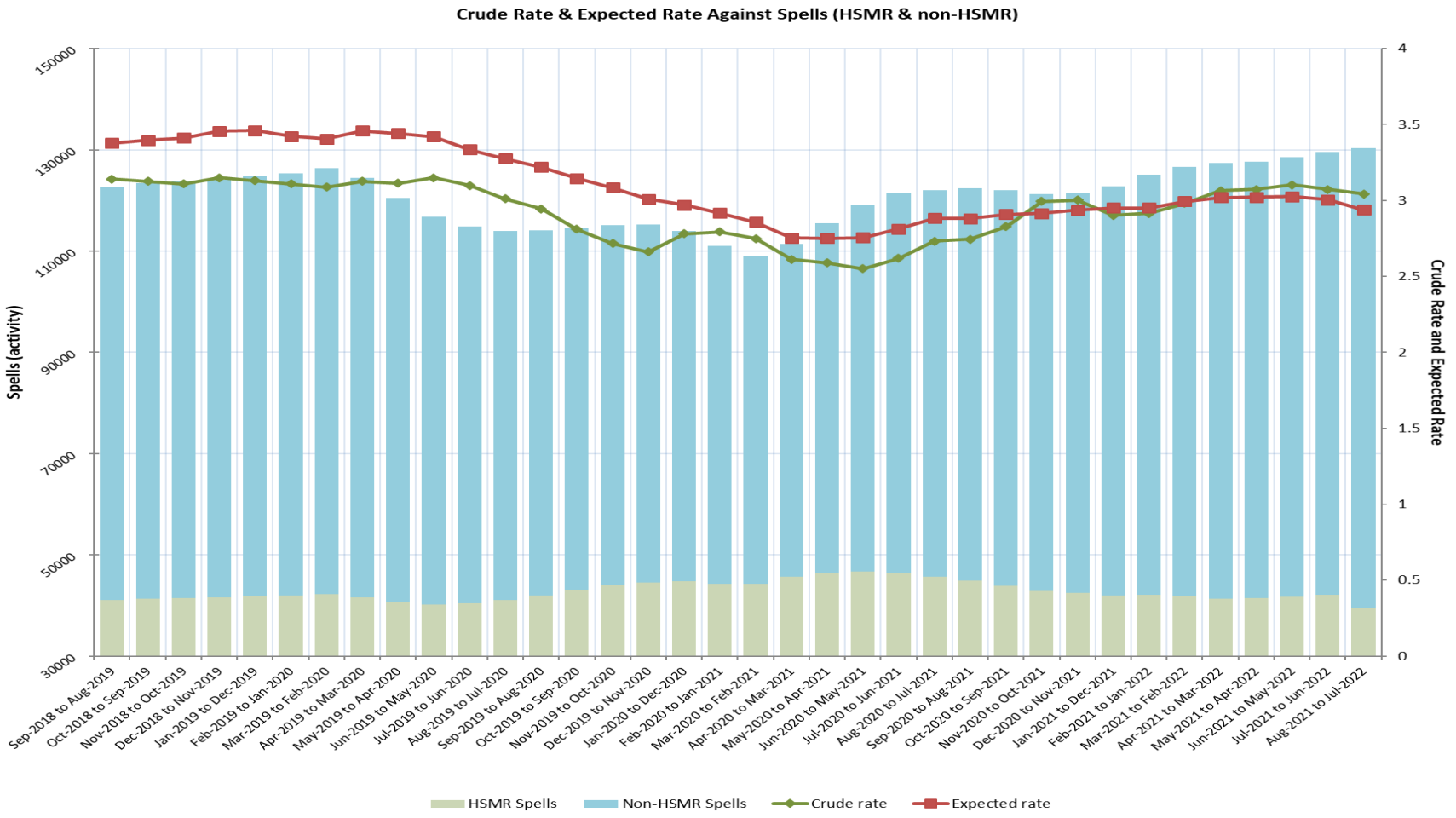
Crude & Expected Rate Against Spell Comparison

Maidstone and Tunbridge Wells NHS Trust



Crude mortality higher than the expected rate, though both are reducing, combined with increased spell volumes.

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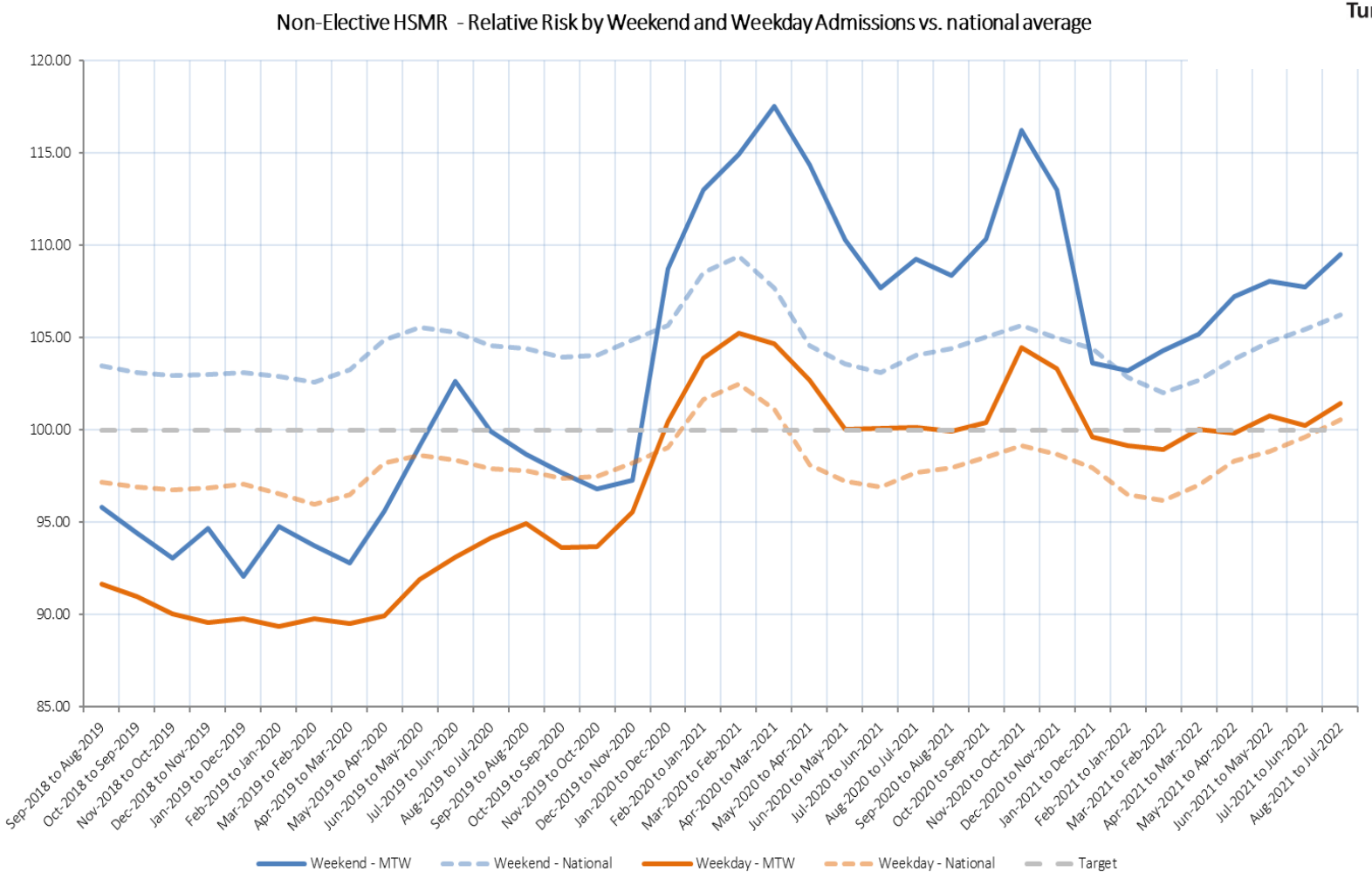
HSMR – Weekend & Weekday Comparison – Non-Elective Care

Maidstone and Tunbridge Wells NHS Trust



Weekend and Weekday HSMR for non-elective care are above the national average, with relative risks of **109.52** and **101.45** respectively. Whilst above the national average, weekday remains in the "as expected" bracket.

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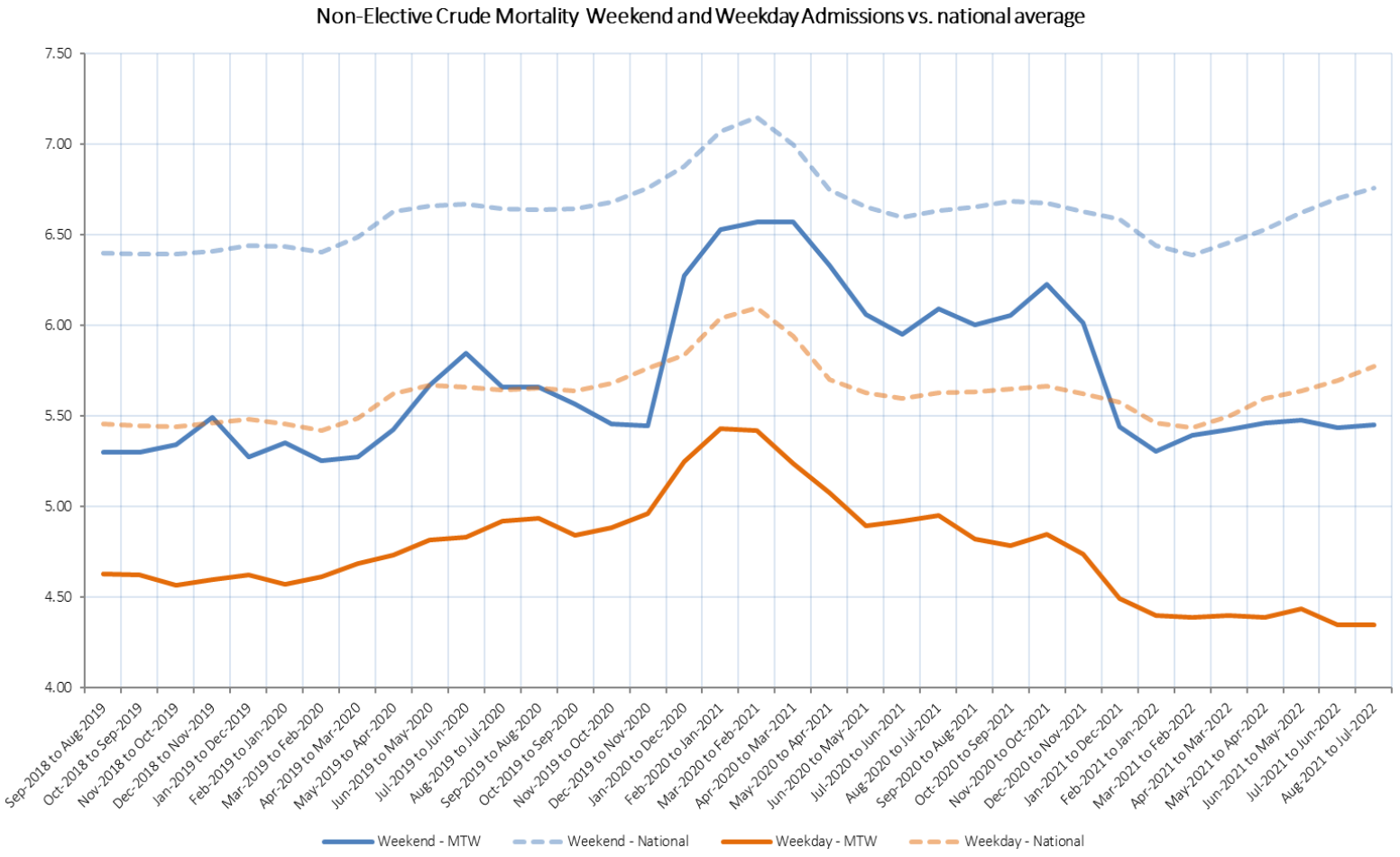
Crude Mortality – Weekend & Weekday Comparison – Non-Elective Care

Maidstone and Tunbridge Wells NHS Trust



When doing the same weekend-Weekday comparison for crude mortality, we see that MTW continues to be consistently lower than the national averages, pointing to an interaction with the **expected** mortality rate driving HSMR above the national average

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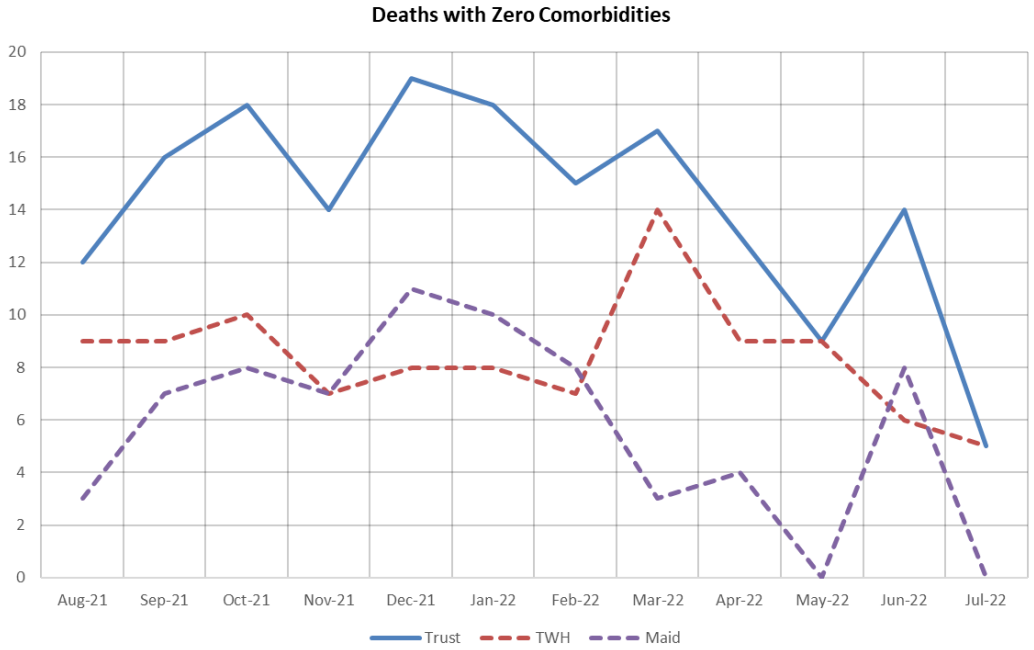
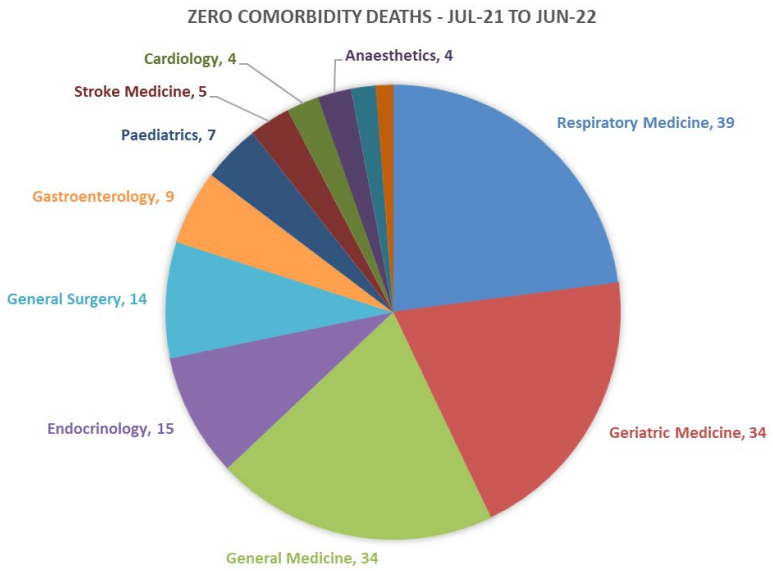
Deaths with Zero Comorbidities



Month	Trust	TWH	%	Maid	%
Aug-21	12	9	75.0	3	25.0
Sep-21	16	9	56.3	7	43.8
Oct-21	18	10	55.6	8	44.4
Nov-21	14	7	50.0	7	50.0
Dec-21	19	8	42.1	11	57.9
Jan-22	18	8	44.4	10	55.6
Feb-22	15	7	46.7	8	53.3
Mar-22	17	14	82.4	3	17.6
Apr-22	13	9	69.2	4	30.8
May-22	9	9	100.0	0	0.0
Jun-22	14	6	42.9	8	57.1
Jul-22	5	5	100.0	0	0.0
All	**170**	**101**	59.4	**69**	40.6

Of the **1,189** deaths recorded in the period of **August 2021 to July 2022**, **170** had no comorbidities recorded (**14.30%**). The volume of deaths recorded with no comorbidities has remained fairly static (169 in previous period).

Deaths with Zero Comorbidities – By Specialty

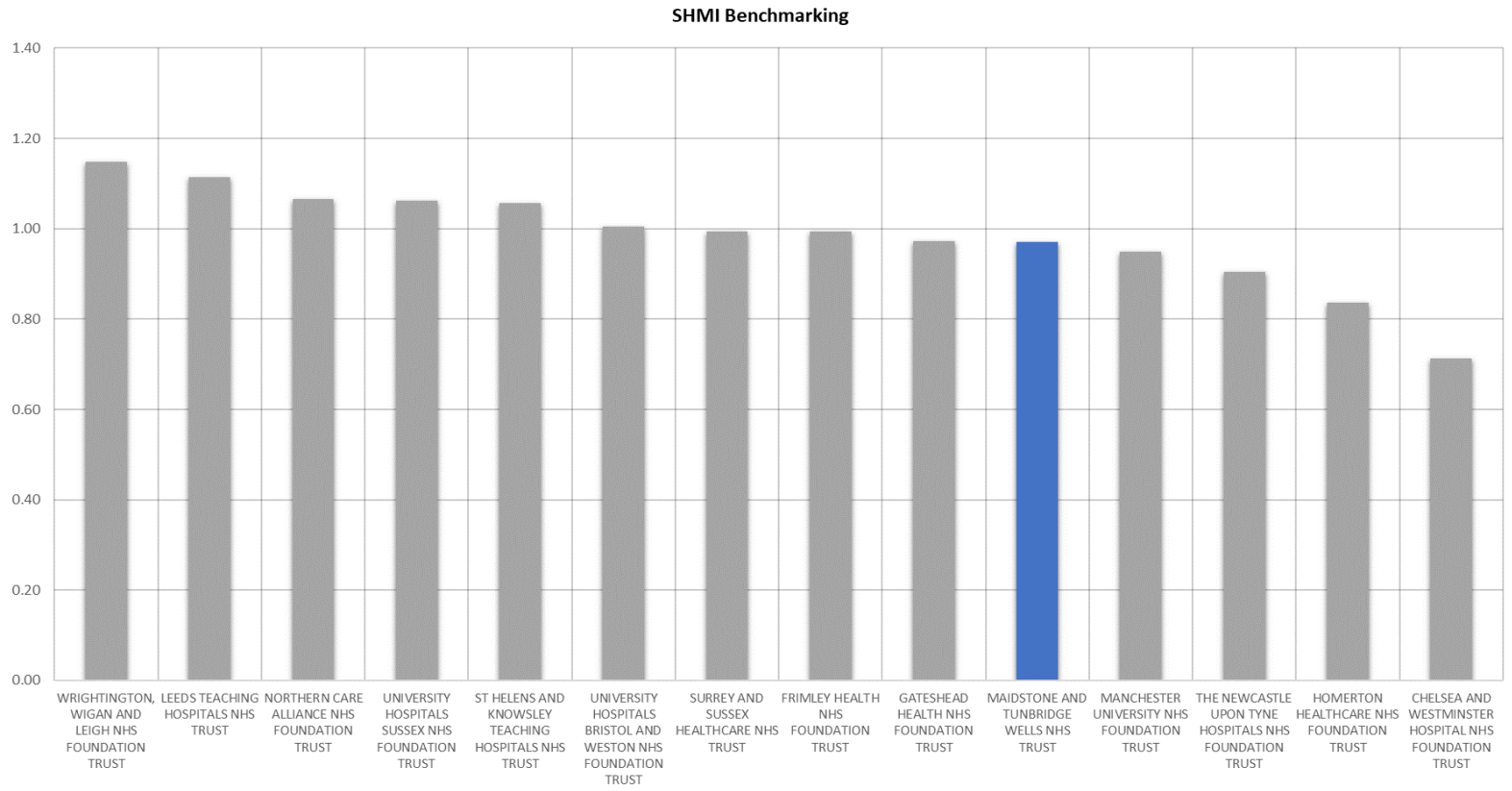


	Jun-21 May-22		Jul-21 Jun-22		Aug-21 Jul-22	
Specialty (of discharge)	**Deaths**	**%age**	**Deaths**	**%age**	**Deaths**	**%age**
Geriatric Medicine	46	27%	41	24%	34	20%
Respiratory Medicine	34	20%	35	21%	39	23%
General Medicine	33	19%	32	19%	34	20%
General Surgery	13	8%	14	8%	14	8%
Stroke Medicine		0%		0%	5	3%
Gastroenterology	11	6%	9	5%	9	5%
Endocrinology	13	8%	16	9%	15	9%
Cardiology	3	2%	4	2%	4	2%
Clinical Haematology	2	1%	2	1%		0%
Trauma & Orthopaedics	3	2%	3	2%	3	2%
Anaesthetics	3	2%	3	2%	4	2%
Accident & Emergency	2	1%	2	1%	2	1%
Paediatrics	8	5%	8	5%	7	4%
ENT		0%		0%		0%
Gynaecology		0%		0%		0%
Well Babies		0%		0%		0%
Urology		0%		0%		0%
All	171		169		170	

The majority of zero comorbidity deaths continue to be in **Geriatric Medicine and Respiratory Medicine Specialties**.

SHMI

Maidstone and Tunbridge Wells NHS Trust



As a trust we are performing favourably against our peers on SHMI – with a SHMI of **0.97** for the period of **June 2021 to May 2022** and continue to be rated 'As Expected'.

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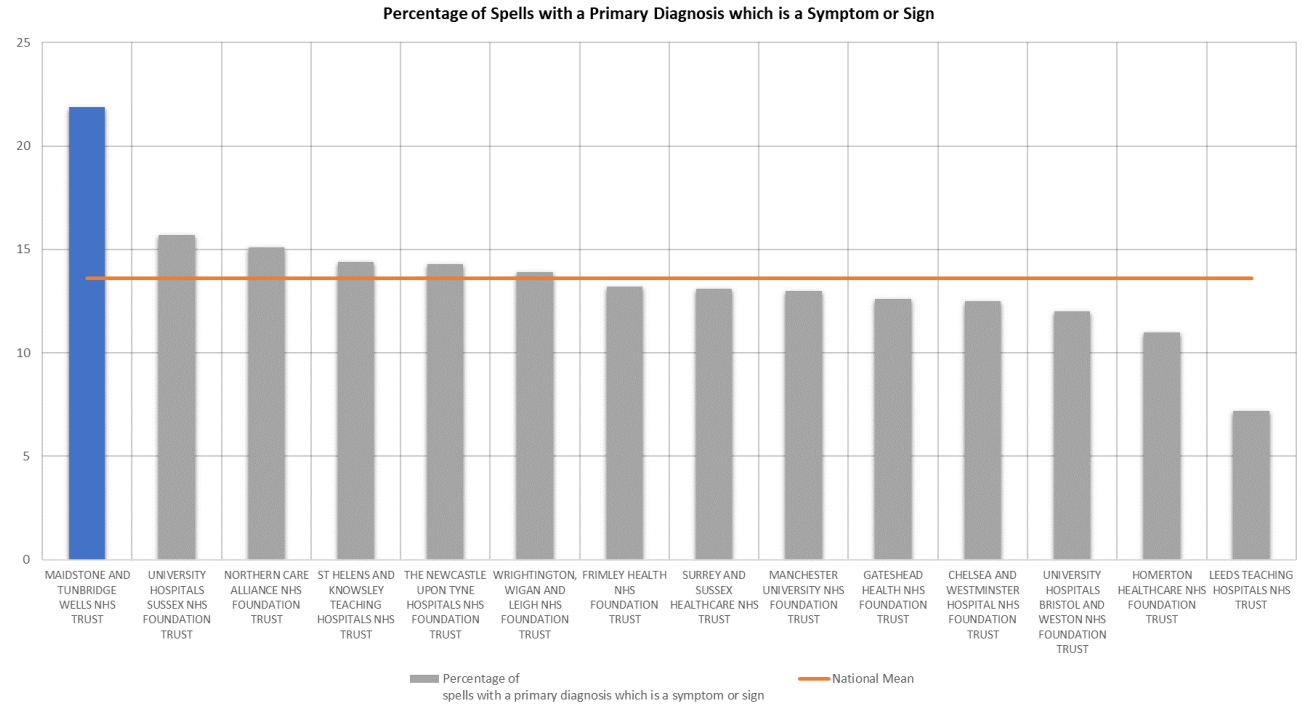
SHMI – Contextual Indicators

Maidstone and Tunbridge Wells NHS Trust



This is historical data that is keeping our primary diagnosis with signs and symptoms score high, Once T Health can reflect October 2022 coded data we should be able to see the improvements that have been made in clinical coding .

These improvements are:

- Only Clinical Coders who hold the National Accreditation Qualification code Deceased patients
- Any deceased patient with a sign or symptom code recorded in primary is validated by our Clinical Coding Audit team

We can now be assured that the Clinical Coding is correct and the focus for improvement would be the what is written in Clinical Documentation.

Action: We need a clinical representative to join one of our clinical coding data quality groups, where we will be able to validate these cases and confirm the content of the healthcare record is correct.

Medical Examiner Service

ME Service Update

- In the month of August 2022, there was a sharp increase in the number of cases scrutinised by the ME Service followed by a decline in September.
- The Service has consistently performed well, scrutinising 100% of in hospital non coronial deaths in the past three months.
- The ME Service continues to scrutinise a small number of community deaths as part of the pilot to roll out of ME Service into the West Kent community. This is expected to become a statutory requirement by April 2023.
- Emis training for members of the Service has now been completed and access to primary care GP records by relevant members of the ME Service is available.

Month	Number of Deaths	Number Scrutinised	% of Deaths Reviewed	Number that Took Over 3 Calendar Days to Complete (of those applicable, not including Coroner cases)	% Over 3 Calendar Days to Complete
Apr-22	150	149	99%	53	36%
May-22	134	133	99%	47	35%
Jun-22	110	109	99%	41	38%
Jul-22	130	130	100%	35	27%
Aug-22	156	156	100%	62	40%
Sep-22	120	120	100%	35	29%

Challenges faced by the ME Service

- Delays to the completion of scrutiny within the stipulated 3 days target has been an issue due to low ME staffing levels resulting from leave.
- Timeliness of death summaries provided to the ME Service by attending physicians has been an ongoing issue since the inception of the Service.
- In addition, the arrival of junior doctors in August contributed to a significant amount of cases not being scrutinised within 3 days
- Financial support by the Trust is needed to enhance the NHSE/I funding envelope provided to extend the ME Service into the community.

Mortality Surveillance Group (MSG)

The role of the Mortality Surveillance Group involves supporting the Trust to provide assurance that all hospital associated deaths are proactively monitored, reviewed, reported and where necessary investigated. A further responsibility of the group is to ensure lessons learnt from Mortality reviews are disseminated appropriately and actions implemented to improve outcome for patients and quality of services provided.

Learning from Mortality reviews identified the following needs:

- Delay in getting an echocardiogram, despite being requested by the cardiology team for a patient with heart failure. Further action by trust mortality lead is in progress to explore if there are cardiac sonographers who can scan only COVID patients, potentially related to risk assessments for staff.
- During periods when the pain team is unavailable (bank holiday/weekend/out of hours), there is the option of utilising the on call anaesthetic team who can facilitate with pain issues
- When patients are repatriated it is important to clarify what treatment limits are in place (if any) and what interventions may/may not be considered in the event of deterioration

The following practice was highlighted in :

- Good management throughout with a high level of consultant involvement, good documentation for key decisions and involvement of other specialities.
- Good early referral to specialist centre (Kings) for hip fracture repair
- Good recognition of sepsis

Mortality Surveillance Group (MSG)

Maidstone and Tunbridge Wells NHS Trust

Structured Judgement Review (SJR)

An SJR is a standardised review of a patient's death undertaken by a trained clinician making safety and quality judgement of care phases. The SJR reviewer makes explicit comments about phases of care with scores attributed to each phase and the overall care received.

Year	Outstanding SJRs	Completed SJRs
Apr 20 to Mar 21	9	60
Apr 21 to Mar 22	20	98
Apr 22 ro Mar 23	13	51
SJR Total backlog	**42**	**209**

- The focus continues to be on completing new SJRs reviews as well as clearing the historical backlog.
- The table indicates the significant number of SJRs raised and completed since the inception of the ME Service, however the trend is a decline in the backlog position.
- The current SJR backlog position is 42, this pertains to SJRs allocated to reviewers, yet to be completed, having exceeded the 4 week stipulated SJR turnaround time.
- There are 17 additional SJRs raised by the ME Service this year not within the backlog.
- This brings the total number of SJRs to be reviewed to 59.

Summary of 'Poor Care' from SJR Review

MSG Meeting	No of SJRs	Overall 'Very poor
Sep-22	0	0
Oct-22	21	0

- In September, the Mortality Surveillance Group meeting was cancelled because the meeting was not quorate inline with the terms of reference of the MSG meeting.
- Therefore SJRs were carried over to the October meeting resulting in 21 SJRs being reviewed
- In October, there were no SJRs with an overall assessment of 'Very poor care' discussed at MSG.
- Learning from both poor care and good practices highlighted from cases reviewed at MSG continue to be fed back to directorates

Mortality Surveillance Group (MSG)

Maidstone and Tunbridge Wells NHS Trust

Actions from 'Poor care' SJR Reviews

- There was no SJR with an overall assessment of 'Poor care' discussed at MSG
- As a result of the above, no SJRs resulted in an SI being raised
- Learning from all SJRs have been feedback to Directorates through Clinical Governance meetings.

Next steps

- Two additional SJR reviewers have been identified, bringing the total number of prospective SJR reviewers joining the pool to four, pending training. Training is scheduled for the 22nd of November 2022
- Work is still ongoing to identify further SJR reviewers to support the process.
- Continue to progress the Medical Examiner community roll out project.

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National HSMR Volatilities

Potential contributory factors to the current fluctuating relative risk may include:

- The 12-month benchmark is more volatile, due to the impact of specific months (covid peak months), with high crude mortality moving out of the latest benchmark, which is used to calculate patients expected risks.
- Regional variances in covid-19 mortality has meant the impact has not been consistent nationally. We advise trusts to assess their rolling relative risk trends, compared to their regional peers.
- The acuity of patients has increased, because of the pandemic. For example, patients presenting with pneumonia, with long covid are potentially a higher risk, which cannot be reflected with the existing case-mix factors.
- The model has only limited data on the impact of Covid-19 on mortality. Therefore, it is less likely to be as accurate at predicting mortality, compared to other conditions.
- Emerging workforce pressures within trusts and primary care, may be driving differences in patient outcomes.
- The model doesn't include risk adjustments for COVID-19 relevant casemix factors, such as obesity and ethnicity, which have been found to have a notable impact on patient pathways and outcomes.
- Patient behaviour has changed during the course of the pandemic, which may be contributing to late presentation and increased complexity.
- Delays to elective treatment has meant that some patients have deteriorated and/or become more complex.
- Ambulance response times have deteriorated, potentially leading to more acutely ill patients

To approve the NHS Resolution maternity incentive scheme submission	**Chief of Service, Women's, Children's and Sexual Health / Acting Head of Midwifery and Gynaecology**

NHS Resolution operates a Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. This is the fourth year of the scheme. To be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution by 12 noon on 02/02/23.

The enclosed report provides details on the Trust's compliance for the NHS Resolution maternity incentive scheme submission.

The Trust Board is asked to:

1. Approve the declaration of compliance in view of the evidence available and give permission to the Chief Executive to sign the Board declaration form prior to submission to NHS Resolution.
2. Note engagement with the RCOG document along with an action plan to review any non-attendance to the clinical situations listed in the document, evidencing current position (see appendix 1) (for Safety Action 4).
3. Note that the Neonatal Junior Medical Staffing standards have been met (for Safety Action 4).
4. Note that an updated action plan is in place to comply with the Neonatal Nursing standards (see Appendix 2) (for Safety Action 4)
5. Note whether the funded establishment is compliant with the latest midwifery workforce calculation and agree action plan if shortfall highlighted (Appendix 3) (for Safety Action 4).
6. Note site of evidence in specific relation to qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme (Appendix 4) (for Safety Action 10)

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 20/12/22

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

For approval

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

CNST Assurance Process Outcome Report

Trust: **Maidstone Tunbridge Wells Hospital Trust**
Date: **8th December 2022**

Visiting Team:

- **Becky Collins, Director of Maternity and Neonatal Services**
- **Claire Haywood, Senior Programme Manager (Maternity Commissioner)**
- **Lindsey McNamara, LMNS Head of Quality Maternity and Neonatal services**
- **Lucia Barnes, LMNS Programme Manager**

Trust Team:

- **Rachel Thomas, Acting Head of Midwifery**
- **Sarah Mander-McGregor, Transformation Matron**
- **Shazia Nazir, Consultant Obstetrician and Gynaecologist, Clinical Director Women's, Children's, and Sexual health**
- **Kym Sullivan, Operational Director - Women's, Children's, and Sexual health**
- **Sarah Flint, Consultant Obstetrician and Gynaecologist, Chief of Service-- Women's, Children's, and Sexual health**

Introduction

Obstetric incidents can be catastrophic and life-changing, with related claims representing the Clinical Negligence Scheme for Trusts (CNST) biggest area of spend. Of the clinical negligence claims notified to NHS Resolution in 2021/22, obstetrics claims represented 12 per cent of clinical claims by number but accounted for 62 per cent of the total value of new claims; almost £6 billion.

The Maternity Safety Strategy set out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety.

The Maternity Incentive Scheme applies to all acute Trusts that deliver maternity services and are members of CNST. Developed in partnership with the National Maternity Safety Champions, Dr Matthew Jolly and Professor Jacqueline Dunkley-Bent OBE, the scheme incentivises ten maternity safety actions designed to improve the delivery of best practice in maternity and neonatal services and rewards Trusts that meet all ten safety actions by being able to recover the element of their contribution relating to the CNST maternity incentive fund and also a share of any unallocated funds.

In the fourth year, the scheme further incentivises the ten maternity safety actions from the previous year with some further refinement.

Year four of the scheme began on 9 August 2021, was paused in December 2021 due to the Covid-19 pandemic, and restarted on 6 May 2022, with a final submission deadline of 12 noon on Thursday 2 February 2023.

Trusts that do not meet all ten safety actions will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help them to make progress against any actions they have not achieved. Such a payment would be at a much lower level their original ten per cent contribution.

In year four of CNST, there is a requirement for the Integrated Care Board (ICB) to be 'fully assured and in agreement' with the compliance submission, with the Accountable Officer for the Integrated Care System required to sign the Board declaration alongside the Trust Chief Executive.

This CNST assurance visit forms the mechanism by which the Kent and Medway Local Maternity and Neonatal System (LMNS) will undertake the assurance required on behalf of the ICB to both support Trust Boards to authorise their Chief Executive Officer to sign the declaration and to inform the Accountable Officer for the Integrated Care System prior to them adding their signature.

The visit took place face to face at the specified Trust. The Trust team presented the position they plan to declare to their Trust Board to the Local Maternity System (LMNS) visiting team. The LMNS team enquired about any risks or challenges to the declared position, and the Trust presented innovations and areas of good practice developed whilst implementing the 10 safety actions. The LMNS team have reviewed key evidence documents to support the assurance process.

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Required standard

a)

i. All perinatal deaths eligible to be notified to MBRRACE UK from 6 May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter.

ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust.

b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each of these reviews will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.

c) For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required. 10

d) Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.

Minimum Evidence Requirement

Notifications must be made and surveillance forms completed using the MBRRACE-UK reporting website.
The perinatal mortality review tool must be used to review the care and reports should be generated via the PMRT.
A report has been received by the Trust Board each quarter from 6 May 2022 onwards that includes details of the deaths reviewed and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard c) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review

Trust declaration:
Compliant

Risk to position
There were no risks identified

Challenges and innovations
There is now a PMRT lead in post who holds the responsibility for producing a high-quality Trust compliance report.
The visiting team identified good practice in the way in which bereaved parents are informed of the PMRT process through the leaflet '*Understanding what happened- hospital review*'. This leaflet contains information on timescales, processes, provides points of contact for bereaved parents and information on what outputs they could expect.
The Trust has a PMRT flow chart which is a clear, step-by-step guide for staff to ensure that the correct process is followed and adhered to.

Evidence Available
The visiting team were provided with Trust Board reports which include a quarterly update including details of the perinatal deaths reviewed and the consequent action plans. The reports evidence that the PMRT has been used to review eligible perinatal deaths and that the standards described in the technical guidance have been met.

Outcome
On the basis of the evidence presented and available the visiting team were able to support the proposed declared position

Safety Action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Required standard

This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.

1. **By October 2022, Trusts have an up to date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework. The strategy must be shared with Local Maternity Systems and be signed off by the Integrated Care Board. As part of this, dedicated Digital Leadership should be in place in the Trust and have engaged with the NHSEI Digital Child Health and Maternity Programme.**
2. **Trust Boards to assure themselves that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022. The data for July 2022 will be published during October 2022.**
3. **July 2022 data contained height and weight data, or a calculated Body Mass Index (BMI), recorded by 15+0 weeks gestation for 90% of women reaching 15+0 weeks gestation in the month.**
4. **July 2022 data contained Complex Social Factor Indicator (at antenatal booking) data for 95% of women booked in the month.**
5. **July 2022 data contained antenatal personalised care plan fields completed for 95% of women booked in the month. (MSD101/2)**
6. **July 2022 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)**
7. **Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in 19 the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022 for the following metrics: Midwifery Continuity of carer (MCoC)**
   - i. **Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed.**
   - ii. **Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided.**
   - iii. **At least 70% of MSD202 Care Activity (Pregnancy) and MSD302 Care Activity (Labour and Delivery) records submitted in the reporting period have a valid Care Professional Local Identifier recorded. Providers submitting zero Care Activity records will fail this criterion. Criteria i and ii are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation.**

Criteria iii are fundamental building blocks and a necessary step towards measuring whether or not women have received midwifery continuity of carer (though it is not the complete measurement). The data for July 2022 will be published in October 2022. If the data quality for criteria 7 are not met, trusts can still pass safety action 2 by evidencing sustained engagement with NHS Digital which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS Digital (see technical guidance for further information).

Minimum evidence requirement

Criteria 1 will be reported to NHS Resolution as part of trusts' self-declaration using the Board declaration form. For criteria 2 to 7, the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series displays whether trusts have passed the requisite data quality thresholds.

Trust declaration

Compliant

Risk to position

There were no risks identified

Challenges and innovations

The Trust's digital team have been working alongside community midwifery teams to provide training to highlight the importance of correct data input entry submission and how it is used to improve the service. This training has resulted in an improvement in data quality and completeness.

Evidence Available

The data integrity scorecard demonstrates compliance with 11/11 Clinical Quality Improvement Metrics.

Trust maternity digital strategy has been shared with the LMNS/ICB with sign off achieved at the November LMNS Executive Board as per Safety Action 2 criteria 1.

Outcome

On the basis of the evidence presented and available the visiting team were able to support the proposed declared position

Safety Action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?

Required Standard

1) **Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.**
2) **The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, LMNS, commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.**
3) **A data recording process (electronic and/or paper based for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place. d) A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.**

e) **Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), LMNS and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.**

f) **Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been 27 cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis.**

g) **An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions Into Neonatal units (ATAIN) reviews (point f) has been agreed with the maternity and neonatal safety champions and Board level champion.**

h) **Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting.**

Minimum evidence requirement

Local policy/pathway available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where:
Evidence for standard a) to include:

- **There is evidence of neonatal involvement in care planning**
- **Admission criteria meets a minimum of at least one element of HRG XA04 but could extend beyond to BAPM transitional care framework for practice**
- **There is an explicit staffing model**
- **The policy is signed by maternity/neonatal clinical leads and should have auditable standards.**
- **The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.**

Trust declaration
Compliant

Risk to position
No risks were identified

Challenges and innovations
Data collated by the Kent Surrey and Sussex neonatal operational delivery network (ODN)
Data collated by the Kent Surrey and Sussex Neonatal Operational Delivery Network (ODN) shows that in MTW the percentage of term babies admitted to the neonatal unit is year to date 3.6% which is below the nationally agreed threshold of 5%.

Evidence Available
The Trust Transitional Care Policy was viewed. Avoiding Term Admissions into Neonatal Units (ATAIN) data transitional care reviews and related audits have been presented quarterly at LMNS Quality Assurance Group (QAG) meetings, along with the progress with the associated action plans. Actions include education and training for the multidisciplinary team to support a reduction in the separation of babies from their mothers.
Trust Board papers include reports to meet the minimum evidence standards for this safety action.

Outcome
On the basis of the evidence presented and available the visiting team were able to support the proposed declared position

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Required Standard

a) Obstetric medical workforce

1. The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service: https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/

2. Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMNS.

b) Anaesthetic medical workforce

A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients (ACSA standard 1.7.2.1)

c) Neonatal medical workforce

The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies.

If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies.

d) Neonatal nursing workforce

The neonatal unit meets the service specification for neonatal nursing standards. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies and share this with the Royal College of Nursing, LMNS and Neonatal Operational Delivery Network (ODN) Lead.

Minimum evidence requirement

Obstetric medical workforce

Sign off at Trust Board level acknowledging engagement with the RCOG document along with an action plan to review any non-attendance to the clinical situations listed in the document. Trusts should evidence their position with the Trust Board, Trust Board level safety champions and LMNS meetings at least once from the relaunch of MIS year 4 in May 2022.

Anaesthetic medical workforce

The rota should be used to evidence compliance with ACSA standard 1.7.2.1.

Neonatal medical workforce

The Trust is required to formally record in Trust Board minutes whether it meets the recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should evidence progress against the action plan developed in year 3 of MIS to address deficiencies.

Neonatal nursing workforce

The Trust is required to formally record to the Trust Board minutes the compliance to the service specification standards annually using the neonatal clinical reference group nursing workforce calculator. For units that do not meet the standard, the Trust Board should evidence progress against the action plan developed in year 3 of MIS to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the Royal College of Nursing (doreen@crawfordmckenzie.co.uk), LMNS and Neonatal Operational Delivery Network (ODN) Lead.

Trust declaration
Compliant

Risk to position
No risks identified

Challenges and innovations
The Trust have implemented a standard operating procedure for the on call Obstetric and Gynaecology consultant to ensure attendance at all required situations.

Evidence Available

Trust Board reports for Q1 and Q2 were reviewed by LMNS visiting team. These included reports on obstetric medical workforce, anaesthetic medical workforce, neonatal medical workforce and neonatal nursing workforce to meet the minimum evidence standards for this safety action.

An audit of consultant attendance in accordance with the RCOG guidance has been completed with the findings and action plan presented to the LMNS Quality Assurance Group as required by this safety action

Trust Board level sign off of the position against RCOG Consultant attendance and any required action plans is scheduled for 22nd December 2022, and evidence of this will be shared with the LMNS following the Board meeting.

Outcome

On the basis of the evidence presented and available, and on the understanding that the position against the RCOG guidance is presented to the Trust Board as planned, the visiting team were able to support the proposed declared position.

Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required Standard

a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.

b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.

c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service

d) All women in active labour receive one-to-one midwifery care e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period.

Minimum evidence requirement

The report submitted will comprise evidence to support a, b and c progress or achievement.

It should include:

- **A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated**
- **In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations.**
- **Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.**
- **The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.**
- **Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. -The midwife to birth ratio - The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not 46 included in clinical numbers. This includes those in management positions and specialist midwives.**
- **Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.**

Trust declaration

Compliant

Risk to position

No risks were identified

Challenges and innovations

Midwifery recruitment continues to work towards achieving full establishment which will further support the labour ward coordinators to remain supernumerary at all times.

A full Birthrate Plus midwifery workforce assessment will be completed in 2023 across all maternity services in Kent and Medway, funded by the LMNS.

There has been one episode in the 2022/2023 financial year where the delivery suite coordinator was unable to maintain supernumerary status. This was recorded via the Datix system in order to capture the detail of the event and any learning. Previous NHSR guidance from October 2022 required 100% compliance with supernumerary status of the labour ward coordinator. The new guidance published by NHSR on 1st December 2022 accepts the unpredictability of the labour ward environment and valuing professional judgement in challenging and unpredictable situations regarding supernumerary status of the coordinator, this now removes any risk to a compliant declaration.

Evidence Available
Midwifery workforce was presented at the LMNS Quality Assurance Group December 2022. The Midwifery workforce paper being presented at Trust Board in December 2022 proposes a number of new roles and will be shared with the LMNS once it has completed this governance process. Dependent on the outcome of the Board discussions the maternity team will develop an action plan to mitigate any risk which will be presented to the Board at the January meeting. The visiting team reviewed quarterly maternity service reports for Q1 and Q2 which have been presented to board which include midwifery staffing updates.

Outcome
On the basis of the evidence presented and available the visiting team were able to support the proposed declared position

Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?

Required Standard

1. **Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019. Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract.**

2. **Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network.**

3. **The quarterly care bundle survey should be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements. The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net from May 2022 onwards. Evidence of the completed quarterly care bundle surveys should be submitted to the Trust board.**

Minimum evidence requirement
Please refer to Appendix 1.0 for full minimum evidence requirement

Trust declaration
Compliant

Risk to position
No risks were identified

Challenges and innovations

The Trust is currently compliant in carbon monoxide monitoring and there is an action plan in place to achieve the higher compliance threshold.

The recruitment of a maternity support worker (MSW) to support the delivery of the new in-house tobacco dependency pathway in line with the NHS Long Term Plan is complete. A further post for an additional MSW to support the pathway is due to go live.

Element 2- The Trust has not yet implemented uterine artery doppler for women identified as high risk. This is due to workforce constraints within the radiology department and the additional training requirements of this intervention. There is an action plan in place for recruitment and retention of sonographers and for the roll out of the required training. The Trust have GAP and Grow in place which is a monitoring programme recognised by the Perinatal Institute and as such can be considered acceptable clinical practice to support a compliant declaration whilst the action plan is progressed.

Evidence Available

All five elements of the SBLCBv2 and their related evidence were presented at Trust Board in Quarter 1 and Quarter 2. The board reports were shared as evidence with the LMNs visiting team.

Outcome

On the basis of the evidence presented and available the visiting team were able to support the proposed declared position

Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?

Required Standard

Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?

Minimum evidence requirement

Evidence should include:

- **Terms of Reference for your MVP. They reflect the core principles for Terms of Reference for a MVP as outlined in annex B of Implementing Better Births: A resource pack for Local Maternity Systems**
- **Minutes of MVP meetings demonstrating how service users are listened to and how regular feedback is obtained, that actions are in place to demonstrate that listening has taken place and evidence of service developments resulting from coproduction between service users and staff.**
- **Written confirmation from the service user chair that they are being remunerated as agreed and that this remuneration reflects the time commitment and requirements of the role given the agreed work programme. Remuneration should take place in line with agreed Trust processes.**
- **The MVP's work programme, minutes of the MVP meeting which agreed it and minutes of the LMNS board that ratified it**
- **Written confirmation from the service user chair that they and other service user members of the MVP committee are able to claim out of pocket expenses, including travel, parking and childcare costs in a timely way.**
- **Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality.**
- **Evidence that the MVP Chair is invited to attend maternity governance meetings and that actions from maternity governance meetings, including complaints' response processes, trends and themes, are shared with the MVP.**

Trust declaration

Compliant

Risk to position

No risks identified

Challenges and innovations

The Trust has had an MVP chair vacancy from July to October 2022.
The newly recruited Chair has been invited and attended the Maternity board meeting. The incoming chair has reviewed the current programme of work and has a meeting in December with the Head of Midwifery to agree a plan for 2022/2023.

Evidence Available

The MVP annual work plan was ratified at the LMNS Executive Board meeting in November 2022.
System wide MVP terms of reference are agreed and ratified and meet the principles required by Better Births and processes for remuneration are set out. There is a system wide agreed core offer for the MVP Chairs in place

Outcome

On the basis of the evidence presented and available the visiting team were able to support the proposed declared position

Safety action 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?

Required standard and minimum evidential \requirement

Can you evidence that:

a) **A local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over the next 3 years**
b) **90% of each relevant maternity unit staff group have attended an annual 'in-house' one day multiprofessional training day, to include maternity emergencies starting from the launch of MIS year four**
c) **90% of each relevant maternity unit staff group have attended an annual 'in-house' one day multiprofessional training day, to include antenatal and intrapartum fetal monitoring and surveillance, starting from the launch of MIS year four**
d) **d) Can you evidence that 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended your annual in-house neonatal life support training or Newborn Life Support (NLS) course starting from the launch of MIS year four.**

Minimum evidence requirement

AS ABOVE

Can you evidence that:

a) **A local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over the next 3 years**
b) **90% of each relevant maternity unit staff group have attended an annual 'in-house' one day multiprofessional training day, to include maternity emergencies starting from the launch of MIS year four**
c) **90% of each relevant maternity unit staff group have attended an annual 'in-house' one day multiprofessional training day, to include antenatal and intrapartum fetal monitoring and surveillance, starting from the launch of MIS year four**
d) **Can you evidence that 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended your annual in-house neonatal life support training or Newborn Life Support (NLS) course starting from the launch of MIS year four**

Trust declaration

Compliant

Risk to position
No risks were identified

Challenges and innovations
The Trust maternity team reported a well-established relationship with the neonatal team, who provide training on the multidisciplinary study days.
The NHSR changing timescales, staff sickness and the need for an increase in uplift have all provided extra challenge to meet training compliance. Despite this compliance has been achieved

Evidence Available
The visiting team were provided with evidence of training compliance which meets the minimum evidence requirement. The training compliance will continue to be monitored quarterly at the LMNS Training assurance group. The LMNS have reviewed the local training plan which contains the six core modules of the core competency framework.

Outcome
Based on the evidence and trajectories presented and available the visiting team were able to support the proposed declared position.

Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Required Standard

a) The pathway developed in year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (LMNS), and the Regional Chief Midwife has been reviewed in line with the implementing-a-revised-perinatal-quality surveillance-model.pdf (england.nhs.uk) The revised pathway should formalise how Trust-level intelligence will be shared with new LMNS/ICS and regional quality groups to ensure early action and support is provided for areas of concern or need.
b) Board level safety champions present a locally agreed dashboard to the Board quarterly, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walk-abouts; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022. NB, The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022.
c) Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. A revised action plan describes how the maternity service will work towards Continuity of Carer being the default model of care offered to all women by March 2024, prioritising those most likely to experience poor outcomes. d) Board level and maternity safety champions are actively supporting capacity and capability building for staff to be involved in the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)

Minimum evidence requirement

Evidence for points a) and b)

- **Evidence of a revised pathway which describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence between a) each other, b) the Board, c) new LMNS/ICS quality group and 67 d) regional quality groups involving the Regional Chief Midwife and Lead Obstetrician to ensure early action and support is provided for areas of concern or need in line with the perinatal quality surveillance model.**
- **Evidence that a clear description of the pathway and names of safety champions are visible to maternity and neonatal staff.**
- **Evidence that discussions regarding safety intelligence, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and engagement sessions; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022. NB- The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022.31 December 2021.**
- **Evidence of bi-monthly engagement sessions (e.g. staff feedback meeting, staff walkaround sessions etc.) being undertaken by a member of the Board.**
- **Evidence of progress with actioning named concerns from staff workarounds are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users.**
- **Evidence that the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions to help target interventions aimed at improving patient safety at least twice in the MIS reporting period at a Trust level quality meeting. This can be a board or directorate level meeting.**

Evidence for point c):

Evidence of an action plan that describes how the maternity service will work towards Midwifery Continuity of Carer (MCoC) being the default model of care offered to all women by March 2024. The plan covers:

- **The number of women that can be expected to receive MCoC, when offered as the default model of care**
- **A midwifery redeployment plan into MCoC teams, phased alongside the fulfilment of safe staffing levels • How MCoC teams are established in compliance with national principles and standards 68**
- **How rollout will be prioritised to those most likely to experience poor outcomes, including ensuring rollout to 75% of women from Black, Asian and mixed ethnicity backgrounds and also from the most deprived 10% of neighbourhoods by March 2024.**
- **Developing an enhanced model of MCoC that provides extra support for women from the most deprived 10% of areas.**
- **How care will be monitored locally, and providers ensure accurate and complete reporting on provision of MCoC using the Maternity Services Dataset**
- **Evidence of Board level oversight and discussion of this revised continuity of carer action plan**

Evidence for point d):
Evidence of how the Board and Safety Champions have supported staff involved in part d) of the required standard and specifically in relation to:

- **active participation by staff in contributing to the delivery of the collective aims of the MatNeo Patient Safety Networks, and undertaking of specific improvement work aligned to the MatNeoSIP national driver diagram and key enabling activities**
- **engagement in relevant improvement/capability building initiatives nationally, regionally or via the MatNeo Patient Safety Networks, of which the Trust is a member • support for clinicians identified as MatNeoSIP Improvement Leaders to facilitate and lead work through the MatNeo Patient Safety Networks and the National MatNeoSIP network**
- **utilise insights from culture surveys undertaken to inform local quality improvement plans**
- **maintain oversight of improvement outcomes and learning, and ensure intelligence is actively shared with key system stakeholders for the purpose of improvement**

Trust declaration
Compliant

Risk to position
No risks identified

Challenges and innovations
The Trust have plans to increase the Maternity board meetings from Bimonthly to Monthly from January 2023. Agendas have become increasingly lengthy and therefore moving to monthly will improve oversight of all items requiring assurance from the Board.

Evidence Available
The LMNS visiting team reviewed Maternity board papers which evidenced safety champion feedback.
Safety champion feedback was presented to LMNS Quality Assurance Group in December 2022.
The visiting team reviewed the Standard Operating Procedure (SOP) detailing the Safety Champion Pathway.

Outcome
On the basis of the evidence presented and available the visiting team were able to support the proposed declared position

Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?

Required Standard

1. A) Reporting of all qualifying cases to HSIB from 1 April 2021 to 5 December 2022

2. B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 April 2022 until 5 December 2022

C) For all qualifying cases which have occurred during the period 1 April 2021 to 5 December 2022, the Trust Board are assured that:

1. **the family have received information on the role of HSIB and NHS Resolution's EN scheme; and**
2. **there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.**

Minimum evidence requirement

Trust Board sight of Trust legal services and maternity clinical governance records of qualifying HSIB/EN incidents and numbers reported to HSIB and NHS Resolution.

Trust Board sight of evidence that the families have received information on the role of HSIB and EN scheme.

Trust Board sight of evidence of compliance with the statutory duty of candour.

Duty of candour- how to you ensure this is discharged appropriately?
Board papers

Trust declaration
Compliant

Risk to position
No risks identified

Challenges and innovations
All cases that meet the criteria for referral to HSIB for investigation are reported as a Serious Incident and are subject to an agreed process for review by the ICB.
Duty of candour is undertaken in line with guidance and is conducted by a senior and experienced member of the team.

Evidence Available The visiting team reviewed the Clinical Risk Management and Safety Strategy for Women's Services. The Duty of candour evidence will be presented to Trust Board in December within the progress with compliance paper. The paper will be shared with the visiting team.
Outcome On the basis of the evidence presented and available the visiting team were able to support the proposed declared position

Appendices

1.0 Safety action 6 – minimum evidence required

Minimum evidential requirement for Trust

Element one

Process indicators:

A. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded.

B. Percentage of women where CO measurement at 36 weeks is recorded.

Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System (MIS) and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. The Trust board should receive data from the organisation's MIS evidencing an average of 80% compliance over a four month period (i.e. four consecutive months in during the MIS year 4 reporting timeframe).

If there is a delay in the provider Trust's ability to submit these data to MSDS then compliance can be determined using their interim data recording method. The denominator should still be the total number of women at booking or 36 weeks gestation, as appropriate for each process indicator.

If the provider Trust is unable to record these data on their maternity information system an audit of 60 consecutive cases would be acceptable evidence to demonstrate >80% of women having a CO measurement recorded at 36 weeks. The denominator for the audit should be 60 consecutive women at 36 weeks gestation, whereas the denominator for the electronic audit would be the total number of women at 36 weeks gestation. In addition to this, the audit should be accompanied by a brief description of the stop smoking strategy within the Trust and any plans for improvement.

A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.

If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.

In addition, the Trust board should specifically confirm that within their organisation they:

1) Pass the data quality rating on the National Maternity Dashboard for the 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric.

2) Have a referral pathway to smoking cessation services (in house or external).
3) Audit of 20 consecutive cases of women with a CO measurement ≥4ppm at booking, to determine the proportion of women who were referred to a smoking cessation service.
4) Have generated and reviewed the following outcome indicators within the Trust for four consecutive months within the MIS year 4 reporting period:
   - Percentage of women with a CO measurement ≥4ppm at booking.
   - Percentage of women with a CO measurement ≥4ppm at 36 weeks.
   - Percentage of women who have a CO level ≥4ppm at booking who subsequently have a CO level <4ppm at the 36 week appointment.

Additional information

If your Trust is planning on using the maternity dashboard to evidence an average of 80% compliance over four months, please be advised that there is a three month delay with MSDSv2 data, for example data submitted at the end of August 2022 will be published on the dashboard at the end of November 2022.

If your Trust does not have an in house stop smoking service or a pathway to an external service, please contact your local authority stop smoking service or escalate to your local maternity system to enable the Trust to ensure provision is in place.

Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded.

Women declining CO testing at booking / 36 weeks appointment

Standard A and B of element 1 require Trusts to demonstrate that 80% of women had CO testing at booking and at 36 weeks respectively and that this is recorded in the Trusts' information system.

In the event of a high number of women declining CO testing a Trust would be at risk of failing standard A and B by not reaching the 80% testing rate. We suggest Trusts proactively monitor their testing rate and consider interventions to maintain adequate compliance.

Element two

Process indicator:

1) Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20 week scan (e.g. Appendix D).

Note: The relevant data items for these indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. The Trust board should receive data from the organisation's MIS evidencing 80% compliance.

If there is a delay in the provider Trust Maternity Information System's ability to record these data at the time of submission an in house audit of 40 consecutive cases of women at 20 weeks scan using locally available data or case records should have been undertaken to assess compliance with this indicator.

A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.

If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.

In addition the Trust board should specifically confirm that within their organisation:

2) Women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards
3) In pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation
4) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation.
5) They have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT).
6) Their risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance or a variant has been agreed with local commissioners (CCGs) following advice from the Clinical Network.
7) They undertake a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation. The review should seek to identify themes that can contribute to FGR not being detected (e.g. components of element 2 pathway and/or scanning related issues). The Trust board should be provided with evidence of quality improvement initiatives to address any identified problems. Trusts can omit the above mentioned quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation for quarter 3 of this financial year (2021/22) if staffing is critical and this directly frees up staff for the provision of clinical care.

Element three

Process indicators:

A. Percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pregnancy.
B. Percentage of women who attend with RFM who have a computerised CTG (a computerised system that as a minimum provides assessment of short term variation).

Note: The SNOMED CT code is still under development for RFM and therefore an in-house audit of two weeks' worth of cases or 20 cases of women attending with RFM whichever is the smaller to assess compliance with the element three process indicators.

A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.

If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.

Element four

There should be Trust board sign off that staff training on using their local CTG machines, as well as fetal monitoring in labour are conducted annually. The fetal monitoring sessions should be

consistent with the Ockenden Report recommendations, and include: intermittent auscultation, electronic fetal monitoring with system level issues e.g. human factors, escalation and situational awareness.

The Trust board should specifically confirm that within their organization 90% of eligible staff (see Safety Action 8) have attended local multi-professional fetal monitoring training annually as above.

Please refer to safety action 8 for more information re training.

Element five

Process indicators:

A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth.

B. Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids.

C. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth.

D. Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).

Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding.

If there is a delay in the provider Trust MIS's ability to record these data then an audit of 40 cases consisting of 20 consecutive cases of women presenting with threatened preterm labour before 34 weeks and 20 consecutive cases of women who have given birth before 34 weeks using locally available data or case records should have been undertaken to assess compliance with each of the process indicators.

The Trust board should receive data from the organisation's Maternity Information System evidencing 80% compliance with process indicators A, C and D. The percentage for process indicator B should be as low as possible and can be reported as the proportion.

A Trust will not fail Safety Action 6 if the process indicator scores are less than 80%. However, Trusts must have an action plan for achieving >80%.

In addition, the Trust board should specifically confirm that within their organisation:

- They have a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention. (Best practice would be to also appoint a dedicated Lead Midwife. Further guidance/information on preterm birth clinics can be found on https://www.tommys.org/sites/default/files/2021-03/reducing%20preterm%20birth%20guidance%2019.pdf

- Women at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided. If this is not the case the board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed is acceptable clinical practice.
- An audit of 40 consecutive cases of women booking for antenatal care has been completed to measure the percentage of women that are assessed at booking for the risk of preterm birth and stratified to low, intermediate and high risk pathways, and the percentage of those assessed to be at increased risk that are referred to the appropriate preterm birth clinic and pathway. The assessment should use the criteria in Appendix F of SBLCBv2 or an alternative which has been agreed with local CCGs following advice from the Clinical Network.
- Their risk assessment and management in multiple pregnancy complies with NICE guidance or a variant that has been agreed with local commissioners (CCGs) following advice from the provider's clinical network.

Consultant Attendance Audit
Maidstone and Tunbridge Wells NHS Trust

Oliver Wildman

Fetal Monitoring Lead

Labour Ward Lead

Joint Obstetric Lead for LMNS maternal medicine network

Goal

To audit Consultant attendance against RCOG expectations when the Consultant on-call must attend.

Audit from

July – Sept 2022

When Consultants must attend

Situations in which the consultant MUST ATTEND
GENERAL
In the event of high levels of activity e.g a second theatre being opened, unit closure due to high levels of activity requiring obstetrician input
Any return to theatre for obstetrics or gynaecology
Team debrief requested
If requested to do so
OBSTETRICS
Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary
Caesarean birth for major placenta praevia / abnormally invasive placenta
Caesarean birth for women with a BMI >50
Caesarean birth <28/40
Premature twins (<30/40)
4th degree perineal tear repair
Unexpected intrapartum stillbirth
Eclampsia
Maternal collapse e.g septic shock, massive abruption
PPH >2L where the haemorrhage is continuing and Massive Obstetric Haemorrhage protocol has been instigated
GYNAECOLOGY
Any laparotomy

MTW exceptional people, outstanding care

Expectations

- Consultants should be informed 100% of the time that one of the situations in the previous slide is occurring
- Ideally Consultants should attend 100% of the time when indicated.

Exceptions

- Late identification of resolved PPH >2litres when consultant off-site
  - There have been no Serious Incidents associated with a PPH which has resolved and the Consultant had not attended
- Presence of SAS Doctors with significant experience (>10 years).
- Times when Consultant attendance is not going to impact on

Benchmarking

There is no national benchmark

Consultants should be informed 100% of the time when a trigger incident has occurred

Due to Exceptions a benchmark of 90% attendance was agreed at a local level.

Audit method

Majority of trigger events are also Datix triggers

Other cases were identified through E3 searches

Cases identified

	Second Theatre Opened	Return to theatre	Team debrief requested	Requested	Critical deterioration	LSCS Major PP or accreta	LCSC BMI >50	LSCS <28/40	Twins <30/40	4th Degree tear	Unexpected intrapartum IUD	Eclampsia	Maternal collapse	PPH >2 litre
Total cases	6	2	0	2	0	2	4	0	0	0	0	0	0	9
Consultant informed	5	2	0	2	0	2	3	0	0	0	0	0	0	7
% Informed	**83%**	**100%**		**100%**		**100%**	**75%**							**78%**
Consultant attended	3	2	0	2	0	2	3	0	0	0	0	0	0	4
%Attended	**60%**	**100%**		**100%**		**100%**	**100%**							**57%**

Compliant with:

- Return to theatre
- When requested
- LSCS for major praevia/accreta
- Also compliant when informed with LSCS for BMI >50

MTW exceptional people, outstanding care

Non-compliant with

- When opening second theatre
- PPH > 2 liters
- Informing consultant of LSCS for Women with BMI > 50

Second theatre opened

Date	Summary of situation	Time of day (0830-1700, 17:00-20:30, 20:30-08:30)	Consultant informed?	If No why?	Consultant attened?	If No Why?
14/08/2022	Failed Kiwi in the room, transeferred to theatre for forceps	20:30-08:30	Not clear		Not clear	
15/08/2022	Face presentation, 3+ - LSCS	20:30-08:30	Yes		Not clear	
15/08/2022	Poor progress in labour -LSCS	08:30-20:30	Yes		Yes	
08/08/2022	Cord prolapse -LSCS	08:30-20:30	Yes		Yes	
12/09/2022	Suspicious CTG, Slow progress	20:30- 08:30	Yes		No	Consultant offered to come in but S/r felt situation under control
25/09/2022	Abnormal CTG	08:30-20:30	Yes		Yes	

PPH > 2 litres

Date	Summary of situation	Time of day (0830-1700, 17:00-20:30, 20:30-08:30)	Consultant informed?	If No why?	Consultant attened?	If No Why?
08/072022	PPH 2.6 litres following instrumental delivery in theatre	08:30-1700	Yes		Yes	
19/08/2022	PPH 4.2 litres following forceps delivery	20:30-08:30	Yes		Yes	
19/08/2022	APH and PPH total ebl 3.3litres	20:30-08:30	Yes		No	Likely as by the time the EBL was identified as being >2 litres the bleeding had stopped as such additional input was unnecessary. SR was involved in care
18/08/2022	PPH 2.4 litres	20:30-08:30	Yes		No	Unclear. Risk review felt that counsultant attendance would have had no impact on care.
09/08/2022	PPH 2.8 litres following SVD	20:30-08:30	Yes		No	Late identification of PPH >2 litres. Bleeding had stopped by the time MBL including bed sheets had been totalled
09/08/2022	PPH following 3.5 litres	17:00-20:30	Yes		Yes	
05/08/2022	PPH 5 litres following LSCS	20:30-08:30	Yes		Yes	
03/08/2022	PPH 2.6 litres following SVD	20:30-08:30	No	Not informed when blood loss was identified as being greater than 2 litres, escalated to senior registrar. Consultant only informed after procedure and blood loss identified as 2.6 litres	No	Not informed
06/08/2022	2.4 litre PPH	20:30-08:30	No	Senior registrar attended prior to delivery. Code red declared appropriately. Bleeding had stopped prior to identification of ebl >2litres	No	Not informed

LSCS for BMI >50

Date	Summary of situation	Time of day (0830-1700, 17:00-20:30, 20:30-08:30)	Consultant informed?	If No why?	Consultant attended?	If No Why?
06/09/2022	Cat 3 LSCS	08:30-17:00	Yes		Yes	
29/08/2022	Cat 2 LSCS	20:30-08:30	Yes		No	Unclear
18/08/2022	Cat 4 LSCS	08:30-17:00	Yes		Yes	
11/07/2022	Cat 3 LSCS	08:30-1700	Yes		Yes	

Findings

- Between 08:30-21:00 the Consultant always attended
- 21:00-08:30 >90% of the time when the Consultant was informed they attended (with exception of PPH)

Recommendations:

- Ensure awareness amongst staff when a consultant must be informed and attend
- Design and disseminate poster to highlight which Emergencies Consultants on-call must be informed of and attend.
- Repeat audit

Action plan:

Recommendation	Action	Owner	Due by	Progress
Ensure awareness amongst staff of when a consultant must be informed and attend	Design and disseminate a poster to highlight which emergencies Consultants on-call must be informed of and attend.	Labour Ward Lead Consultant	Dec 2022	RCOG list available – new poster to be designed
On-going reporting	Spreadsheet for monitoring Trigger events and Consultant attendance	Labour Ward Lead Consultant And Risk Team	Dec 2022	Complete
On-going reporting	Add to Directorate Board agenda to monitor monthly and report to Maternity Safety Board quarterly	Labour Ward Lead Consultant	Dec 2022	On-going

Safe, sustainable and productive staffing - An improvement resource for neonatal care- review

	Recommendations	2021	2022
1	Boards must ensure there is a strategic multi professional staffing review at least annually (or more frequently if service changes are planned or quality or workforce concerns are identified), which is aligned to the operational planning process. In addition a mid-year review should provide assurance that neonatal services are safe and sustainable. This should assess whether current staffing levels meet the recommended levels and are likely to do so in future	• Annual review with HR, Deputy Chief Nurse and NICU leads / Paediatric leads in place – last completed November 2020 • Ongoing issues with band 6 recruitment – action plan in place for this and in house training provision. Agency line and increase in qualified bank staff • BAPM standards staffing review task and finish group identified and dates set for review • Business case to be submitted and reviewed – delayed due to covid-19 to ensure compliance with future workforce plans , currently using bank to support staffing levels • New pathways in place for staff development –. Advanced clinical nurse specialist in place and pathway from band 7-8a. Band 6 link roles in place • 21% uplift in place for nursing staffing to cover leave, study leave etc • Designated lead consultant in place who is responsible for clinical and professional leadership, and management of the service along with the Matron and General Manager are in place • Clinical Educator in place • AHPs- physio , dietician, paediatric pharmacist in place	• Annual review completed October 2022 with multi-professional panel including Deputy Chief Nurse Paediatric Lead Matron, Finance and HR • Business case agreed for submission and included in current business planning for supernummary nurse on a shift. This will be a phased approach to also review quality standards for additional roles with possible funding from ODN • Review of staffing levels agreed with ODN at GIRFT review November 2022 and action plan in place. Bespoke package for recruitment and retention to be developed • Review underway regarding enhancement for Band 6 QIS trained staff to support recruitment in line with other local trust • Review of 21% uplift underway with trust executives currently to increase for specialist areas requiring additional training including NICU • 2 x 8as ACP roles in place and out to advert for Band 7 training post currently • Lead consultant and separate Neonatal Risk Lead in place • Additional funding for ACP, SALT and physio agreed by ODN following Ockenden funding. Psychology declined as part of this funding currently
2	All neonatal units should work collaboratively within an operational delivery network (ODN), sharing their	• Operational delivery network in place • Allocated staff attend and feedback to unit	• Good network engagement with consultant, neonatal matron and ACPs at ODN meetings

Safe, sustainable and productive staffing - An improvement resource for neonatal care- review

	Recommendations	2021	2022
	workforce plans and strategies for recruitment and retention across the ODN	• Neonatal Transfer pathways in place and sharing of best practice • Effective networking within the designated ODN and co-operation with staff in other units and the transport service are in place • ODN action plan in place	• Policies and Guidelines up to date and linked to Network with clear pathway in place to support to development, governance processes and staff access / training • Excellent networking with tertiary units
3	Skill mix should be regularly reviewed to ensure that the most suitable staff are in undertaking the correct roles and are available in sufficient numbers.	• Skill mix reviewed regularly and adapted • Rotation with paediatric in patient in ward to maintain skill set of staff • Medical rota split – neonatal specific consultant rota in place now compliant • Business case submitted to network for neonatal outreach plan – new service gap due to transition of CCNT to KCHFT • BAPM standards staffing review task and finish group identified and dates set for review • Business case to be submitted and reviewed – delayed due to covid-19 to ensure compliance with future workforce plans , currently using bank to support staffing levels	• Dedicated Neonatal consultant rota in place with clear separation from the paediatric rota • No outreach funding agreed by ODN – despite business case submission, to be reviewed following GIRFT • KCHFT are developing a 7-day service from Jan and are currently supporting Neonates who require community support until an outreach team is in place – this has been agreed with the ICB • Overseas recruitment in place with pathways for paediatric and adult nurses to join the register • Paediatric and neonatal rotation in place to support recruitment and retention for trained and untrained staff
4	Professional judgement should be used together with appropriate workforce and acuity tools	• Professional judgement method utilised at yearly safe staffing review • Safe care module being launched on NICU August 2021 – currently under development specifically for NICU standards. Trust lead and NICU lead in place	• Staffing continues to be monitored via the new CRG /Dinning Tool and shared with the network • Safecare Tool implemented on Unit • Professional judgement method utilised alongside Safecare data and dinning tool

Safe, sustainable and productive staffing - An improvement resource for neonatal care- review

	Recommendations	2021	2022
5	Data collected using Badgernet and the neonatal nurse staffing tool (Dinning) should be used to calculate the required establishment according to the level of activity shared with the neonatal ODN	• Safe care module being launched on NICU August 2021 – currently under development. Trust lead and NICU lead in place • Trust does not use Dinning , however data collected using Badgernet	• Badgernet in place and staffing continues to be monitored via the new CRG /Dinning Tool and shared with the network • Safecare Tool implemented on Unit linked to Care hours per patient day and Quality Dashboard in place with trust oversight
6	Training and development must be linked to annual individual appraisals and development plans, and must be provided within the resources available to the team	• Annual appraisal system in place with clear development processes for staff • Clinical educator band 7 in post (maternity leave) however replaced by university lecturer practitioner doing post on bank) • Staff training in place specific to needs – parent support, bereavement, infant feeding • Access to multidisciplinary education and training including neonatal simulation • Bliss accreditation achieved • Baby Friendly level 2 achieved • Peer review completed	• 100% compliant with annual appraisals for 2022 • Clinical Educator in post • Awaiting outcome of Trust business case for Clinical skills facilitators • GIRFT completed 2022 – no actions for training requirements • Preparing for Baby Friendly level 3
7	Organisations should recognise the increasing need for flexible working patterns to meet the fluctuating needs in neonatal services.	• Flexible working policy in place for trust and implemented on NICU • Retire and return pathway in place • Working from home for some staff in key positions implemented during covid	• Flexible working policy in place • Retire and return pathway in place • Laptops in place for key staff to enable working from home • Internal transfer pathway in place to support staff wishing to move areas • Variety of shift patterns available both long days and short
8	All neonatal units should adhere to the pathways agreed with the ODN and specialised commissioning teams to ensure efficient working across the network.	• Clear pathways in place with ODN and specialist commissioning teams. • HDU and SCBU funding adapted and awaiting ITU contracts and funding • Transfer to tertiary centres pathways in place	• Clear pathways and discussions in place with ODN led by Neonatal Matron and Consultant Lead Neonatologists • Good networking • Shared guidelines and transfer pathways in place • GIRFT review completed Nov 22

Safe, sustainable and productive staffing - An improvement resource for neonatal care- review

	Recommendations	2021	2022
9	All neonatal units should input data into Badgernet to enable national benchmarking.	• Badgernet in place and updated daily / as required. • Staff trained in use	• Badgernet in place – to be reviewed regarding upgrade in 2023 • Data reviewed internally and externally by ODN and recent GIRFT review
10	Areas of concern highlighted by parents/families or staff using workforce planning and analysis methods must be carefully scrutinised and appropriate actions taken to address them.	• Weekly complaints meeting • Complaints and incidents pathway for review in place - Monthly risk meeting with Bimonthly Neonatal specific overview • Monthly PALS report • Monthly Neonatal Management Meeting in place • Monthly Neonatal and Paediatric Directorate meeting in place • Bimonthly Divisional Quality • Risk leads for NICU in place – Lou Mair and Dr Raj Gupta • FFT – have Neonatal feedback – currently being transferred to trust FFT system awaiting confirmation of layout of parent forms as will then be available on line • Parent group in place • BLISS feedback and reports	• Complaints and PALS pathways in place and now available on datix system to ensure actions completed • Datix leads in place to support area within patient safety team • Formal pathway and report system in place to monitor Quality and Governance from floor to executive level • Separate Neonatal Risk and Governance meeting in place chaired by Consultant

Maidstone and Tunbridge Wells NHS Trust

CNST Safety Action 5 - Midwifery Workforce Planning, Action Plan

Recommendation	Action(s) required to comply with the recommendation	Evidence of Implementation	RAG	Progress
Fulfil staffing deficit, including specialist midwives, as identified in the BirthRate+ review	Secure funding to increase staffing establishment to match BirthRate+ recommendations	• Ockenden Funding received – 8 WTE, 1 allocated to each community team		Complete
Full maternity service with Birthrate+ methodology to be completed	Birthrate + review to be completed before March 2023 (funded by LMNS)			Awaiting information from LMNS
Additional 4 days B3 Discharge Coordinator (to make a 7-day service)	Submit a Business Case			

Increase infant feeding service to 7 days	• Submit a Business Case • Consider recruitment of breast buddy volunteers to cover weekends			
Increase staffing on delivery suite and postnatal ward with registered nurses	• Submit Business Case			
Increase staffing on Antenatal Ward	• Submit Business Case			

MTW MTW Maternity Incentive Scheme CNST Year 4 Safety Action 10

December 2022

MTW

NHS
Maidstone and Tunbridge Wells
NHS Trust

Safety Action 10 - Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?

Required Standard

A) Reporting of all qualifying cases to HSIB from 1 April 2021 to 5 December 2022

B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 April 2022 until 5 December 2022

C) For all qualifying cases which have occurred during the period 1 April 2021 to 5 December 2022, the Trust Board are assured that:

1. the family have received information on the role of HSIB and NHS Resolution's EN scheme; and
2. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.

Evidence of 100% compliance

Standard	Total no. of cases	Total no. of cases reported	Total no. of cases achieving standard C1	Total no. of cases achieving standard C2
A	12	12	12	12
B	3	3	3	3

NHS
Maidstone and Tunbridge Wells NHS Trust

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

The infection prevention and control board assurance framework was submitted to the December 2020 meeting and each month thereafter. It was then agreed at the Trust Board meeting in June 2021 that the infection prevention and control board assurance framework would only be submitted to the Trust Board in the event of a significant change. The framework was last reported to the Trust Board in June 2022, and the enclosed report contains details of the response to the changes that have occurred since then.

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

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

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

Infection prevention and control board assurance framework

The IPC BAF is required to be updated and reviewed by the Trust Board on a regular basis during the Covid-19 pandemic
Changes are highlighted in red in the document.

For this reporting period the changes are marked in red in the main document and summarised here

Section 1:

- Flu admissions discussed with IPC and plans in place
- Immunocompromised patients nursed in single rooms. Haematology ward has isolation facilities with positive pressure lobby to prevent spread
- Escalation wards open all year. High occupancy with little flexibility
- Review of space ongoing
- Universal mask wearing in clinical areas re-introduced in November 2022
- Transfer of care documentation in place for infectious patients. Transfers for clinical reasons and for move to isolation facilities
- NIPCM has not been launched within the Trust. All IPC policies reviewed for compliance with NIPCM. Change programme under development to introduce new terminology
- For the 10 elements of SICPs, all elements are covered by the IPC audit plan, routine ward based audits and others e.g. sharps audit

Section 2:

- Additional cleaning instructions and training in place for management of point of use filters on water outlets
- The Categorisation of levels of environmental cleaning/disinfection RWF-OWP-APP233 clearly describes staff roles in cleaning/decontamination. Available in poster format and in IPC resource folders on wards and clinical areas and the intranet
- MDGH - New Ventilation equipment in past 12 months is compliant, existing ventilation equipment is non-compliant due to end or near to end of life, capital funding plan for replacement being developed for 23/24 and 24/25 financial years
- MDGH - Critical ventilation systems assessments are carried out annually,
- Ventilation Safety Group now setup, maintenance team / authorised engineer are carrying out surveys on existing ageing ventilation systems to identify/improve/mitigate inadequate ventilation systems
- TWH - Critical ventilation systems assessments are carried out annually by Mitie who are maintenance / service provider for this site

Section 3:

- Antimicrobial prescribing guidance available in the on line formulary and also available in App form.
- Training given to new doctors on prescribing including Start Smart then Focus
- Trust undertaking CQUIN on prescribing in UTI in adults for 2022/23
- Antimicrobial prescribing audit (against the standards contained in the antimicrobial prescribing policy) undertaken by antimicrobial pharmacist on all wards and reported to IPCC. Outcomes shared with clinical teams

Section 4:

- A variety of leaflets are available for patients, visitors and carers.
- Posters are displayed at entrances to remind visitors to wear face coverings on entering the hospital
- Hand hygiene facilities are widely available
- Two birth partners allowed. Two hours open visiting on post-natal unit per day. Children permitted to visit
- Posters are displayed at entrances to remind visitors to wear face coverings on entering the hospital
- Decision to reinstate mandatory mask wearing agreed by ETM

Section 5

- Respiratory and non-respiratory pathways in place in ED
- Target to triage all patients within 15 minutes of arrival
- Staff vaccination programme in place. Communicated to staff in different media.
- Mobile vaccination teams visit staff in the workplace to vaccinate
- In-patient vaccination programme not in place
- Discussions re planning in June 2023 for next winter beginning

Section 6:

- National IPC e-learning package in use for new starters and annual/biannual updates
- Face to face training for some staff groups including junior doctors
- The WHO five moments for Hand Hygiene is in common usage in the Trust. Included in the Standard infection Control Policy. Included in training for staff

Section 7:

- All patient facing staff are trained in IPC precautions
- Respiratory precautions used for infection respiratory agent, Enteric precautions for patients with diarrhoea etc
- SIPC precautions are used universally unless a patient has a known or suspected infection or colonization
- Policies and training in place to support staff to use the appropriate IPC precautions for the individual patient

Section 8:

- Turnaround times are monitored for a range of tests
- Patient to result TAT is less accurate than laboratory TAT as sample time is not always recorded and not always the same as the time of request. Solutions being sought through the EPR.
- Any inpatient who develops respiratory symptoms has a laboratory PCR test for respiratory viruses including Covid and clinical review
- Other infection screens are completed depending on clinical presentation

Section 9:

- Antimicrobial prescribing guidance available in the on line formulary and also available in App form.
- Antimicrobial prescribing audit (against the standards contained in the antimicrobial prescribing policy) undertaken by antimicrobial pharmacist on all wards and reported to IPCC. Outcomes shared with clinical teams

Section 10:

- All non-elective patients have rapid COVID-19 test on admission to enable correct patient placement and protect other more vulnerable patients

Infection Prevention and Control board assurance framework

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • A respiratory plan incorporating respiratory seasonal viruses that includes: ○ point of care testing (POCT) methods for infectious patients known or suspected to have a respiratory infection to support patient triage/placement according to local needs, prevalence, and care services ○ segregation of patients depending on the infectious agent taking into account those most vulnerable to infection e.g clinically immunocompromised.	•POCT in place for all admissions including Covid-19, Influenza A & B, RSV as appropriate. Also available for selected patients as required •Streaming in place for respiratory and non-respiratory pathways in ED with front door triage. •Isolation facilities and Covid cohort areas/wards in place. •Flu admissions discussed with IPC and plans in place •Immunocompromised patients nursed in single rooms. Haematology ward has isolation facilities with positive pressure lobby to prevent spread •Escalation plan in place.		

○ A surge/escalation plan to manage increasing patient/staff infections. ○ a multidisciplinary team approach is adopted with hospital leadership, operational teams, estates & facilities, IPC teams and clinical and non- clinical staff to assess and plan for creation of adequate isolation rooms/cohort units as part of the plan. • Organisational /employers risk assessments in the context of managing infectious agents are: ○ based on the measures as prioritised in the hierarchy of controls. ○ applied in order and include elimination; substitution, engineering, administration and PPE/RPE. ○ communicated to staff. ○ further reassessed where there is a change or new risk identified eg. changes to local prevalence. • the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.	• Close liaison between ops team and IPCT • In place. IPC attend site meetings and daily strategic command meetings with MDT. • Additional side room capacity created during Covid • Requires frequent updating depending on the current situation. • Hierarchy of Controls risk assessment template in place and available on the Trust intranet • Risk assessment for the use of FFP3 masks in place and available on the staff intranet. Updated for Omicron variant • All staff caring for Covid positive patients wear FFP3 masks • Communicated to staff via the Pulse and team briefs/huddles • Universal mask wearing in clinical areas re-introduced in November 2022 • Safe systems of working in place following national guidance • IPCT attend weekly system and regional IPC meetings • DIPC chairs K&M IPC leadership forum • All changes of guidance discussed at system and	Escalation wards open all year. High occupancy with little flexibility Review of space ongoing	Teletracking in place. Active management of capacity HASU ward open and additional escalation capacity created

• risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with the infectious agents. • ensure that transfers of infectious patients between care areas are minimised and made only when necessary for clinical reasons. • resources are in place to monitor and measure adherence to the NIPCM. This must include all care areas and all staff (permanent, flexible, agency and external contractors).	regional level and reviewed at IPCC •Risk assessments completed by ward managers in collaboration with IPCT •Transfer of care documentation in place for infectious patients •Transfers for clinical reasons and for move to isolation facilities •Policies in place which are compliant with NIPCM •IPC audit plan in place and is included in the annual work plan. •Additional auditing undertaken for ward-based periods of increased incidence of C. difficile and Meticillin sensitive *Staphylococcus aureus*. •All staff receive infection control training at induction which includes a section on Covid-19 •National e-learning package level 1 and 2 in place since November 20. Face to face training prior to this. •All clinical staff have annual infection prevention and control training (level 2) which includes Covid-19 •Non-clinical staff have bi-annual training (level1) which includes Covid-19 •Additional ad hoc training on ward during IPC visits	NIPCM has not been launched within the Trust.	All IPC policies reviewed for compliance with NIPCM Change programme under development to introduce new terminology

• the application of IPC practices within the NIPCM is monitored e.g. 10 elements of SICPs • the IPC Board Assurance Framework (BAF) is reviewed, and evidence of assessments are made available and discussed at Trust board level. • the Trust Board has oversight of incidents/outbreaks and associated action plans.	• Junior doctors have induction training including Covid delivered by DIPC • IPC booklet available for bank and agency staff. • Contractors required to adhere to appropriate IPC measures including mask wearing where required • All elements are covered by the IPC audit plan, routine ward based audits and others e.g. sharps audit • IPC Board Assurance Framework is updated by the DIPC and reviewed monthly at Trust Board. Evidence base is available as required • From July 2021, BAF to be reviewed by Board when new guidance is published or there is significant change to report • Outbreak meetings take place weekly when required. • Summary reports reviewed at IPCC and reported to Board through the Quality committee • Executive team receives the daily outbreak sitrep and weekly HCAI report	Terminology not yet in routine practice IPC processes not yet in line	Change programme to introduce new terminology is being developed IPCT members to attend AAR training

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

• enhanced/increased frequency of cleaning should be incorporated into environmental decontamination protocols for patients with suspected/known infections as per the NIPCM (Section 2.3) or local policy and staff are appropriately trained.
 	
• manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.
 	
• For patients with a suspected/known infectious agent the frequency of cleaning should be increased particularly in:
  ○ patient isolation rooms
  ○ cohort areas
	• Bespoke MyAudit platform developed by collaboration between MTW and parent company.
	
	• Cleaning levels well established and implemented for all areas.
	• Covid areas have enhanced cleaning as routine
	• Diff X is cleaning/disinfecting agent used in the Trust. Confirmed as active against respiratory viruses and enveloped viruses including Covid
	
	• Manufacturer's guidance is followed in all areas
	• Instructions are displayed where needed
	• Environmental cleaning policy reflects manufacturers requirements
	• Additional cleaning instructions and training in place for management of point of use filters on water outlets
	
	• Increased frequency of cleaning complies with national guidance for isolation rooms, cohort areas and donning and doffing areas
	• Increased frequency of cleaning complies with national guidance for isolation rooms, cohort		

○ donning & doffing areas – if applicable ○ 'Frequently touched' surfaces e.g., door/toilet handles, chair handles, patient call bells, over bed tables and bed/trolley rails. ○ where there may be higher environmental contamination rates, including: ▪ toilets/commodes particularly if patients have diarrhoea and/or vomiting. • The responsibility of staff groups for cleaning/decontamination are clearly defined and all staff are aware of these as outlined in the National Standards of Healthcare Cleanliness • A terminal clean of inpatient rooms is carried out: ○ when the patient is no longer considered infectious ○ when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens). ○ following an AGP if clinical area/room is vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).	areas and donning and doffing areas • Frequently touched surfaces cleaning in place since June 2020 • Increased frequency in place • Commode cleaning audited with triangulation audits in addition. Reported to IPCC • The Categorisation of levels of environmental cleaning/disinfection RWF-OWP-APP233 clearly describes staff roles in cleaning/decontamination • Available in poster format and in IPC resource folders on wards and clinical areas and the intranet • Level 3 clean plus UVC decontamination for areas/rooms stepped down from Covid to non-covid • Terminal clean of single rooms based on infectivity of patient. Information on levels of cleaning widely available. • Disposable curtains used throughout the Trust with criteria in place for replacement • Following AGP level 3 terminal clean plus UVC decontamination completed when room vacated		

• reusable non-invasive care equipment is decontaminated:
  ○ between each use
  ○ after blood and/or body fluid contamination
  ○ at regular predefined intervals as part of an equipment cleaning protocol
  ○ before inspection, servicing, or repair equipment.
 	
• compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.
 	
• ventilation systems, should comply with HTM 03:01 and meet national recommendations for minimum air changes
 	
https://www.england.nhs.uk/publication/specialised-ventilation-for-healthcare-buildings/
	• Re-usable non-invasive care equipment decontaminated according to the Trust policy.
	• Pre-Covid guidance remains in place for clinical areas
	• Disinfectant wipes used which are active against Covid-19 and respiratory viruses.
	• DiffX used for commode cleaning
	
	• Commode cleaning audited with triangulation audits in addition. Reported to IPCC
	• Other cleaning of nursing equipment monitored daily by matrons as part of daily ward checks
	• PII audits including equipment cleanliness
	
	• Tunbridge Wells Hospital was constructed fourteen years ago and is designed with ventilation supply and extract systems in clinical, rest, dining and administration areas. The ventilation in this building is compliant with the NHS Health Technical Memoranda HTM 03-01. HTM 03-01 specifies a high standard of supply and extract ventilation design with single pass air supply and no recirculation of internal for infection control purposes.		

• ventilation assessment is carried out in conjunction with organisational estates teams and or specialist advice from the ventilation group and/ or the organisations, authorised engineer and plans are in place to improve/mitigate inadequate ventilation systems wherever possible.	• Maidstone Hospital was constructed in 1986. The building is a “Nucleus Design“ hospital constructed on design concept of natural ventilation rather than mechanical ventilation by the use of opening windows. Operating Theatres and pharmaceutical production areas all installed with HTM 03-01 ventilation systems. • MDGH - New Ventilation equipment in past 12 months is compliant, • Estates team work closely with IPCT on risk assessments for ventilation • Upgrades to ward areas include air handling assessment and replacement with compliant systems • MDGH - Critical ventilation systems assessments are carried out annually, • Ventilation Safety Group now setup, maintenance team / authorised engineer are carrying out surveys on existing ageing ventilation systems to identify/improve/mitigate inadequate ventilation systems • TWH - Critical ventilation systems assessments are carried out annually by Mitie	• existing ventilation equipment is non-compliant due to end or near to end of life,	• capital funding plan for replacement being developed for 23/24 and 24/25 financial years

• where possible air is diluted by natural ventilation by opening windows and doors where appropriate	who are maintenance / service provider for this site • Trickle ventilation is in use in Tunbridge Wells Hospital • Windows can be opened at MDGH but is weather dependent for the comfort of patients		
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure that: • arrangements for antimicrobial stewardship (AMS) are maintained and a formal lead for AMS is nominated • NICE Guideline NG15 https://www.nice.org.uk/guidance/ng15 is implemented – Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use	• Antimicrobial stewardship continues as for pre-Covid. • Antimicrobial stewardship group (ASG) reports to Drugs, Therapeutics and Medicines Management Committee • Antimicrobial report to IPCC • A consultant microbiologist is the lead for antimicrobial prescribing • NG15 is implemented by and monitored through the Antimicrobial Stewardship Group • Antimicrobial guidelines in place		

• the use of antimicrobials is managed and monitored:
  ○ to optimise patient outcomes
  ○ to minimise inappropriate prescribing
  ○ to ensure the principles of Start Smart, Then Focus https://www.gov.uk/government/publications/antimicrobial-stewardship-start-smart-then-focus are followed
 	
• contractual reporting requirements are adhered to, and boards continue to maintain oversight of key performance indicators for prescribing including:
  ○ total antimicrobial prescribing;
  ○ broad-spectrum prescribing;
  ○ intravenous route prescribing;
adherence to AMS clinical and organisational audit standards set by NICE: https://www.nice.org.uk/guidance/ng15/resources
 	
• resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency and external contractors).
	• Certain antibiotics controlled and can only be prescribed with permission of the microbiologist
	• Empirical guidance in place
	• Sepsis pathway in place
	• Guidelines for antibiotic treatment of Covid patients issued by ASG
	
	• Mandatory reporting of antimicrobial usage continues.
	• ASG reviews data monthly and investigates unusual patterns of prescribing
	• IPCC and DTMMC report to Quality committee
	
	• Antimicrobial prescribing guidance available in the on line formulary and also available in App form.
	• Training given to new doctors on prescribing including Start Smart then Focus
	• Trust undertaking CQUIN on prescribing in UTI in adults for 2022/23
	• Antimicrobial prescribing audit (against the standards contained in the antimicrobial prescribing policy) undertaken by antimicrobial pharmacist on all wards and reported to IPCC. Outcomes shared with clinical teams
		Start Smart then focus is not currently routinely audited
		
		Training not yet in place for bank and agency doctors.
			EPMA will provide greater oversight and analysis of prescribing of antibiotics when fully embedded
			
			EPMA has built in prescribing rules to restrict certain antibiotics

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			
• **Key lines of enquiry**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • IPC advice/resources/information is available to support visitors, carers, escorts, and patients with good practices e.g. hand hygiene, respiratory etiquette, appropriate PPE use • visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors • national principles on inpatient hospital visiting and maternity/neonatal services will remain in place as an absolute minimum standard. national guidance on visiting patients in a care setting is implemented. • patients being accompanied in urgent and emergency care (UEC), outpatients or primary care services, should not be alone during their episode of care or treatment unless this is their choice.	• A variety of leaflets are available for patients, visitors and carers. • Posters are displayed at entrances to remind visitors to wear face coverings on entering the hospital • Hand hygiene facilities are widely available • Open visiting from midday to 7pm. Maximum of two visitors at the bedside • Two birth partners allowed. Two hours open visiting on post-natal unit per day. Children permitted to visit • Both parents and grandparents can visit in neonatal unit. • Outpatients have accompanying person plus a carer when needed • ED patients have accompanying person plus a carer when needed	• Visibility of hand hygiene gel at main entrances needs to be improved	• Dispensing stands on order

• restrictive visiting may be considered by the incident management team during outbreaks within inpatient areas This is an organisational decision following a risk assessment and should be communicated to patients and relatives. • there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, respiratory hygiene and cough etiquette. The use of facemasks/face coverings should be determined following a local risk assessment. • if visitors are attending a care area to visit an infectious patient, they should be made aware of any infection risks and offered appropriate PPE. • Visitors, carers, escorts who are feeling unwell and/or who have symptoms of an infectious illness should not visit. Where the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting.	• Surgical mask provided to patients and visitors as required • Extended visiting for compassionate reasons e.g end of life • Visiting not permitted on outbreak wards unless for compassionate/end of life reasons • Visiting kept under regular review with decision making at executive level • Visiting information is available on the trust website • Posters are displayed at entrances to remind visitors to wear face coverings on entering the hospital • Decision to reinstate mandatory mask wearing agreed by ETM • PPE guidance for visitors available – ward staff advise individual visitors. • All visitors are expected to wear a mask whilst in the hospital • Visitors asked about respiratory symptoms on arrival on the ward and turned away if they are symptomatic unless compassionate reasons etc. Arrangements for video call made as required		

• Visitors, carers, escorts should not be present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/guardian. • implementation of the supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted where required C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	• Visitors are not present during AGPs unless essential carers or for compassionate /end of life • Use of the toolkit has been considered and elements will be implemented as part of the IPC strategy		
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • all patients are risk assessed, if possible, for signs and symptoms of infection prior to treatment or as soon as possible after admission, to ensure appropriate placement and actions are taken to mitigate identified infection risks (to staff and other patients). • signage is displayed prior to and on entry to all health and care settings instructing patients with symptoms of infection to inform receiving reception staff, immediately on their arrival (see NIPCM). • the infection status of the patient is communicated prior to transfer to the receiving organisation, department or transferring services ensuring correct management /placement	• Respiratory and non-respiratory pathways in place in ED • Target to triage all patients within 15 minutes of arrival • Signage displayed at main entrance, oncology entrance and ED entrance. • Infection status discussed at referral • Infection status and other diagnoses included on electronic discharge notification.		

• triaging of patients for infectious illnesses is undertaken by clinical staff based on the patients' symptoms/clinical assessment and previous contact with infectious individuals, the patient is placed /isolated or cohorted accordingly whilst awaiting test results. This should be carried out as soon as possible following admission and a facemask worn by the patient where appropriate and tolerated. • patients in multiple occupancy rooms with suspected or confirmed respiratory infections are provided with a surgical facemask (Type II or Type IIR) if this can be tolerated. • patients with a suspected respiratory infection are assessed in a separate area, ideally a single room, and away from other patients pending their test result and a facemask worn by the patient where appropriate and tolerated (unless in a single room/isolation suite).	• Also included in handover documents for ward to ward transfers and transfers to other care facilities • ED triage carried out by senior nursing staff. • Immediate allocation of patient to pathway • Obstetric triage in place with senior midwife. Labour ward has designated respiratory beds • All patients encouraged to wear face masks as long as tolerated • Inpatients who become symptomatic are tested and isolated wherever possible • All patients are provided with FRSM and encouraged to wear them where it can be tolerated. • All patients encouraged to wear masks when moving away from their bed space. • Patients with respiratory symptoms move through the ED respiratory pathway and are separated from other non-respiratory patients • Patients on this pathway have rapid Covid test and rapid FluA, FluB and RSV tests at the point of referral. Where negative and viral infection still suspected, a laboratory PCR test is also taken.		

• patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting test results and a facemask worn by the patient where appropriate and tolerated only required if single room accommodation is not available. • patients at risk of severe outcomes of infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room protective isolation • if a patient presents with signs of infection where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes. • The use of facemasks/face coverings should be determined following a local risk assessment • patients that attend for routine appointments who display symptoms of infection are managed appropriately, sensitively and according to local policy.	• Patients isolated whilst awaiting results • Patients with respiratory symptoms are isolated pending results of tests • Patients are encouraged to wear a face mask where tolerated • Criteria in place for admission to haematology ward to ensure only Covid negative patients are on the ward • Staff LFT monitored • CEV patients isolated in ED and prioritised for single rooms on wards • In place. Clinical review determines risk vs benefit of proceeding with treatment in symptomatic patients • Local risk assessment in place for the reinstatement of mandatory mask wearing in clinical areas • Patients with fever are reviewed by clinician to determine whether to continue with appointment or to go home to self-isolate and rebook • Patients for elective admission who are unwell on the day of admission have a medical		

• Staff and patients are encouraged to take up appropriate vaccinations to prevent developing infection • Two or more infection cases linked in time, place and person trigger an incident/outbreak investigation and are reported via reporting structures.	review to determine if their planned treatment can proceed. • Staff vaccination programme in place. Communicated to staff in different media. • Mobile vaccination teams visit staff in the workplace to vaccinate • In place. IPC team monitor infections and discuss possible linked cases. • Outbreak policy in place using these criteria • Reported via IPCC to quality committee • Confirmed outbreaks reported as Serious Incidents	• In-patient vaccination programme not in place	• Discussions re planning in June 2023 for next winter beginning
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • IPC education is provided in line with national guidance/recommendations for all staff commensurate with their duties.	• National IPC e-learning package in use for new starters and annual/biannual updates • Face to face training for some staff groups including junior doctors		

• training in IPC measures is provided to all staff, including: the correct use of PPE
 	
• all staff providing patient care and working within the clinical environment are trained in hand hygiene technique as per the NIPCM and the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it (NIPCM);
• adherence to NIPCM, on the use of PPE is regularly monitored with actions in place to mitigate any identified risk
 	
• gloves and aprons are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's.
 	
• hand hygiene is performed:
  ○ before touching a patient.
  ○ before clean or aseptic procedures.
  ○ after body fluid exposure risk.
	• Local induction for new staff. PPE officers provide training.
	• Dedicated FIT testing team. All results recorded and database maintained
	• Nurse in Charge of a shift ensures bank and agency staff aware of PPE expectations
	• PPE officers provide face to face training on wards.
	• IPC team provide training to staff
	• Donning and Doffing videos available on Trust intranet site.
	
	• Hand hygiene training included in IPC training package.
	• Face to face for certain staff groups
	• IPCT and PPE team visit wards for hand hygiene and PPE training
	• PPE audits are carried out by the PPE team and reported to the IPCC
	
	• All wards use Standard Infection Control Precautions– informal training on wards by IPCT and circulated through Pulse
	
	• The WHO five moments for Hand Hygiene is in common usage in the Trust.
	• Included in the Standard infection Control Policy
	• Included in training for staff		

○ after touching a patient; and ○ after touching a patient's immediate surroundings. • the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination (NIPCM) • staff understand the requirements for uniform laundering where this is not provided for onsite.	• Hand air dryers are not in use in the Trust • All hand wash basins are co-located with paper towel dispensers • Scrubs are laundered by the Trust laundry and staff are advised not to take them off-site • Staff launder their own uniforms. Guidance has been published through the daily bulletin and Covid intranet page. • All staff advised to travel to and from work in their own clothes and change on site • Staff changing and shower facilities provided on both sites		
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • that clear advice is provided; and the compliance of facemask wearing for patients with respiratory viruses is monitored (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs.	• All in-patients advised to wear face masks where this can be tolerated and especially when moving away from their bed space • Patients with respiratory viruses are encouraged to wear face masks where in a bay	• Audits not consistently in place	• TWH is >90% single roomed hospital • No capacity to undertake additional audit

• patients who are known or suspected to be positive with an infectious agent where their treatment cannot be deferred, care is provided following the NIPCM. • patients are appropriately placed i.e.; infectious patients are ideally placed in a single isolation room. If a single/isolation room is not available, cohort patients with confirmed respiratory infection with other patients confirmed to have the same infectious agent. • standard infection control precautions (SIPC's) are applied for all, patients, at all times in all care settings • Transmission Based Precautions (TBP) may be required when caring for patients with known / suspected infection or colonization	• All patient facing staff are trained in IPC precautions • Respiratory precautions used for infection respiratory agent, Enteric precautions for patients with diarrhoea etc • Isolation Policy and procedure details the appropriate PPE for different infectious agents • Patients cared for in single rooms wherever possible or cohorted together depending on infecting organism • Standard infection control policy in place • All patient facing staff trained in SIPC precautions • SIPC precautions are used universally unless a patient has a known or suspected infection or colonisation • Policies and training in place to support staff to use the appropriate IPC precautions for the individual patient • Respiratory precautions used for infection respiratory agent, Enteric precautions for patients with diarrhoea etc	• NIPCM terminology is not yet in common usage within the Trust	• Change programme under development

8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • Laboratory testing for infectious illnesses is undertaken by competent and trained individuals.	• Testing undertaken by registered BMS staff and unregistered MLA staff with documented competencies and scope of practice • Method validated prior to diagnostic testing		
• patient testing for infectious agents is undertaken promptly and in line with national guidance.	• In house main laboratory testing turnaround time of less than 24 hours for respiratory viruses • All non-elective patients have POC tests on admission as appropriate • All results reported to PHE via Co-surv • POCT available in both EDs • 24/7 service for near patient testing across the Trust • On call BMS for critical samples		
• staff testing protocols are in place for the required health checks, immunisations and clearance	• All new staff have occupational health screening and clearance with vaccinations given as appropriate		
	• Turnaround times are monitored for a range of tests	Patient to result TAT is less accurate than laboratory TAT as	

• there is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available. • inpatients who go on to develop symptoms of infection after admission are tested/retested at the point symptoms arise. **COVID-19 Specific** • patients discharged to a care home are tested for SARS-CoV-2, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge. Coronavirus (COVID-19) testing for adult social care services - GOV.UK (www.gov.uk) • for testing protocols please refer to: COVID-19: testing during periods of low prevalence - GOV.UK (www.gov.uk) C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)	• Any inpatient who develops respiratory symptoms has a laboratory PCR test for respiratory viruses including Covid and clinical review • Other infection screens are completed depending on clinical presentation • All patients who have been negative throughout their inpatient stay are tested 48 hours prior to discharge to a care home • Results are shared with the receiving care facility	sample time is not always recorded and not always the same as the time of request. Solutions being sought through the EPR.

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Systems and processes are in place to ensure that • resources are in place to implement, measure and monitor adherence to good IPC and AMS practice. This must include all care areas and all staff (permanent, flexible, agency and external contractors). • staff are supported in adhering to all IPC and AMS policies.	• Antimicrobial prescribing guidance available in the on line formulary and also available in App form. • Training given to new doctors on prescribing including Start Smart then Focus • Trust undertaking CQUIN on prescribing in UTI in adults for 2022/23 • Antimicrobial prescribing audit (against the standards contained in the antimicrobial prescribing policy) undertaken by antimicrobial pharmacist on all wards and reported to IPCC. Outcomes shared with clinical teams • Online training for EPMA • Ward based support during transition • IPC resource folders on all wards • Handbook for agency and bank staff for IPC • Ad hoc training on wards for all staff • PPE team and IPC team regularly visit wards to assist • Feedback given to wards on IPC audit outcomes • Outbreak policy in place • Active management by infection control team	• Training not yet in place for bank and agency doctors. • Online EPMA training available for all • Online antimicrobial formulary available. Also available as App • EPMA has built in prescribing rules

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

Systems and processes are in place to ensure that: • staff seek advice when required from their occupational health department/IPCT/GP or employer as per their local policy. • bank, flexible, agency, and locum staff follow the same deployment advice as permanent staff. • staff understand and are adequately trained in safe systems of working commensurate with their duties. • a fit testing programme is in place for those who may need to wear respiratory protection.	• Guidance for staff is available on the Trust Intranet, daily Pulse, through team brief and daily huddles • Staff guided towards staff absence line, occupational health and managers for advice • IPCT available for advice to managers • Advice applies equally to permanent, flexible, bank and agency staff • Staff are trained in safe systems of working including the use of PPE as appropriate • Regular updates provided through daily huddles, the Pulse, staff intranet, etc • The fit testing team is part of the IPCT • All clinical staff required to be fit tested annually • Ongoing programme in place • Urgent fit testing can be facilitated if required • New staff fit tested during induction • System in place to monitor staff illness and absence		

• where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will:
  ○ lead on the implementation of systems to monitor for illness and absence.
  ○ facilitate access of staff to treatment where necessary and implement a vaccination programme for the healthcare workforce as per public health advice.
  ○ lead on the implementation of systems to monitor staff illness, absence and vaccination.
  ○ encourage staff vaccine uptake.
• staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in NIPCM.
• a risk assessment is carried out for health and social care staff including pregnant and specific ethnic minority groups who may
	• Occupational health work closely with IPCT and microbiologists to facilitate treatment as necessary.
	• Occupational Health lead on vaccination for staff
	• Monitoring systems in place.
	• Occupational health work closely with HR and IPCT
	• Staff uptake of vaccine encouraged and facilitated
	• Current data:
	  ○ Covid One dose 97.14%
	  ○ Covid Two doses 95.36%
	  ○ Covid Booster 92.44%
	  ○ Covid 2nd booster 55.3%
	  ○ Influenza 45.4%
	• Clear guidance given to staff to ensure infection control precautions followed by staff who have been vaccinated and/or recovered from Covid.
	• National guidance followed
	• Risk assessments carried out for all staff in at risk categories including pregnant women.		

be at high risk of complications from respiratory infections such as influenza or severe illness from COVID-19. ○ A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups. ○ that advice is available to all health and social care staff, including specific advice to those at risk from complications. ○ Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff. ○ A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff. • testing policies are in place locally as advised by occupational health/public health. • NHS staff should follow current guidance for testing protocols: C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk) • staff required to wear fit tested FFP3 respirators undergo training that is compliant with HSE guidance and a record of this training is maintained by the staff member and held centrally/ESR records.	• Risk assessments completed through discussion between staff and line managers • Advice is widely available through the Trust intranet pages • Updates shared through intranet, Pulse, team brief and staff huddles • Bank, agency and locum staff follow the same advice • Risk assessments completed as required. • Testing advice and protocols in place. Multi-disciplinary approach to decision making • Guidance followed • In addition all non-elective patients have rapid covid test on admission to enable correct patient placement and protect other more vulnerable patients • FIT testing in place including training on fit, maintenance and cleaning. • Powered air respirators available for staff who fail all fit testing • Individual use reusable respirator masks available • FIT testing register held on central database • Dedicated Fit testing team in place and fully trained		

• staff who carry out fit test training are trained and competent to do so. • fit testing is repeated each time a different FFP3 model is used. • all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks • those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators or an alternative is offered such as a powered hood. • that where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions	• Line managed by Deputy DIPC/ Nurse consultant in IPC • All staff required to wear a FFP respirator are fit tested • Fit testing on new models available as required • All staff required to wear a FFP3 respirator are tested on at least two different masks • A database of fit testing outcomes is maintained • Staff are provided with information identifying the type of mask to be worn • Re-usable masks and hoods are available for staff who fail FIT testing with disposable masks • Records are kept and stored electronically • Re-usable masks and hoods are available for staff who fail fit testing with disposable masks • Training is given in care and decontamination of the re-usable mask or hood. • If all respirator options are unsuitable staff work from home wherever possible and appropriate • Manager works with HR to identify re-deployment opportunities		

• members of staff who fail to be adequately fit tested: a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm. • a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health. • boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board. • staff who have symptoms of infection or test positive for an infectious agent should have adequate information and support to aid their recovery and return to work.	• Discussions are documented and records stored electronically • database of all staff maintained and includes record of all FIT testing • Any staff not tested and required to wear FFP3 provided with FIT testing prior to shift • All areas have access to powered air respirators • Occupational health support staff and advise on return to work and re-testing • Psychological support available through Employee Assistance Programme		

NHS Maidstone and Tunbridge Wells NHS Trust

Proposed Trust submission to the Independent review of integrated care systems ('Hewitt review')	**Director of Strategy, Planning and Partnerships / Chief Executive**

It was agreed at the Trust Board 'Away Day' on 15/12/22 that the Director of Strategy, Planning and Partnerships and Chief Executive should submit a "Proposed Trust submission to the Independent review of integrated care systems ('Hewitt review')" report to the Trust Board meeting on 22/12/22. The report is therefore enclosed.

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

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

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

MTW Contribution to the Hewitt Review of ICSs: Delivering added value on the ground

MTW
Exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells NHS Trust

The Hewitt Review

- The Secretary of State for Health and Social Care has appointed the Rt Hon Patricia Hewitt to consider the oversight and governance of integrated care systems (ICSs).
- The review will consider how the oversight and governance of ICSs can best enable them to succeed, balancing greater autonomy and robust accountability.

- In particular it will consider and make recommendations on:
  - how to empower local leaders to focus on improving outcomes for their populations, giving them greater control while making them more accountable for performance and spending
  - the scope and options for a significantly smaller number of national targets for which NHS ICBs should be both held accountable for and supported to improve by NHS England and other national bodies, alongside local priorities reflecting the particular needs of communities
  - how the role of the Care Quality Commission (CQC) can be enhanced in system oversight

MTW Feedback

- Varying Modus Operandi by Issue:
  - Convene/facilitate, e.g. improvement collaboratives, workforce Ts&Cs
  - Lead and do, e.g. public consultation, commissioning
  - Oversee, e.g. constitutional standards, financial improvement

  → Right MO for the right issue; Proportionate resourcing

- Focus on adding value at each level (through accountability and action):
  - System
  - Place
  - Organisation

  e.g. Workforce

  - System: Primary Care Workforce, HEE interface
  - Place: Support for VS partners and Social Care employers
  - Organisation: Job evaluation; temporary staffing; workforce plans; training and development

MTW Feedback

- Aligning system “Levers” to deliver sustainable, high quality services:
  - Capital
  - Commissioning
  - Oversight
  - Appointments
  - Signing off plans
  - Development funds
  - Spec. Comm.
  - HEE
  - Digital
- Delegation from NHSE:
  - Spec Comm. (NB collaborative commissioning models)
  - Education contracts
  - Business case approvals
- Assume ‘corporate’ responsibility for Primary Care:
  - Leadership and engagement
  - Securing plans to achieve sustainability
  - Workforce planning and development
  - Estate management and asset renewal

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NHS Trust

NHS Maidstone and Tunbridge Wells NHS Trust

Nursing and Midwifery staffing review (annual review) **Chief Nurse**

Executive Summary:

This report outlines the progress made in relation to Nursing & Midwifery workforce, describing the current staffing position, recruitment pipeline and the monitoring of safe staffing. It also provides the highlights and key recommendations following the recent annual establishment review.

The process for reviewing the Nursing & Midwifery workforce at Maidstone and Tunbridge Wells NHS Trust has been revised with the introduction of a new Nursing & Midwifery Establishment Review Policy in September 2022. The primary purpose of this new policy is to ensure safe patient care and excellent patient experience through appropriate nurse/midwife staffing that meets patient acuity and dependency. This approach is aligned to national recommendations from the National Quality Board (2016) in providing assurance to the Trust Board that staffing levels are appropriate to deliver safe and effective patient care.

The first annual establishment review in this new format was completed in October 2022 to ensure that there are the right Nursing & Midwifery staffing and skill mix to meet the needs of patients. This was a review all clinical areas within the Trust including adult and paediatric inpatient wards, out-patient services, clinical nurse specialists, critical care, theatres, endoscopy and maternity services. The establishment review cycle is aligned with business planning taking into consideration any proposed workforce changes the recommendations of which are included in this report.

Which Committees have reviewed the information prior to Board submission?
- Executive Team Meeting, 13/12/2022

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

This report presents a full annual review of Nursing & Midwifery workforce to assure the Board and the public regarding Nursing & Midwifery safe staffing levels. In addition, this report outlines progress made over the past 12 months in relation to Nursing & Midwifery workforce.

1. Nursing & Midwifery Workforce progress over the last 12 months:

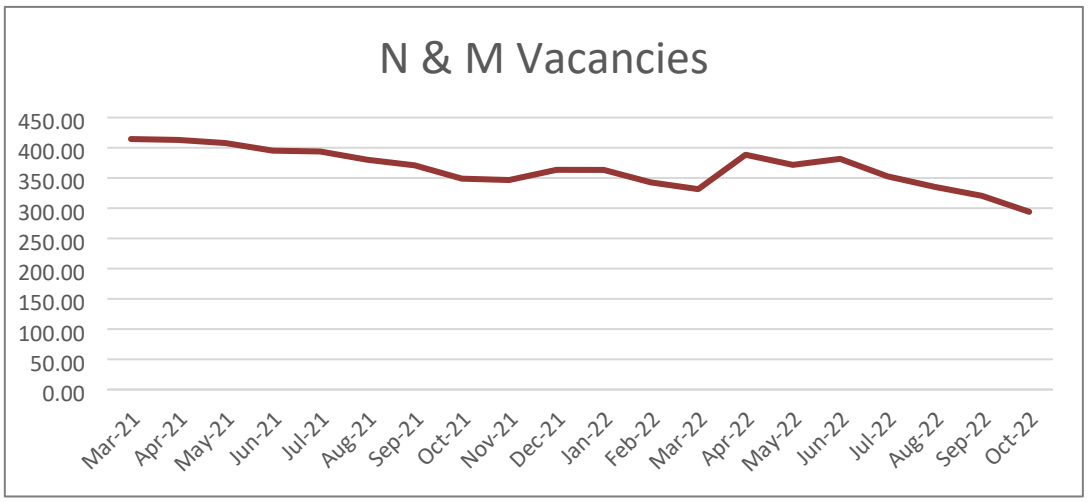
Working closely with HR colleagues significant progress has been made as outlined below:

Theme	Action
Healthcare Support Workers (HCSW)	• Standardisation of title and introduction of New to Care pathway for HCSW. • 61 HCSW completed the OET programme which supports HCSW to meet the English language requirements to successfully practice as a nurse in the UK. 32 have now completed their OSCE and are practicing as a registered Nurse.
Recruitment	• Enhanced advertising including social media activity and local radio advertising. • Introduction of monthly Saturday recruitment open days for Healthcare Support Workers • Introduction of quarterly Saturday recruitment open days for Registered Nurses & Midwives. • Delivery of ambitious international recruitment campaigns including two in-country campaigns with a total of 171 IENs recruited since January 2022. • Progress with the implementation of Divisional Nursing Workforce Trackers with starters and leavers in real time to enable accurate recruitment to turnover. • Standardisation of job descriptions with rolling adverts and interviews.
Retention	• Introduction of Retention Programme Board and associated working groups. • Introduction of monthly Recruitment & Retention newsletter. • Introduction of Staff Forums for all bands.
Safe Staffing	• Development of rag rated Safe Staffing levels with guidance. • Embedding of daily huddles and development of daily staffing reporting. • Night time staffing levels on Tunbridge Wells wards 12, 20, 22 and 30 have been increase by an additional registered nurse on duty at night. • Healthroster Confirm & Support framework written with monthly support meetings established to ensure rostering is effective. • SafeCare project on inpatient wards now live. • Development of Establishment Review Policy & Process.
Training & Development	• Recruitment of 7x Band 6 Clinical Skills Facilitators to support newly recruited Internationally Educated Nurses (IENs). • Increase in OSCE training capacity with a new expanded location for training. • Expansion of registered nurse/midwife degree apprenticeship (RNDA/RMDA) programme with 31 additional places funded this financial year. • Introduction of Learning Needs Analysis process to ensure training and development needs are being supported and met. • Implementation of monthly Career & Wellbeing Roadshows. • Introduction of Ward Manager/Unit Leader Band 7 Leadership Programme

2. Current Staffing Position

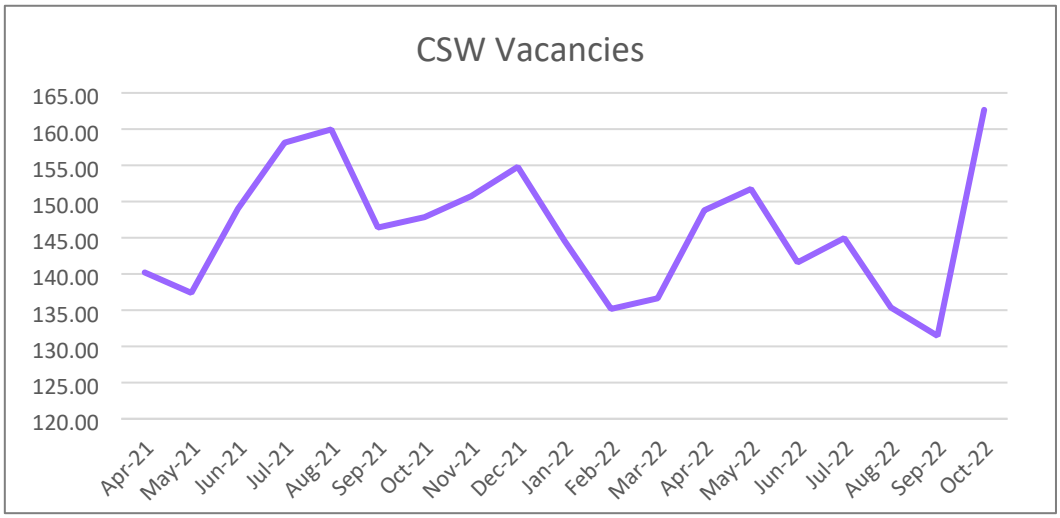
Significant recruitment progress has been made with the most recent data showing that the number of Registered Nurses/Midwives (RN/RM) in post increased to 1794.90 wte. Registered Nursing & Midwifery vacancies have reduced to 281.40 wte resulting in an improved vacancy rate of 13.6%, see Figure 1. Currently there are 72.81 wte internationally educated nurses that are pending completion of the OSCE exam and subsequent NMC pin. Following receipt of NMC pin vacancies drop to 221.29 wte.

Figure 1: Registered Nursing & Midwifery Vacancies



In September 2019 NHS England launched a national programme to minimise the number of Healthcare Support Worker (HCSW) vacancies this is linked to the NHS Long Term Plan. This encourages organisations to provide more opportunities for members of the public from other industries to join the NHS. As part of our response to this in May 2022 the New to Care Pathway for HCSWs was introduced this has improved our recruitment rates for this staff group. There are now 591.91 wte HCSW in post, 153.55 wte vacancies with a current vacancy rate of 20.6%, see Figure 2. An elevation in HCSW vacancies can be seen, which is attributed to escalation wards now having a funded establishment. It is recognised that continual improvement is required for this staff group which is being achieved through the monthly recruitment open days for HCSWs.

Figure 2: Healthcare Support Worker Vacancies



Data Source: November 2022 BI Recruitment Dashboard for Nursing Midwifery

Current recruitment pipeline

Recruitment activity is planned in advance with an annual calendar of events, social media campaigns, radio advertising and attendance at national recruitment events such as those from the Nursing Times. In April 2022 on-site recruitment open days were introduced monthly for HCSW and quarterly for RN/RMs. In addition, there is an ambitious international nurse recruitment plan of 140 nurses per year as outlined in the associated approved business case, see figure 3 for new IEN starters.

These recruitment initiatives have been highly successful in reducing the number of vacancies as shown in pipeline data; see figure 4.

Figure 3: New Starters - Internationally Educated Nurses

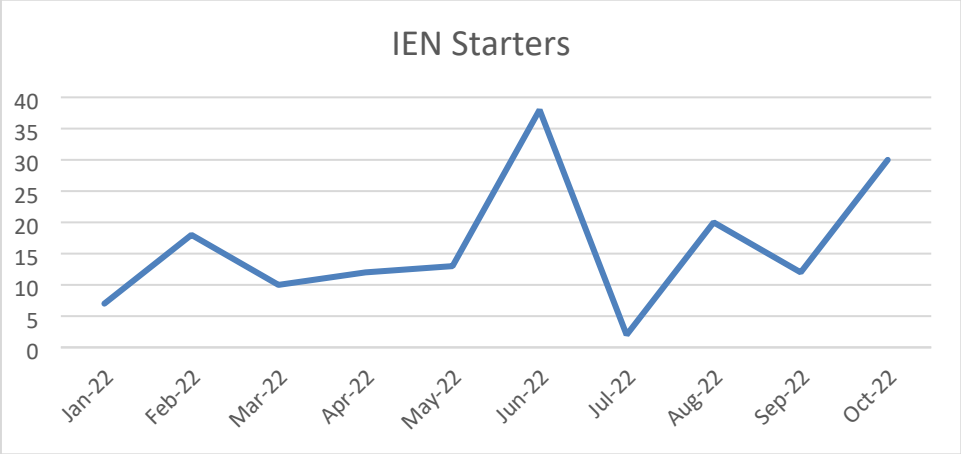


Figure 4: Nursing & Midwifery recruitment pipeline.

Department	Authorisation	Advert	Shortlisting	Interview	Offer pending	Employment checks	Checks done	Total
Healthcare Support Workers	21.9	10	0	5.5	2	65.4	34.9	**139.7**
Nursing and Midwifery Registered	17.4	49	12.3	24	1	87	54.5	**245.2**

Data compiled by the recruitment team November 2022

Additional Recruitment Pipelines

Progress has been made on the development and incorporation of new roles and apprenticeships to support the recruitment, retention and development of the nursing & midwifery staff. The business case to support a further 31 RNDA/RMDA's has been successful and provides a recruitment stream to 'grow our own' at MTW. The Registered Nursing Associate (RNA) role is now embedded and we now offer a two-year top up degree for RNA's wanting to progress to RN's.

As part of the establishment review process the current and predicted expansion of RNDAs/RNAs was captured as follows:

Registered NA's	Current TNA	Predicted additional TNA	Current RNDA/RMDA	Predicted additional RNDA/RMDA
19	25	14	30	17

Data captured during establishment reviews October 2022

3. Monitoring of Safe Staffing

Ensuring safety within the clinical areas is of paramount importance therefore a number of key daily staffing reviews are in place to support this. The monitoring of safe staffing levels has been strengthened over the past 12 months and staffing levels are closely monitored daily in real time at site meetings, daily staffing reports, daily staffing huddles and weekly recruitment activity progress. Progress has been made through the development of a Safe Staffing Guideline this includes rag rating staffing levels to ensure processes are in place to manage safety and risk in relation to staffing. The full safe staffing policy is due for ratification by the end of this calendar year.

A monthly report and publication return to NHSI/E indicating 'planned' and 'actual' nurse staffing by ward is submitted known as Staffing Fill rates (see figure 5). The safe staffing paper is published monthly and incorporated in the executive team workforce update, it is also shared with Divisional Nursing and Midwifery Leads and at the monthly Nursing & Midwifery Recruitment & Retention Programme.

Safe Care®

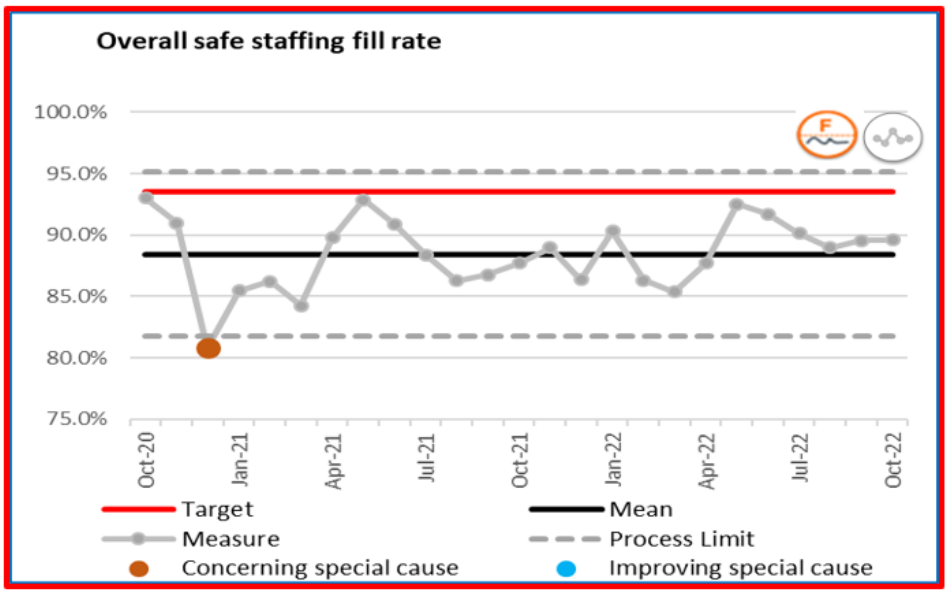
Safe Care® is used across all adult and children inpatient areas to support the real time visibility of staffing levels across the Trust. The next stage of this project is to use the 'Red Flag' function and use the data collected to highlight and support decision making relating to the deployment and redistribution of staff to meet patient needs in other areas. NICE (2014) developed the 'Red flag events' guidance which warn when nurses in charge of shifts must act immediately to ensure they have enough staff to meet the needs of patients on that ward.

Staffing Fill Rates

Planned Vs actual staffing fill rates are monitored monthly and submitted to NHSIE. Safe Staffing fill rate remains 3.7% below target at 89.6%. Achievement of target has not occurred since May 2021 (see figure 5) this has been partly due to escalation beds being open resulting in the redeployment of staff from other areas and Covid related absence impacting on staffing fill rates. The escalation areas are now funded and being recruited to improve this.

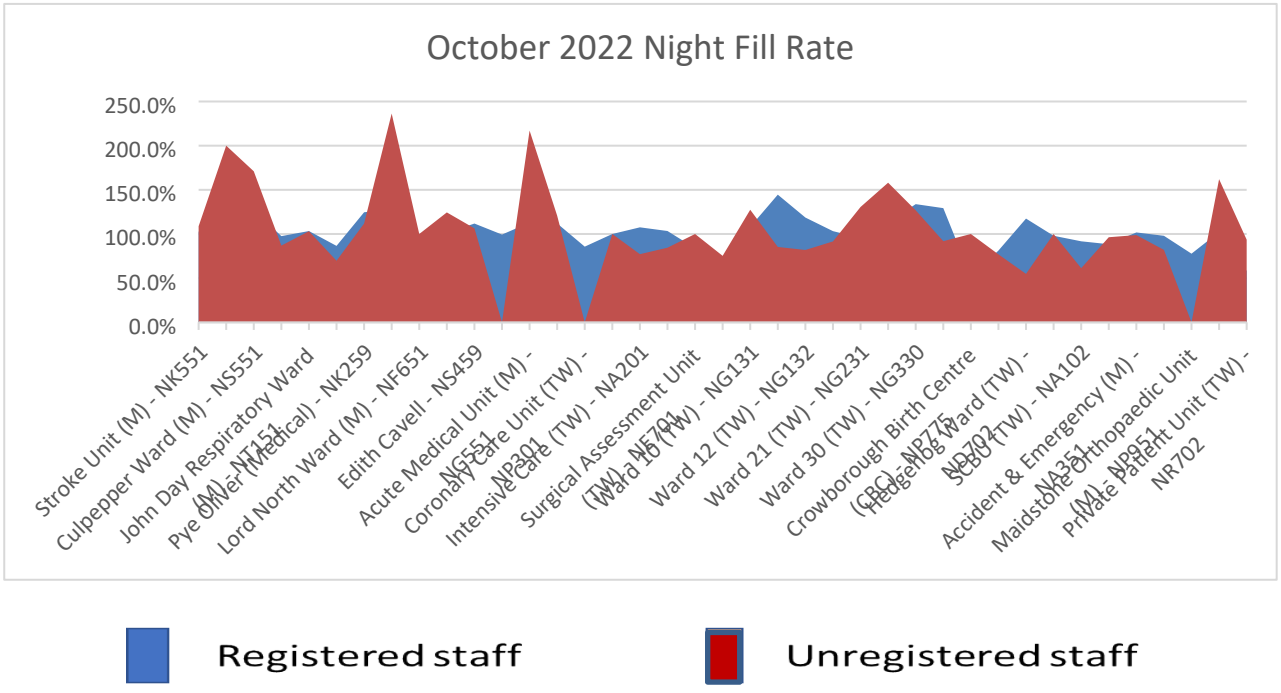
Progress has been made to monitor and improve the staffing fill rates with significant improvements in recruitment efforts described above. Corrections are being made to Healthroster to ensure roster templates match the funded establishment. There has also been an increase in registered nurse staffing at night on four of the wards at Tunbridge Wells following the November 2021 establishment review.

Figure 5: Staffing Fill Rates



Oct-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

Figure 6: Night Staffing Fill Rates



Data Source: November 2022 BI staffing fill rate data (most recent report)

Overfill on nights is a consistent trend (see figure 6), this is likely linked to the incorrect template for unregistered staff (HCSW) and enhanced care needs of patients such as those with mental health illness. This was recognised in the establishment review and is contributing to an increase temporary staffing spend on nights with numerous additional shifts being added to the roster to meet patient equity and demand. Correct night establishments will support a reduction of temporary staffing spend resulting in any investment being cost neutral or a potential cost saving.

4. Annual Establishment Review

As outlined above the establishment review cycle has been revised to ensure alignment with the business planning cycle. Reviews were carried out using methodologies set out by the National Quality Board (NQB) 'Right staff, right Skills, in the right place' (2013), 'Safe, sustainable productive staffing' (July 2016) and the Developing Workforce Safeguards: using a triangulated approach to ensure the use of:

- Evidence based tools (where they exist)
- Professional Judgement
- Based on patients' needs, acuity, dependency and risks.

At present we are yet to implement the use of the Safer Nursing Care Tool (SNCT) however, now have the licence agreements for this tool and training has commenced to launch acuity and dependency data collection in February 2023. SNCT is an NHSE/I approved and validated tool for use in establishment setting that measures patients acuity and dependency. Birthrate+ is due to be completed in maternity in 2023.

Key Recommendations of Workforce Changes following Establishment Review

Careful review by department was carried out to ensure we have safe, effective and consistent establishments across the Trust. The recommendations in workforce have been proposed as a result of this annual establishment review. It is recognised that these recommendations would require financial investment and an increase in headcount which would be prioritised with a phased approach if financial approval was given. Close monitoring of temporary staffing spend will also be required with a view of this reducing as we better align the nursing roster templates.

These recommendations have been reviewed and prioritised by the Chief Nurse and Deputy Chief Nurse for Workforce and Education and split into four categories; recommended change, consider change, divisional review and on hold. Whilst this is not a financial case a summary of the recommended and consider changes are below with associated costs. The remaining categories can be found in appendix 1. Important to note many of the recommendations for divisional review require a review of activity in conjunction with business planning and workforce demand.

Summary of totals:

Cost	wte	Prioritisation notes
£2,957,094	67.71 wte	For progressing in 2023/2024
£593, 378	13.76 wte	Not for progressing this financial year
£1,739,531	40.7 wte	
£110,924	3.00 wte	
£5, 400,927	**125.17 wte**	

Surgical Division Recommendations

	Band	Recommend Change
Ward 30 (TW) - NG330	2	increase night by 1 HCSW
Ward 31 (TW) - NG331	2	increase night by 1 HCSW
Short Stay Surgical Unit (TW) - NE901	5	Additional RN at night weekends (currently 1)
Short Stay Surgical Unit (M) - NE751	2	Increase 1 HCSW at night due to lone working
Ward 10 (TW) - NG131	2	Extend HCSW early into LD - total 4 HCSW
Ward 10 (TW) - NG131	2	Increase HCSW by 2 at night
Total cost: £505, 962		**Total wte: 14.08 wte**

	Band	Consider Change
Ward 30 (TW) - NG330	5	Extend 1 early into LD - Total of 5 RN on LD + 1 Early
Ward 31 (TW) - NG331	5	Extend 1 early into LD - Total of 5 RN on LD + 1 Early
Vascular Access Service - NT401	6	Additional 2 B6 WTE.
Vascular Access Service - NT401	3	Additional 2 B3 WTE.
Total cost: £390, 816		**Total wte: 9.42 wte**

Medicine & Emergency Care Division Recommendations

	Band	Recommended Change
Whatman Ward - NK959	2	Additional 1 HCSW at night
Mercer Ward (M) - NJ251	2	Extend early into LD - Total of 4 HCSW on LD
Stroke Unit (M) - NK551	2	Additional 2 HCSW at night (Total of 6 HCSW)
Ward 2 (TW) - NG442	2	Additional 1 HCSW at night
Pye Oliver (Medical) - NA901	5	Additional RN
Ward 11 (TW) Winter Escalation 2019 - NG144	5	Increase nights by 1 RN to align with other TWH wards
Ward 21 (TW) - NG231	5	Extend RN early into LD - Total of 6 RN on LD
Ward 21 (TW) - NG231	2	Increase HCSW by 1 LD
Ward 21 (TW) - NG231	2	Increase HCSW by 1 Night
John Day Respiratory Ward (M) - NT151	5	Additional 1 RN LD
John Day Respiratory Ward (M) - NT151	2	Increase HCSW by 2 Night
Total cost: £1,179,316		**Total wte: 30.49 wte**

	Band	Consider Change
A&E Paediatric Services Riverbank - NC370	5	Increase by 1 RCN
A&E Paediatric Services Riverbank - NC370	3	Increase by 1 NN to support 7-day service
Total cost £145,025		**Total wte: 3.34 wte**

Women Children & Sexual Health Division Recommendations

	Band	Recommendation
Midwifery Services - Postnatal Ward - NF102	5	1 RN to support with care of the mother
Midwifery Services - Postnatal Ward - NF102	5	1 RN to support with care of the mother
Midwifery Services - Delivery Suite - NF102	5	1 RN to support caesarean list
Midwifery Services - Delivery Suite - NF102	5	1 RN to support caesarean list
Midwifery Services - Antenatal Ward - NF102	6	Additional RM LD

Midwifery Services - Antenatal Ward - NF102 Maternity Day Assessment Unit SCBU (TW) - NA102 SCBU (TW) - NA102 **Total cost: £1,214, 279**	6 3 7 7	Additional RM Night 1 Additional MSW Supernumerary for BAPM Standards (day) Supernumerary for BAPM Standards (night) **Total wte: 22.14 wte**

	Band	Consider Recommendation
Paediatrics Out Patients - LC451 & LC402	7	BCG Clinic paediatrics & maternity
Total cost: £57, 537		**Total wte: 1.00 wte**

Other recommendations for WC&SH include reviewing shift times for maternity to increase the handover time in the evening moving from 15 mins to 30 mins in line with the morning handover and rest of the Trust.

Important to note that the maternity review was done in the absence of a recent completion of Birth rate+ which is provisionally planned for 2023.

It was reported that the safeguarding demand has increased in both paediatrics and maternity – this has been reported to the Deputy Chief Nurse for Quality who is currently reviewing the safeguarding demand and proposed that we increase the resource (see below).

Corporate Nursing* Recommendations

	Band	Consider Recommendation
Safeguarding Practitioner – AV851	7	1 Safeguarding Practitioner
Total cost: £57, 537		**Total wte: 1.00 wte**

*Excludes all other aspects of corporate nursing – safeguarding only.

Cancer Division Recommendations

Currently no recommendations in relation to establishment.

Expected Benefits

It is proposed that a phased approach to these workforce changes is planned focusing initially (within the first 6 months of financial year) on the recommended changes. The expected benefits are as follows:

1. Standardisation of nurse to patient ratios across all wards.
2. Reduction in temporary staffing spend in particular for RMNs and HCSW who provide enhanced care.
3. Improved patient and staff experience.
4. Improved patient flow with more time to focus on discharge planning.
5. Reduced redeployment of staff subsequently improving staff morale.
6. Improved retention rates.
7. Potential to increase placement capacity for Student Nurses.
8. Safer nursing & midwifery care delivery.

5. Other Key Highlights following Establishment Review

As a result of the establishment review a number of themes and actions were identified highlights of which are outlined below. These have been developed in to a Nursing & Midwifery Workforce Action

Plan (see appendix 2) which is being overseen by the Deputy Chief Nurse for Workforce & Education. These actions will be discussed at the monthly Nursing & Midwifery Workforce planning group the membership of which includes the Deputy Director of Finance - Performance, Deputy Chief People Officer – People & Systems, Head of Financial Management, Head of Nursing for Safe Staffing and representation from BI, Workforce and Learning & Development.

General Nursing & Midwifery Themes

The review highlighted the need to standardise the supernumerary time for Band 7 Ward Managers and the skill mix i.e number of Band 6 per ward. The supernumerary/clinical time varied from an 80/20 to a 20/80 split, the establishment review policy recommends an 60/40 split therefore this will be considered across the Trust by the Chief Nurse.
The use of Registered Mental Health Nurses (RMNs) and Mental Healthcare Support Workers to provide 1-1 care were reviewed by ward and demonstrated a significant reliance on temporary staff to fill these shifts. The majority of the Ward Managers reported the Mental HCSWs were valuable in providing 1-1 care in particular at night and felt there was an overuse of RMNs which could be reduced or replaced by HCSWs. As a result of this an immediate action was taken to reduce the number of pool RMNs which will instead be booked on a case by case basis according to patient need.

There is a need to improve the numbers of HCSWs on some wards as outlined in the divisional recommendations. This is felt to be a necessary action to enhance patient safety, staff experience and reduce temporary staff spend in some areas such as the stroke and respiratory wards.

General Finance Themes

The review revealed a need to improve the governance in relation to healthroster, ESR and budget alignment. This requires collaboration between corporate nursing, workforce, finance and HR.

Currently MTW apply a 21% uplift to mitigate annual leave, study leave, sickness etc. The NHSI National Quality Board (2018) recommend an uplift of 22.2% for ward areas and 25% for specialist areas such as ED. It is unlikely we will be able to make any changes to the uplift % during the next round of business planning (2023/2024) in order to prioritise the recommended template changes (in green). Further consideration to uplift allowance will be given in next year’s annual establishment review. It is also necessary to understand how uplift is calculated for Band 7&6 and Ward Clerks with some inconsistency/misunderstanding associated with this.

During the review it was recognised that increases in activity and consultant posts have not necessary considered all aspects of the nursing and midwifery workforce such the increase demand on Clinical Nurse Specialists, Outpatients, Preoperative Assessment and Theatres. Correct modelling of activity in these specific areas is required to ensure we have the right workforce to meet the demand in particular when running additional Saturday operating/clinic lists where the template is historically reduced at weekends.

There were some inconsistencies with the arrangements for escalation areas and a review of the budget for and wte for Cornwallis, Whatman and Ward 11 is necessary to ensure standardisation.

The review revealed that the Medicine Division overrecruit by 2 wte band 5's per ward to allow for turnover however, this is not the case for other large divisions such as Surgery and should be considered for consistency in our recruitment approach.

General Human Resources & Workforce Themes

As part of the process the healthroster for each department was reviewed identifying actions in relation to roster changes which have been shared with the e-roster team and will also be addressed through the monthly roster Confirm & Support meetings.

Flexible working agreements for each department were reviewed and a total of 448 formal flexible working agreements are in place across Nursing & Midwifery. It is recommended that this information is recorded centrally to demonstrate how flexible, or not, we are as a Trust and also to trigger a 12-month review of any agreed arrangements. Many areas raised concerns about flexible working arrangements that result in staff working only nights and felt further supportive guidance of line managers is needed in regards to this

6. Other Nursing & Midwifery Workforce considerations & on-going objectives

- Safe Staffing Policy is in draft and planned for ratification by the end of this calendar year.
- SNCT to be implemented in February 2023
- Birthrate+ to be completed in 2023.
- Ensure workforce modelling is robust for new services such as Cardiology, Stroke, Ortho Centre to include methodology outlined in establishment review policy.
- ACP role expansion to be scoped further and included in business planning.
- Development of business cases for various pipelines such as OET, RNDA and TNA. To include how the Band 4 RNA position is to be factored into establishments.

Conclusion

This report has provided a summary following a comprehensive establishment review of the entire Nursing & Midwifery workforce. It has enabled a clear understanding of the workforce priorities which have been reviewed by the Chief Nurse. It is recognised that financial consideration is required in particular given the current financial position of the Trust and NHS as a whole. The recommendations have been shared with the Divisional Directors of Nursing & Head of Midwifery and will be considered as part of the business planning process.

The report has demonstrated the significant progress made with the Nursing & Midwifery workforce over the past 12 months with numerous initiatives and on-going actions. Continual effort is required to reduce the vacancy rate with particular attention being paid to retention. Focus is currently being given to the retention of IENs with a working group established to ensure the onboarding process and welcome to the Trust is of an exceptional standard including the accommodation offer. There are also plans to develop an internal council/network for IENs.

More focus is required to monitor our CHPPD (Care Hours Per Patient Day) and Staffing Fill Rate data comparing MTW across the system and wider NHS. Finally, there is more attention required to monitor bank and agency spend and support the plans to reduce temporary staffing spend. To aid this the Deputy Chief Nurse for Workforce & Education is actively contributing to the working group for the breakthrough objective to reduce premium workforce spend.

Appendix 1: Workforce Prioritisations - Divisional Considerations

Surgical Division

	Band	Division to consider with activity plans
Ward 30 (TW) - NG330	3	Activity co-oridnator
Ward 31 (TW) - NG331	3	Activity co-oridnator
Intensive Care (TW) - NA201	7	Additional Clinical Educator
Short Stay Surgical Unit (M) - NE751	5	Increase by 2 RN on the late to cover increased theatre activity
Short Stay Surgical Unit (M) - NE751	2	Consider additional HCSW to cover increased theatre activity
ENT Services EEMU - VC754	5	1 additional WTE RN
ENT Outpatients (TW) - LB101	5	1 additional WTE RN
Total cost: £215, 694		**Total wte: 5.58 wte**

Medicine & Emergency Care Division

	Band	Division to consider with activity plans
Accident & Emergency (TW) - NA301	5	Float nurse & additional triage nurse
Accident & Emergency (M) - NA351	5	Float Nurse
Accident & Emergency (M) - NA351	5	Float Nurse
Acute Medical Unit (TW) - NA901	5	Increased AEC by 1 RN weekend
Neurology Nurse Specialists - NA602	3	Additional 1 WTE A&C
Gastroenterology Specialist Nursing - NA604	7	Additional 1WTE
Endocrinology Specialist Nursing - NA603	6	Additional 1 WTE
Endocrinology Specialist Nursing - NA603	3	Additional 1 WTE A&C
Cardiology Specialist Nursing - DE201	6	Additional 1 WTE B6 (currently a secondment)
Total cost: £742, 180		**Total wte: 16.36 wte**
Ward 22 (TW) - NG332	6	Increase B6 by 0.7 - % to be funded by unfilled B5 post

Women Children & Sexual Health Division

	Band	Division to consider with activity plans
Paediatrics Out Patients - LC451 & LC402	2	1 additional HCSW for either site
Ward 33 (Gynae) (TW) - ND302	6	Triage Phone EGAU
Gynae Outpatient (TW) - LC502	2	2 additional HCSW
Gynae Outpatient (TW) - LC502	4	Need to calculate costs
Whitehead Ward (Gynae) (M) - NK359	6	Additional 0.8 WTE B6
Whitehead Ward (Gynae) (M) - NK359	3	Additional B3 A&C to make 1 WTE post, currently 0.64
Midwifery Services - Postnatal Ward - NF102	3	Additional 4 days B3 d/c co-oridnator (7-day service
Midwifery Services - Postnatal Ward - NF102	4	Increase infant feeding service to 7 days
Maidstone Birth Centre - NP751	3	1 WTE Ward Clark
Community Midwifery Services - NP751*	6	Consider additional 10 WTE B6 midwifes (needs review)
Maternity Services - Specialist Midwifery	6	Additional 1 WTE B6 Patient Experience midwife
Total cost: 892,581		**Total wte: 21.76 wte**
All Midwifery areas with Long Days		Handover increase 15 mins (not costed)

Appendix 2: Nursing & Midwifery Workforce Action Plan (from establishment review)

Workforce Planning Action Tracker November 2022

Action	Owner	Date for Completion	Status
Prioritise workforce proposals (red, amber, green, blue)	Chief Nurse/DCN	07/11/2022	Complete
Complete gap analysis using Workforce Rota Calculator Vs roster	Matrons & Finance Managers	30/11/2022	Partial
Understand how uplift is calculated for all bands	DCN/Head of Finance	01/02/2023	Not due
Understand how band 4 roles sit in budget	Head of Finance	01/02/2023	Not due
Agree how Healthroster actions will be completed	DCPO	30/11/2022	Not due
Standardise skill mix % i.e number of Band 6 per ward	DCN	01/02/2023	Not due
Correct discrepancies with HCSW numbers	DCN/business planning	01/04/2023	Partial
Ensure workforce modelling is robust for new services	Chief Nurse/DCN	on-going	On going
Review shift handover times in maternity	DCN/Head of Midwifery	01/02/2023	Not due
Completion of birth rate+ in Maternity	DCN/Head of Midwifery	TBC 2023	Not due
Scope safeguarding demand paediatrics and maternity	DCN Quality & Patient Experience	30/11/2022	Partial
Standardise Band 7 Supernumerary time	Chief Nurse/DCN	01/02/2023	Not due
Standardise admin time for CNS with a clear job planning process	DDNQ	01/02/2023	Not due
Consider increase in Student nurses – rotational placements	Head of Nursing Safe Staffing	01/02/2023	Not due
ACP role expansion to be included in business planning	DCN	01/04/2023	Not due
Improve governance in healthroster, ESR and budget alignment	DCN/Head of Finance/DCOP	on-going	On going
Standardise use Workforce Rota Calculator	Matrons & Finance Managers	on-going	On going
Uplift not meeting national recommendations of 22% ward areas and 25% specialist areas	DCN/business planning	01/04/2023	Not due
Confirm Ward Clerk uplift	Head of Finance	30/11/2022	Partial
Review activity in divisional business planning and impact on nursing workforce – ED, Clinical Nurse Specialists, Outpatients, Preop, Theatres.	DDNQ/DDO	01/02/2023	Not due
Increase in consultants Vs outpatient/CNS workforce mapping	DDNQ/DDO	01/02/2023	Not due
Create model for nursing establishments within outpatient settings	Head of Finance	01/12/22	Complete
Standardise recruit to turnover by 2 WTE band 5's per ward	DCN/Head of Finance	01/02/2023	Not due
Review budget for escalation areas	DCN/Head of Finance	01/02/2023	Not due
Correct Healthroster discrepancies	DCPO	01/02/2023	Not due
Flexible working agreements to be recorded centrally	DCPO	01/02/2023	Not due
Flexible working guidance for working predominately nights.	DCPO	01/02/2023	Not due
Agree process for professional nursing support for temporary staff	Head of Nursing SS/DCPO	30/02/2023	Not due
Review drop down reasons for additional shifts	Head of Nursing SS/DCPO	30/02/2023	Not due

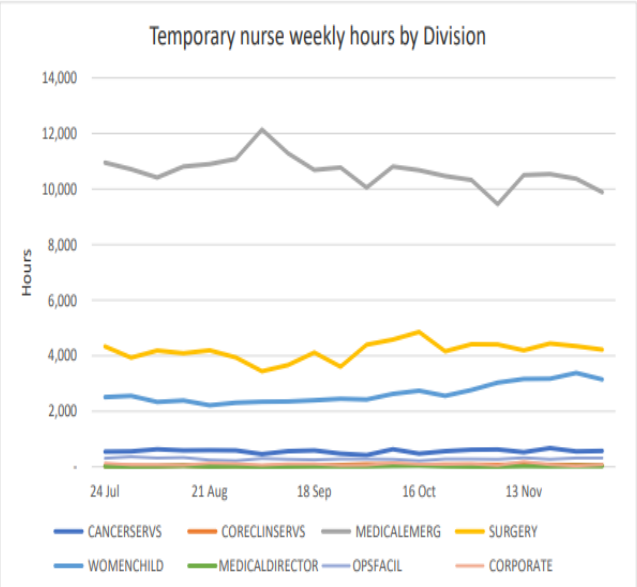
Appendix 3: Current Nursing Spend (year to date)

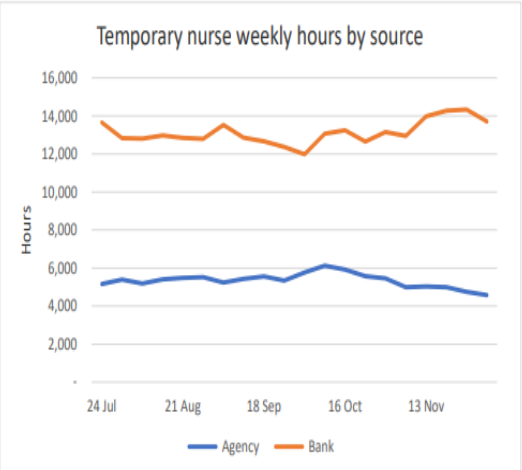
Registered Nursing

Division	YTD Budget	YTD Actual	YTD Var
	£ 000	£ 000	£ 000
ACANCERSERVS	5,426	5,088	338
ADIAGSUPPORT	678	687	-9
AMEDICALDIRECTOR	599	547	52
AMEDICALEMERG	27,932	26,999	933
ASURGERY	19,760	19,863	-103
AWOMENCHILD	15,143	15,331	-188
CHF-FINANCE-OFF	7	26	-19
CORPORATE	2,976	1,946	1,029
NONDIRECT	782	142	640
OPSFACIL	2,317	2,300	17
	75,619	**72,929**	**2,690**

Unregistered Nursing (HCSW)

Division	YTD Budget	YTD Actual	YTD Var
	£ 000	£ 000	£ 000
ACANCERSERVS	1,365	1,177	188
ADIAGSUPPORT	433	483	-50
AMEDICALDIRECTOR	0	22	-22
AMEDICALEMERG	9,468	9,963	-495
ASURGERY	5,162	5,241	-78
AWOMENCHILD	2,731	2,790	-59
CHF-FINANCE-OFF	297	289	9
CORPORATE	105	61	43
NONDIRECT	294	0	294
OPSFACIL	257	251	6
	20,112	**20,277**	**-165**





Data source: HealthRoster
From week ending 24 Jul to 04 Dec

NHS Maidstone and Tunbridge Wells NHS Trust

To approve the Charitable Fund Annual Report and Accounts for 2021/22	Associate Non-Executive Director, Vice Chair of the Charitable Funds Committee

It was agreed at the Charitable Funds Committee meeting on 17/11/22 that the Charitable Fund Annual Report and Accounts for 2021/22 be recommended for approval at the December 2022 'Part 1' Trust Board meeting subject to the findings of the independent examination by the Trust's External Audit Service. The audit has since taken place and no material amendments were suggested, therefore the report is enclosed for approval prior to submission to the Charity Commission.

Which Committees have reviewed the information prior to Board submission?
- Charitable Funds Committee, 17/11/22

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

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

Annual Report and Accounts

For the year ended 31st March 2022

Charity Number 1055215

Contents

Fundraising foreword

This year the Trust has starting the long recovery from managing the response to COVID-19. Our staff are still dealing with the COVID-19 outbreaks but this year has really been one of resetting and getting back to normal. Our hard-working staff are managing to keep our performance high with our staff securing outstanding performance in Cancer Care, Emergency Department performance and waiting lists down. We continue to invest charity funds in supporting our staff after such a draining period in their careers.

Every donation is important and many people have been inspired to donate as a result of excellent care which either they, or their loved ones, have received from the Trust

This year the Charitable Fund received total income of £202k from individuals, groups and organisations. This included monies from national fund raising as a member of NHS Charities Together.

Thank you to all our fantastic fundraisers and supporters.

Our performance

The charity aims to strategically grow its income and supporter base to add value to the patient and staff experience. Significant progress has already been made to develop corporate fundraising which has been identified as a key area for growth.

Our achievements

The Corporate Trustee (Trustee) presents the Maidstone and Tunbridge Wells NHS Trust Charitable Funds (the Charity's) Annual Report and the audited financial statements for the year ended 31st March 2022.

The financial statements set out on pages 20 to 36 comply with the charity's trust deed, Accounting Standards in the United Kingdom and the Statement of Recommended Practice (SORP) relevant to charities preparing their accounts in accordance with the Financial Reporting Standard (FRS) applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2019).

Trustee Statement

The generosity of the many people who have raised funds, given donations and made provisions in their will, is recognised by the Trustee, the Charitable Funds Committee, and staff. The Trustee, Charitable Funds Committee and staff would like to express their sincere gratitude to all those who have made a contribution which has enabled the Charity to enhance the standard of care, services and facilities provided by Maidstone and Tunbridge Wells NHS Trust to patients, their relatives, visitors and staff.

The role of the Charity

Maidstone and Tunbridge Wells NHS Trust ('the Trust') is the Corporate Trustee of the charitable fund under paragraph 16c of Schedule 2 of the NHS and Community Care Act 1990. The Charity is constituted by a Trust Deed and registered with the Charity Commission under charity number 1055215, and includes funds in respect of the hospitals of Maidstone and Tunbridge Wells NHS Trust.

During the year the Charity was situated on two main sites in Kent: Maidstone Hospital and Tunbridge Wells Hospital.

The Charity is an 'NHS Umbrella Charity' under which there are individual sub-funds that are held for administrative purposes, principally to respect the wishes of the donors.

Within the Umbrella there were a total of 37 individual funds at the 31st March 2022 with a total value of £1.1m. The number of funds in each category is as follows:

- 18 restricted funds[1].
- 2 endowment funds (capital in perpetuity) - only the net income to be spent, whilst the capital remains invested.
- 17 unrestricted[2] or designated[3] funds created for donations received for use by hospitals, wards and departments to reflect donors' wishes. These do not form a binding trust.

[1] Restricted funds are the funds of the charity that are required to be expended in a certain way, or limited to expenditure for a particular purpose.
[2] Unrestricted funds are the funds of the charity that may be spent entirely at the discretion of the Trustee
[3] Designated funds are funds set aside for designated purposes. Designated funds are unrestricted as the Trustee can remove the designation at any time

- The major funds within each of these categories are disclosed in Note 8 in the accounts.

The Corporate Trustee

Maidstone and Tunbridge Wells NHS Trust is the sole Corporate Trustee of the Charity.

The Trust Board effectively adopts the role of Trustee as defined by the Charity Commission (it is considered to be the agent of the Trustee). Individual members of the Trust Board are therefore not trustees under charity law.

Details of appointments and terminations within the financial year are shown below:

Executive Directors	**Non-Executive Directors**	**Other Directors**
Miles Scott – Chief Executive	David Highton – Chair of the Trust Board	Sara Mumford – Director of Infection Prevention & Control
Steve Orpin – Deputy Chief Executive / Chief Finance Officer	David Morgan	
Peter Maskell – Medical Director	Sarah Dunnett (until 31/12/21)	
Sean Briggs – Chief Operating Officer	Maureen Choong	
Joanna Haworth – Chief Nurse (started 03/08/21)	Neil Griffiths	
Sue Steen – Chief People Officer (started 01/04/21)	Emma Pettitt-Mitchell	
Amanjit Jhund – Director of Strategy, Planning and Partnerships	Wayne Wright (started 13/01/22)	
Claire O'Brien, Chief Nurse (retired 25/06/21)	Jo Webber – Associate Non-Executive Director	
Gemma Craig, Acting Chief Nurse (between 26/06/21 – 22/07/21)	Karen Cox – Associate Non-Executive Director	
	Richard Finn – Associate Non-Executive Director	

None of the Members of the Trust Board have received any remuneration from the Charity in this financial year for work relating to their responsibilities for the Charity as agent of the Corporate Trustee (in 2020/21 this was also none)

The principal office of the Charity is:
Trust Headquarters,
Maidstone and Tunbridge Wells NHS Trust
Maidstone Hospital,
Hermitage Lane,
Maidstone,
Kent,
ME16 9QQ

Principal advisors:

Independent Examiner Grant Thornton UK LLP 30 Finsbury Square London EC2A 1AG	Bankers National Westminster Bank Kent Corporate Business Centre PO Box 344 Maidstone Kent ME14 1AT
Solicitors Brachers Solicitors Somerfield House 59 London Road Maidstone Kent ME16 8JH	Bankers Santander Business Banking Bridle Road Bootle Merseyside L30 4GB
Solicitors Capsticks Solicitors LLP 1 St George's Road Wimbledon, London SW19 4DR	Bankers National Westminster Bank PLC (RBS/GBS) 2nd Floor 280 Bishopsgate London EC2M 4RB
Investment Managers Charities Aid Foundation 25 Kings Hill Avenue Kings Hill West Malling Kent ME19 4TA	Bankers Clydesdale Bank 6/8 London Road Unit 5 Peveril Court Crawley RH10 8JB

Governance and Management of the Charity

Governance

The Board of Maidstone and Tunbridge Wells NHS Trust became responsible for the funds with effect from the 1st April 2000, following the merger of Kent and Sussex Weald NHS Trust, which was based at Tunbridge Wells, and Mid Kent Healthcare NHS Trust, which was located at Maidstone. The Trust Board delegates the daily stewardship of the funds to the Charitable Funds Committee, which within its annual programme of meetings, includes relevant training and updates as required to assist in the performance of its role as Trustee.

The Charitable Funds Committee operates according to Terms of Reference that are approved annually by the Trust Board, and plans to meet at least three times a year; for the financial year 2021/22 the Committee met five times.

The proceedings and decisions of the committee are recorded. The minutes of each meeting are formally agreed by the Chair of the Committee and circulated to all members. A written summary of each Charitable Funds Committee meeting is also submitted to the Trust Board.

Recruitment and Training of Trust Board and Charitable Funds Committee Members

All Trust Board and Committee members undertake an induction programme within the Trust upon joining. They are also able to focus on a particular area of the Trust in which they have a special interest or concern.

Management of the Charity

The management of the Charity is operated in accordance with the Trust's "Policies and Procedures for Charitable Funds", which are approved by the Charitable Funds Committee. That policy was reviewed and updated during 2021/22, approved by the Charitable Funds Committee on 28th July 2021, and then ratified by the Policy Ratification Committee on 10th September 2021. There is a tightly controlled scheme of authorisation in place in order to spend the funds. This is achieved by delegating the day to day expenditure to the duly authorised Fund Holders. The Fund Holders consist mainly of senior department managers. Each individual Fund Holder is approved by the general manager or Clinical Director of the Directorate, and also made aware of the Trust's Standing Orders and Standing Financial Instructions that apply to Charitable Funds. Each Fund Holder receives a detailed financial statement of the fund each month.

Risk Management

The major risks to the Charity have been assessed, and in the opinion of the Corporate Trustee, all necessary action has been taken and procedures have been put in place to minimise those risks wherever possible. The risk policies and financial controls of the Trust also apply to the Charitable Funds, but it was agreed at the Charitable Funds Committee meeting in November 2020, that a separate section of the Trust's risk register should be created (using the Trust's existing risk assessment process and framework) to register risks that are relevant to the Charitable Fund; that an "Annual review of the risk register entries relevant to the Charitable Fund" item be scheduled for consideration at the Committee; and that the outcome of that review be included in the "Risk Management" section of this Annual Report

The second annual review of risks was duly considered at the Charitable Funds Committee's meeting in March 2022; and the risk assessments of three high-level risks (which were informed by the Charity Commission's "NHS charities guidance" and "Managing your charity…" guidance; and the charitable fund risk registers at several other NHS Trusts) were reviewed and agreed. The three high-level risks were as follows:

1. Governance arrangements and management of charitable funds (i.e. that a lack of sufficient governance arrangements and resources within the corporate Division to adequately manage the raising, allocation and financial management of Charitable Funds could result in adverse outcomes);
2. Potential, actual or perceived misuse/misallocation of charitable funds (i.e. that damage could be caused should charitable funds be misappropriated, not allocated with due governance; not used for their intended purpose; or not used optimally within the bounds of Trust policy and procedure); and
3. The response to COVID-19 and other business continuity incidents COVID-19 (and other similar outbreaks) can impact the Trust's ability to manage its charitable funds (i.e. that decreased on site staffing resource could affect day to day running of charitable activities, that the inability to undertake normal charitable activities could impact earning potential, and that a significant increase in donations could result in funds being unallocated for specific or intended purposes).

The Committee was apprised of the control measures in place to reduce these risks.

One aspect of the management of charitable funds relates to investment performance the Corporate Trustee has adopted a relatively low risk policy regarding this, although 50% of funds will remain exposed to those risks normally associated with investing in stocks and shares and regarded as medium to long term investment. The cash balances will be invested in bank accounts which have a low credit risk and are covered by the Financial Services compensation scheme up to a maximum of £85k per banking institution operating under a separate banking licence. The adopted policy is that the maximum investment is up to £85k in each banking institution outside the Government Banking Scheme. Therefore there is no risk on these investments.

Investment Powers

The investment powers of the charitable fund are stated in the Declaration of Trust registered with the Charity Commission, which provides for the following:

''*to invest the trust fund and any part thereof in the purchase of or at interest upon the security of such stocks, funds, securities or other investments of whatsoever nature and where so ever situate as the trustee in their discretion think fit but so that the trustees:*

a) shall exercise such power with the care that a prudent person of business would in making investments for a person for whom he felt morally obliged to provide;

b) shall not make any speculative or hazardous investment (and, for the avoidance of doubt, this power to invest does not extend to the laying out of money on the acquisition of futures or traded options);

c) shall not have power under this clause to engage in trading ventures; and

d) shall have regard to the need for diversification of investments in the circumstances of the Charity and to the suitability of proposed investments.''

Investment strategy

The investment strategy of the charity is defined, by the charitable fund committee on behalf of the corporate trustee as follows:

"*to maximise total returns whilst minimising any risk to the total value of the fund in both the short to medium term.*"

The strategy identifies the current preferred investment mix for the charity as:

- 50% Cash;
- 25% Equities; and
- 25% Bonds.

The Charitable Funds Committee monitors the performance of the investments on a regular basis.

Professional Advisors

Grant Thornton UK LLP is the Trust's appointed External Auditor and they act as the charitable fund's independent examiner. For the 2021/22 financial year, an independent examination was carried out as the charity's gross income falls below £1m.

In addition, TIAA, the Internal Auditors of the Trust, review on a planned basis the systems and procedures put in place by the Corporate Trustee.

Aims and Objectives for the Public Benefit

The key objective of the Trustee of the Maidstone and Tunbridge Wells NHS Charity is to ensure that donations and legacies received are used in accordance with the wishes of the donor and the aims of the Trust. The Trustees therefore consider that the charity clearly falls within the definition of a public benefit entity under the terms of FRS 102.

The Corporate Trustee confirms that the guidance provided by the Charity Commission has been referred to with regard to the need for public benefit when reviewing their aims and objectives and future activities.

The purpose of the Charity is to provide benefit to the public by supporting the prevention and treatment of illness in all its forms and to promote research and education in healthcare through:

- Improving the patient and carer experience;
- Improving healthcare facilities and equipment;
- Facilitating high quality research programmes;
- Encouraging and supporting innovation in the development of services; and
- Supporting the training, personal development and welfare of staff.

The objects of the Charity are stated in the Trust deed as follows:-

"*The Trustees shall hold the trust fund upon trust to apply the income, and at their discretion, so far as may be permissible, the capital, for such purposes relating to Hospital Services (including Research), or to any other part of the Health Service associated with any hospital as the Trustees think fit.*"

The restricted funds have individual specified purposes that govern their use, in conjunction with the objects of the Charity.

Strategy for Achieving its Objectives

The Charitable Funds are used to support the overall objectives of the Trust, and include the provision of a wide range of equipment and facilities for both patients and staff. This allows the Trust to develop its services through new equipment and facilities and to provide training for staff which enhances their skills and knowledge allowing them to improve their contribution to the provision of its services to the public benefit.

The development of the Trust's services may be dependent on both the Charitable Funds and the funds received from the Exchequer. This interdependency provides opportunities for the Charity to contribute to services which make a greater impact than the cash sum would make on its own.

Reserves and Commitments

Charity Reserves as defined by Charities SORP (FRS 102) are those funds which become available to the charity to be spent at the Trustee's discretion in furtherance of the charity's objectives, excluding funds which are spent or committed or could only be realised through the disposal of fixed assets. These are therefore classified as 'free'.

The Corporate Trustee has not made any changes to policy during the year and still requires that commitments against each fund are made only when the resources needed are available.

Major items of expenditure for both goods and services are agreed in advance in order that the necessary liquid resources can be released from the Investment Managers on a planned and timely basis. None of the funds held by the Investment Managers are committed on a long-term basis as

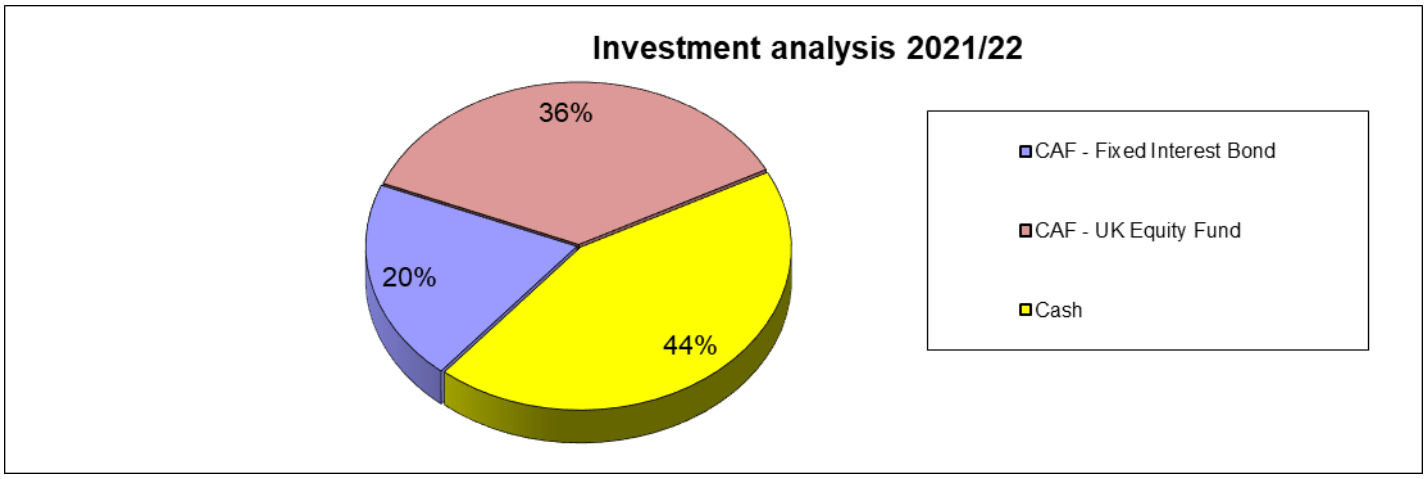
the Corporate Trustee has a policy to put the funds to the best possible use as quickly as is reasonably possible, taking into consideration any particular restrictions imposed by individual donors.

Investment Performance

Investment income for the year was £24k (in 2020/21, £21k). In the current economic climate this is considered to indicate an acceptable performance for an investment strategy based on a low risk portfolio of investments. The value of investments was low on 31 March 2022 compared to pre-covid performances but they have improved compared to the 31st March 2021 value; the total performance return on the portfolio of the investments (equity and bond) was a profit of just £7.4k. This reflects a significant downturn in market performance compared with the previous year (profit of £104k). The Trustee continues to review its investment strategy to seek to maximise its resources whilst maintaining liquidity and security of assets.

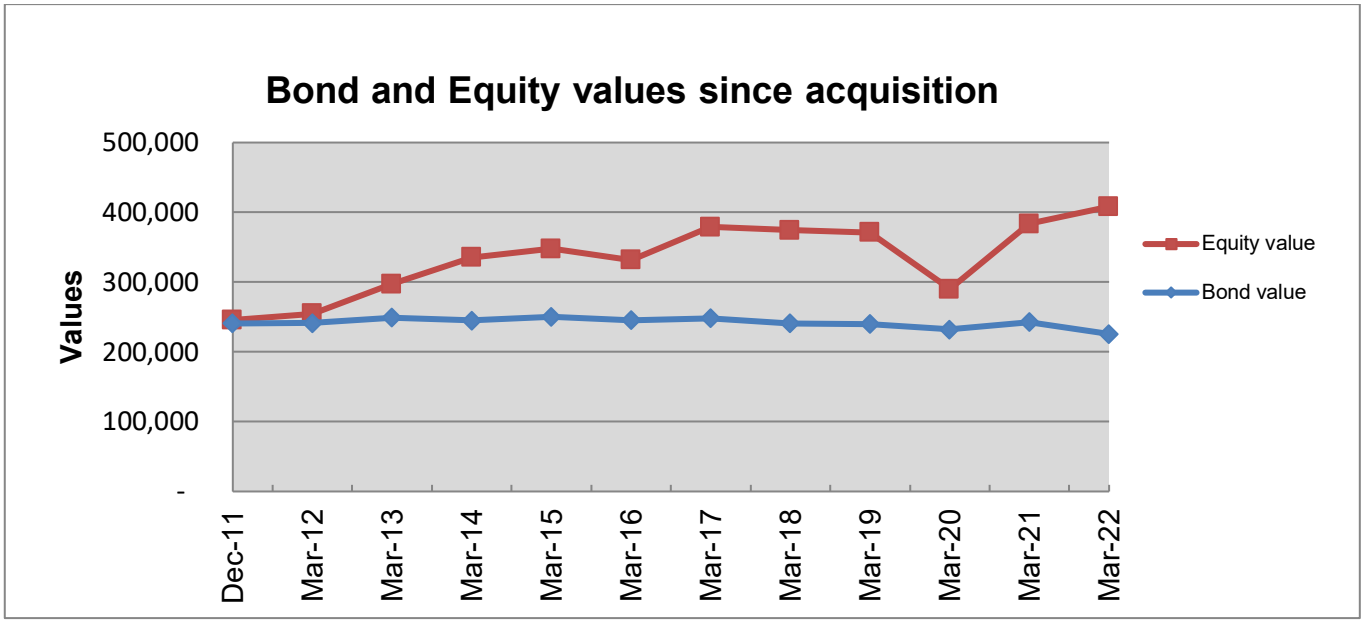
The value of equities and bonds varies according to market forces with the CAF bonds and equities portfolio increasing in market value to £634k at 31 March 2022 (£626k at 31 March 2021). The cash investment at 31 March 2022 was £493k (£865k at 31 March 2021).

The current asset portfolio of cash and investment allocation totalling £1,127k at 31 March 2022 is shown in the following graph:



The cash allocation at 44% is currently lower than the strategy of Cash of 50%. The bonds investment of 20% is lower than the 25% bond strategy; and the equities investment is the most performing out them at 36% higher than the planned strategy of 25%. The bond investments have not performed well this year, (although better than 2020/21 at 16%) due to the ongoing influence of the COVID-19 pandemic and impact of inflation on the money markets so the valuation has fallen, reducing their proportion of the total.

The graph below demonstrates the performance of the bonds and equities since their purchase in December 2011.

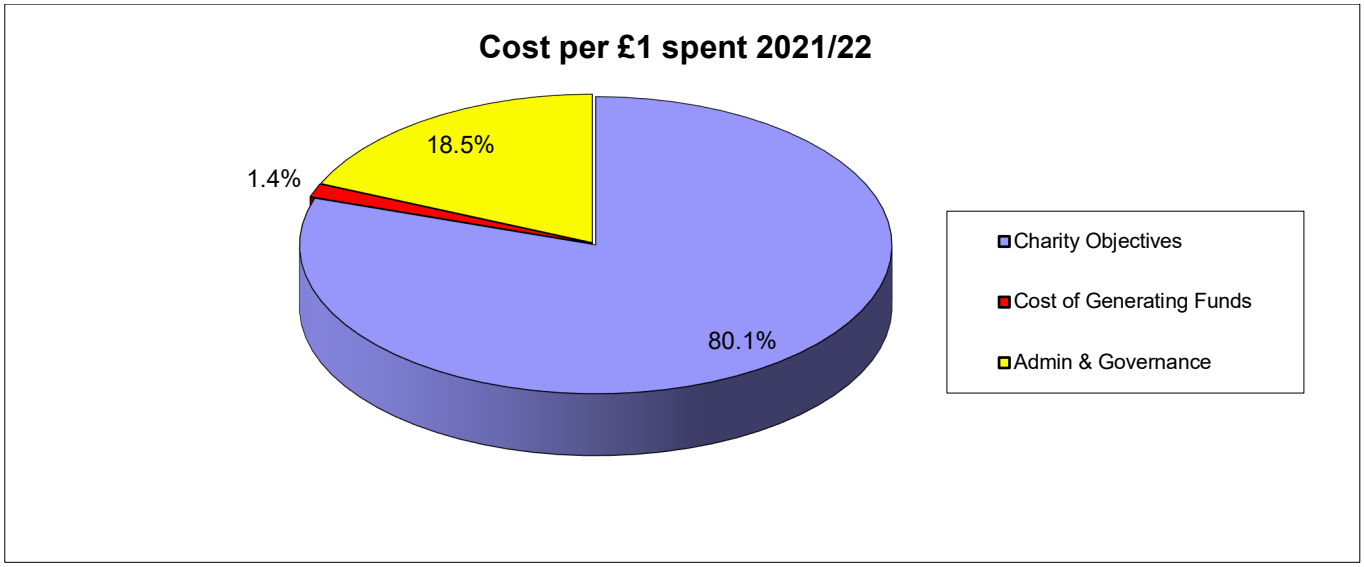


Performance of the portfolio is monitored and reviewed by the Charitable Funds Committee.

Achievement of public benefit

The Trust applies its charitable funds to enhance services and amenities for the public both as patients and visitors as well as staff through the purchase of equipment and support for projects.

The graph below shows that in this financial year for every £1 of expenditure, 80 pence was spent in directly achieving the objectives of the charity. This has changed compared to equivalent ratio for 2020/21 (88 pence).



Expenditure

Total resources expended by the Charity within this financial year were £213k (in 2020/21, £326k), breakdown as follows:

Contribution to NHS:
- £89k Medical Equipment (in 2020/21, £129k)
- £0 IT consumables and hardware (in 2020/21, £4k)

Support and fundraising cost:
- £43k Support and fundraising costs (in 2020/21, £86k)

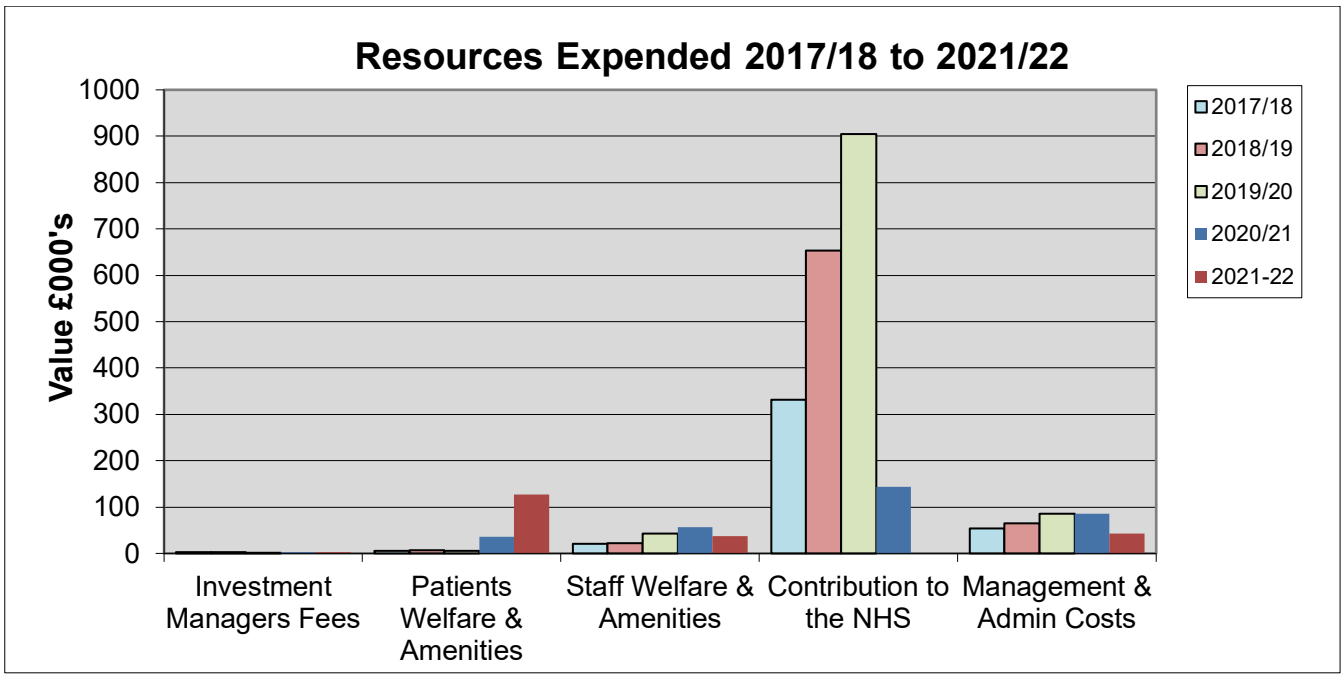
Staff Welfare:
- £40k Staff Welfare and amenities (in 2020/21, £56k)

Patients Welfare:
- £23k Patients welfare and amenities (in 2020/21, £36k)
- £15k Furniture and Fittings (in 2020/21, £12k)

Cost of Generating funds £3k (2020/21 £3k)

Included within the governance cost of £43k are the internal management fees for financially administering the funds and the costs of the Fundraiser Manager. The fees are agreed each year by the Trustees. These costs are charged proportionately across the unrestricted funds whose balance is greater than £1k on a quarterly basis.

The following graph provides an analysis and comparison with previous years:



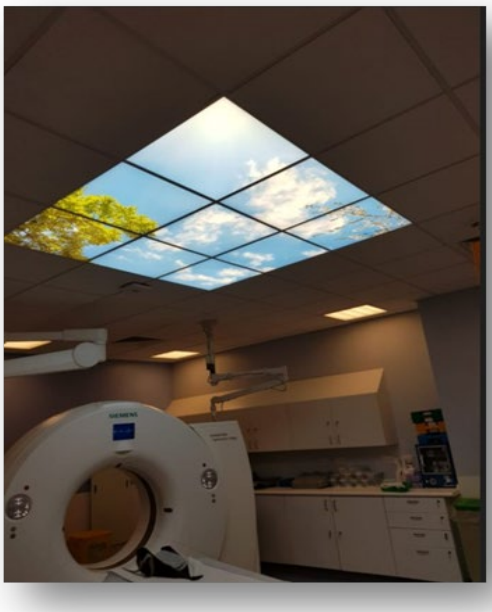
Charitable expenditure for the year is detailed below.

Medical Equipment – Total spend £89k (in 2020/21, £129k)

Medical equipment has been purchased within the reporting year to provide additional resources to enhance the quality of treatment, services and amenities within the Trust. Of which the main items purchased were: £48.8k on x-ray equipment for TWH cardiology, £21k on 3 bladder scanners and £7.5k on indoor sky relax and view panels.

Bladder scanner:

Sky Panels:

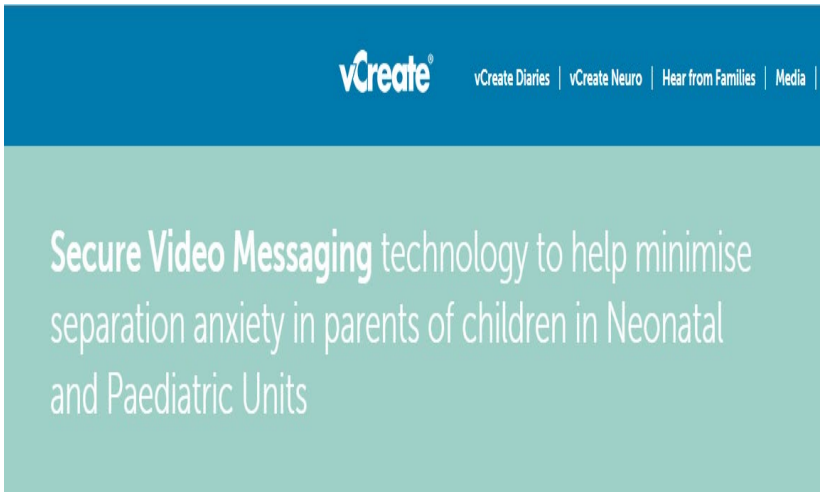


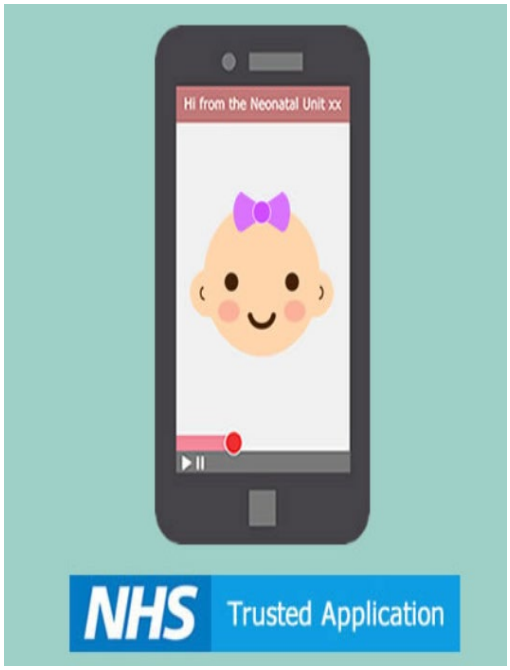
Cardiology Echocardiograph System:

Patient Welfare and amenities – Total spend £23k (in 2020/21, £36k)

The most significant spends were:

£8.6k – Vcreate SCBU computer software to enable parents to view babies in neonatal
£3.6k – Glideaway guest beds





Staff Amenities and Welfare – Total spend £40k (in 2020/21, £56k)

Staff throughout the Trust 'go the extra mile' to ensure the best quality of care for patients. The corporate Trustee recognises this commitment and the hard work and care given to patients and to those who visit the Trust.

Of the £40k; £32k related to various items - £17k Unrestricted funds and £15k Restricted funds,

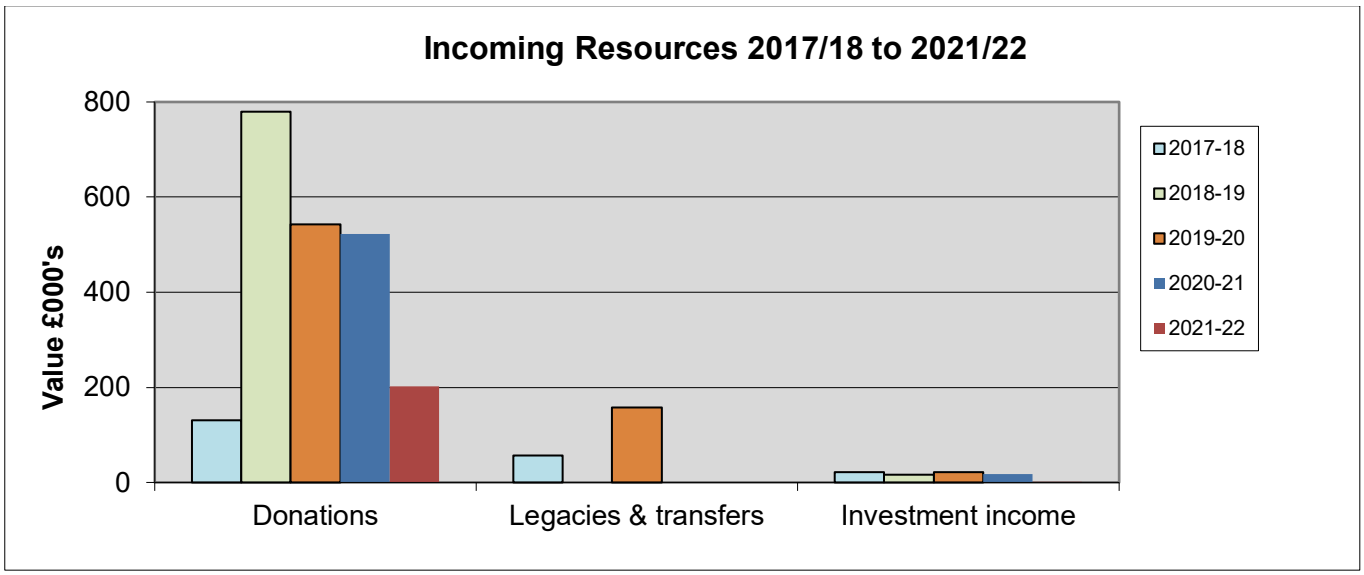
£3k for staff wellbeing, £2k on training and £4k for Christmas events.

Other – Total spend £9k (in 2020/21, £16k)

Furnitures and fittings for various items to benefit wards.

Income

The graph below shows an analysis of income sources for the current and two previous financial years:



The majority of income received by the Charity is from grateful patients and relatives who wish to support the Trust in appreciation of the work and care provided by the Trust staff.

A total of £165k was received from donations (in 2020/21, £522k).

Legacies

The Trust has received a legacy of £36.5k (£0 in 2020/21), from the Late Mr Alfred (Peter) Ernest Bartlett and Mrs Ivy Winifred Bartlett for the benefit of the Eye, Ear and Mouth Unit of the Maidstone and Tunbridge Wells NHS Trust.

We will continue to promote gifts in wills as a way for people to support the Charity.

Online fundraising

The Charity's 'Just Giving' page received donations of £62k this year (£247k 2020/21).

This year we continued to extend the choice of online platforms to include Virgin Money Giving.

Intangible Income

The Statement of Financial Activity does not include any estimation of intangible income in respect of volunteers' services or the free use of Trust premises.

Looking Forward - our plans for the future

Work is continuing at pace to develop the Charity and make it a more vibrant and proactive organisation than ever before. The Trustee is dedicated to strengthening the Charity, working in partnership with the Trust to achieve their aim to deliver an outstanding healthcare service for our patients.

The Trust is currently a member of NHS Charities Together and continues to work in partnership with members to ensure best fundraising practice.

We look forward to working with new and existing supporters to enhance the patient, carer and staff experience.

Making donations

There are several ways people can donate including making online donations via www.justgiving.com/mtwnhscharitablefund. Please make cheques payable to Maidstone and Tunbridge Wells Hospital Charity. Payments can also be made via Bacs on request or via the cashiers at our hospitals.

Statement of Trustee responsibilities in respect of the Trustee Annual Report and the financial statements

Under charity law, the Corporate Trustee is responsible for preparing the Annual Report and the financial statements for each financial year which show a true and fair view of the state of affairs of the Charity and of the financial position at the end of the year.

In preparing these financial statements, generally accepted accounting practice requires that the trustee:

- select suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- state whether the recommendations of the SORP FRS 102 have been followed, subject to any material departures disclosed and explained in the financial statements;
- state whether the financial statements comply with the Trust deed, subject to any material departures disclosed and explained in the financial statements;
- prepares the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue its activities.

The trustee is required to act in accordance with the trust deed of the charity and the rules of the charity, within the framework of trust law. They are responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the charity and to enable them to ensure that where any statements of accounts are prepared by the trustee under section 132(1) of the Charites Act 2011, those statements of accounts comply with the requirements of regulations under that provision. The trustee has general responsibility for taking such steps as are reasonably open to the trustee to safeguard the assets of the charity and to prevent and detect fraud and other irregularities.

The trustee is responsible for the maintenance and integrity of the corporate and financial information included on the charitable company's website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Statement as to disclosure to our Independent Examiner

In so far as the trustee is aware at the time of approving its Annual Report:

- there is no relevant information, being information needed by the Independent Examiner in connection with preparing their report, of which the Independent Examiner is unaware, and
- the trustee, having made enquiries of fellow directors and the Independent Examiner that they ought to have individually taken, have each taken all steps that he/she is obliged to take as a director in order to make themselves aware of any relevant audit information and to establish that the auditor is aware of that information.

By Order of the Trustee

Signed:

David Highton,
Chair of the Trust Board
Maidstone and Tunbridge Wells NHS Trust

Date: 22nd December 2022

Independent examiner's report to the corporate trustee of Maidstone and Tunbridge Wells NHS Charity

I report on the accounts of Maidstone and Tunbridge NHS Trust Charity (the "charity") for the year ended 31 March 2022, which are set out on pages **21 to 36**.

Independent examiner's statement

In connection with my examination, no matter has come to my attention:

- which gives me reasonable cause to believe that in any material respect, the requirements:
  - to keep accounting records in accordance with section 130 of the Charities Act 2011;
  - to prepare accounts which accord with the accounting records; and
  - to comply with the applicable requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008

  have not been met, or
- to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

Basis of independent examiner's statement

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a comparison of the accounts with the accounting records kept by the charity. It also includes consideration of any unusual items or disclosures in the accounts and seeking explanations from you as corporate trustee concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit, and consequently no opinion is given as to whether the accounts present a 'true and fair' view and the report is limited to those matters set out in the statement above.

Respective responsibilities of corporate trustee and examiner

The charity's corporate trustee is responsible for the preparation of the accounts. The charity's trustee considers that an audit is not required for this year under section 149(2) of the Charities Act 2011 and that an independent examination is needed.

It is my responsibility to:

- examine the accounts under section 149 of the Charities Act 2011;
- to follow the procedures laid down in the general Directions given by the Charity Commission under section 149(5) of the Charities Act 2011; and
- to state whether particular matters have come to my attention.

Your attention is drawn to the fact that the charity's trustee has prepared the charity's accounts in accordance with the Statement of Recommended Practice 'Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2019) issued in October 2019 in preference to the Statement of Recommended Practice 'Accounting and Reporting by Charities: Statement of Recommended Practice (revised 2005)' issued in April 2005 which is referred to in the Charities (Accounts and Reports) Regulations 2008 but has been withdrawn. I understand that the charity's trustee has done this in order for the charity's accounts to give a true and fair view in accordance with United Kingdom Generally Accepted Accounting Practice effective for reporting periods beginning on or after 1 January 2019.

Use of this report

This report is in respect of an examination carried out under section 149(3) of the Charities Act 2011. This report is made solely to the charity's corporate trustee, as a body, in accordance with the

regulations made under section 154 of the Charities Act 2011. My work has been undertaken so that I might state to the charity's trustees those matters I am required to state to them in an independent examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's trustee, as a body, for my work, for this report or for the opinions I have formed.

[Signature]

Grant Thornton UK LLP
Chartered Accountants

London

Date: 22nd December 2022

Statement of Financial Activities for the year ended 31st March 2022

					2021/22	2020/21
	Note	**Unrestricted Funds**	**Restricted Funds**	**Endowment Funds**	**Total Funds**	Total Funds
		£000	£000	£000	**£000**	£000
Income	2					
Donations		155	10	0	**165**	522
Legacies		37	0	0	**37**	0
Total Donations and Legacies		**192**	**10**	**0**	**202**	522
Investment income		24	0	0	**24**	20
Total income		**216**	**10**	**0**	**226**	542
Expenditure	3					
Costs of generating funds	3.1	(3)	0	0	**(3)**	(3)
Charitable Activities						
Activities in furtherance of Charity's objectives	3.2	(93)	(117)	0	**(210)**	(323)
Total expenditure		**(96)**	**(117)**	**0**	**(213)**	(326)
Gains / (losses) on investments	4	3	4	0	**7**	104
Net income/expenditure		**123**	**(103)**	**0**	**20**	(322)
Fund transfer	4	0	0	0	**0**	0
Net movement in funds	4	**123**	**(103)**	**0**	**20**	322
Fund balances brought forward at 31 March 2021		362	714	8	**1084**	762
Fund balances carried forward at 31st March 2022		**485**	**611**	**8**	**1104**	1084

The notes at pages 23 to 36 form part of these financial statements.
Please note there may be some rounding's within the numbers

Balance Sheet as at 31st March 2022

					2021/22	2020/21
	Note	**Unrestricted Funds**	**Restricted Funds**	**Endowment Funds**	**Total Funds**	Total Funds
		£000	**£000**	**£000**	**£000**	£000
Fixed Assets	5					
Investments	5.1	280	354	0	**634**	626
Total Fixed Assets		**280**	**354**	**0**	**634**	626
Current Assets	6					
Cash at bank and in hand	6.1	214	270	8	**493**	864
Debtors due within one year	6.2	9	12	0	**21**	0
Total current Assets		**223**	**282**	**8**	**514**	864
Liabilities						
Creditors due within one year	7.1	(19)	(24)	0	(43)	(407)
Net Current Assets / (Liabilities)		**204**	**258**	**8**	**470**	458
Total Net Assets		**484**	**611**	**8**	**1104**	1084
Funds of the Charity	8					
Endowment Funds		0	0	8	**8**	8
Restricted Funds		0	611	0	**611**	714
Unrestricted Funds		484	0	0	**484**	362
Total Funds		**484**	**611**	**8**	**1104**	1084

For purposes of splitting assets / liabilities by category, restricted and unrestricted funds are categorised by transactions, whilst endowment funds are categorised only as cash.

The charitable funds financial statements were approved by the Trust Board on the 22/12/22 and signed on its behalf as Trustee by:

_____

David Highton, **Date: 22nd December 2022**
Chair of the Trust Board, Maidstone and Tunbridge Wells NHS Trust

Statement of cash flows at 31st March 2022

	Note	2021/22 £000's	2020/21 £000's
Cash flows from Operating activities:			
Net Income /(Expenditure) for the reporting period	4	20	321
Adjustments for:			
(Gains)/losses on investments	4	(7)	(104)
Dividends, interest and rents from investments	2	(24)	(21)
(increase)/Decrease in debtors	6.2	(21)	0
Increase/(decrease) in creditors	7.1	(364)	(182)
Net Cash provided by (used in) operating activities		**(396)**	**14**
Cash flows from investing activities:			
Dividends, interest and rents from investments		24	21
Net Cash provided by (used in) investing activities		**24**	**21**
Cash flows from financing activities		0	0
Change in cash and cash equivalents in the reporting period		(372)	34
Cash and cash equivalents at the beginning of the reporting period		864	830
Cash and Cash equivalents at the end of the reporting period	6.1	493	864
Cash in hand		**493**	**864**

1. Principal accounting policies

1.1. Basis of preparation

The financial statements have been prepared in accordance with applicable Accounting and Reporting by Charities: Statement of Recommended Practice (SORP) applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) effective October 2019 and the Charities Act 2011. A summary of the principal accounting policies, which have been applied consistently, are set out below.

The financial statements are prepared in accordance with the historical cost convention, except for Investments, which are included at market value. During the year, the Charity reviewed its accounting policies and made no changes.

The Trustees consider that there are no material uncertainties about the Charity's ability to continue as a going concern and uncertainties affecting the current year's accounts. The charity ended the year with £1,104k in available funds which the trustees consider to be sufficient to ensure that the charity is able to meet its existing plans and obligations. The charity receives donations and legacies at differing levels from year to year but the underlying healthcare activities are continuing which supports a reasonable assumption of future donations. The Trustees are considering a range of proposals to enhance the visibility of the charity and to increase its fundraising effectiveness.

Whilst the COVID-19 pandemic has had a negative impact on our charity's ability to generate income from fundraising plans and investment income, this has not made a material impact in the 2021/22 financial year.

1.2. Reconciliation with previous generally accepted accounting practices

These accounts are continued to be prepared in accordance with FRS 102 and the charities SORP FRS 102.

Governance and administration costs are classified as a support cost and have therefore been apportioned between fundraising activities and charitable activities on a cost basis (see note 3). The Trustees consider this is an equitable treatment to avoid disadvantaging funds with high volume low value transactions. All funds attract administrative costs even without any expenditure as these have to be monitored, fund managers approached for future plans, investment transactions and overhead charges. The cost of the transaction does not necessarily reflect on the work involved to achieve that expenditure and therefore consistency is maintained by working with an activity cost based apportionment.

1.3. Income

Donations, grants, legacies and gifts in kind (voluntary Income)
All incoming resources are recognised once the charity has evidence of entitlement and it is probable (more likely than not) that the resources will be received and the monetary value can be measured with sufficient reliability. It is not the charity's policy to defer income.

Where there are terms or conditions attached to the incoming resource (particularly grants) then these must be met before the income is recognised as the entitlement will not be evidenced, or where there is uncertainty that the conditions can be met, and then the income is not recognised in the year. It is not the Charity's policy to defer income even where a pre-condition for use is imposed.

Legacies are accounted for as incoming resource either on receipt or where the receipt of the legacy is probable. Receipt is probable when:

- Confirmation has been received from the representatives of the estate(s) that probate has been granted
- The executors have established that there are sufficient assets in the estate to pay the legacy and
- All conditions attached to the legacy have been fulfilled or are within the charity's control
- Where the amount of the legacy can be reliably estimated.
- Legacies which are subject to a life interest party are not recognised.

Where a reliable estimate cannot be identified, then the legacy is disclosed as a contingent asset.

Income resources from Capital Endowments are placed into an income fund when received. Income will be placed into funds in accordance with donors' wishes, but without forming a binding trust, unless a signed document is received and approved by Trustees.

Gifts in kind are valued at a reasonable estimate of their value to the Charity. Gifts donated for resale are included as income either when they are sold or at the estimated resale value after deduction of the cost to sell the goods.

Intangible Income
Intangible income, which comprises donated services or use of Trust property, is included in income at a valuation which is an estimate of the financial cost borne by the donor where such a cost is material, quantifiable and measurable. No income is recognised when there is no financial cost borne by a third party.

Investment Income
Investment Income and gains and losses on investments are credited / charged to the funds quarterly using the average fund balance to apportion the gain / loss.

1.4. Expenditure

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to the category of expense shown in the Statement of Financial Activities. All expenditure is recognised when the following criteria are met:

- There is a present legal of constructive obligation to make a payment to a third party – primarily to the Trust in furtherance of the charitable objectives.
- It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
- The amount of the obligation can be measured or estimated reliably.

The Trustees have control over the amount and timing of grant payments and are usually given with the condition that an item or service has been purchased. Conditions have to be met before the liability is recognised.

Irrecoverable VAT
Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

Allocation of support costs
Support costs are those costs which do not relate directly to a single activity. These include some staff costs, costs of administration, costs of fundraising, internal and external audit costs and IT support. These costs include recharges of appropriate proportions of the staff costs

and overheads from Maidstone and Tunbridge Wells NHS Trust and are apportioned on an average fund balance monthly across all funds.

Charitable activities
Expenditures are given as grants made to third parties (including NHS bodies) in furtherance of the charitable objectives of the funds. They are accounted for on an accruals basis, in full, as liabilities of the Charity when approved by the trustees and accepted by the beneficiaries.

Exceptional Items
Exceptional Items are shown on the face of the Statement of Financial Activities under the category to which they relate with further detail, where appropriate, provided in the notes. For the financial year 2021/22 there were no Exceptional Items.

Costs of generating funds
The costs of generating funds are the costs associated with generating income for the funds held on trust. This will include the costs associated with Investment Managers, Fundraising staff and other promotional and fundraising events including any trading activities.

Recognition of liabilities
Liabilities are recognised as and when an obligation arises to transfer economic benefits as a result of past transactions or events.

Analysis of grants
The Charity does not make grants to individuals. All grants are made to the Trust to provide for the care of NHS patients in furtherance of it charitable aims. The total cost of making grants, including support costs, is presented on the face of the Statement of Financial Activities and further analysis in relation to activity is provided in note 3.

1.5. Structure of funds

Unrestricted funds are general funds, which are available for use at the discretion of the Trustee in furtherance of the objectives of the Charity. Funds which are not legally restricted but which the Trustee has chosen to earmark for set purposes are designated funds.

Where there is a legal restriction or a binding agreement with a donor, on the purpose for which a donation may be use, the fund is classified in the accounts as a restricted fund.

Endowment Funds are funds that hold capital in perpetuity. Investment income resulting from these capital holdings may be utilised in accordance with the donor's wishes.

Transfers between funds are made at the discretion of the Trustee, taking account of any restrictions imposed by the donor.

The purposes of each fund with a balance in excess of £10k at the year-end are set out in note 8.1 to the financial statements.

1.6. Finance and Operating Leases

The Charity has no finance or operating leases.

1.7. Fixed Assets

Investments Fixed Assets
Investments held by the Trustee's investment advisers are included at closing market value at the balance sheet date. Any realised and unrealised gains and losses on revaluation or

disposal are combined in the Statement of Financial Activities. All investments held are pooled across all of the funds. Please see investment strategy on page 9 for further information.

1.8. Gains and losses

Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later).

Unrealised gains and losses are calculated as the difference between market value at the year end and opening market value (or date of purchase if later). Investment income and gains/losses are allocated quarterly according to the average fund balance, to the appropriate fund and included within the Statement of Financial Activities.

1.9. Cash and Cash equivalents

Cash is represented by the balance maintained in the charity bank accounts and is used to meet the operational costs of the charity as they fall due.

Cash equivalents are short term liquid investments held for a period of 3 months or less in interest bearing accounts that are readily convertible to cash with no risk of change in value.

As a requirement of FRS 102, a statement of cash flows has been included in the accounts to provide information about the ways in which the charity uses the cash generated by its activities and about changes in cash and cash equivalents held by the charity.

1.10. Financial Instruments

The Charity only has financial assets and financial liabilities that qualify as basic financial instruments. Basic financial instruments are initially recognised at transaction value and subsequently measured at their settlement value with the exception of investments which are subsequently measured at fair value.

A financial asset is derecognised when it is settled, or when the contractual rights to the cashflows expire. If substantially all the risks and rewards are transferred, the financial asset is derecognised. If substantially all the risks and rewards are retained, the financial asset is not derecognised. A financial liability is derecognised only when it is cancelled, expired or discharged.

1.11. Pensions

The Charity has no direct employees but does charge costs relating to finance support staff and the full costs of the fundraiser. These employees are contracted by the Trust and pension liabilities are charged as part of the recharge.

1.12. Prior Year Adjustments

The Charitable Fund has not made any prior year adjustments

Due to the following tables being reported in thousands there may be some rounding differences but the overall totals are correct

2. Income

				2021/22	2020/21
Voluntary Income	Unrestricted Funds	Restricted Funds	Endowment Funds	**Total Funds**	Total Funds
	£000	£000	£000	**£000**	£000
Donations	93	10	0	**103**	275
Donations – website	62	0	0	**62**	247
Legacies	37	0	0	**37**	0
Total Donations and Legacies	**192**	**10**	**0**	**202**	**522**
Investment income					
Dividends from investment portfolio	21	0	0	**21**	18
Interest from investment portfolio	3	0	0	**3**	3
Bank Interest	0	0	0	**0**	0
Total Investment income	**24**	**0**	**0**	**24**	**21**
Total incoming resources	**216**	**10**	**0**	**226**	**542**

3. Expenditure

3.1. Cost of generating funds				**2021/22**	2020/21
	Unrestricted Funds	Restricted Funds	Endowment Funds	**Total Funds**	Total Funds
	£000	£000	£000	**£000**	£000
Investment managers fees	(3)	0	0	**(3)**	(3)

				2021/22	2020/21
3.2. Charitable Activities	Unrestricted Funds	Restricted Funds	Endowment Funds	**Total Funds**	Total Funds
	£000	£000	£000	**£000**	£000
Patients welfare and amenities					
Hospitality	0	0	0	0	0
Other	(17)	(6)	0	(23)	(36)
Complementary Therapies	0	0	0	0	(0)
Total patients welfare and amenities	**(17)**	**(6)**	**0**	**(23)**	**(36)**
Staff welfare and amenities					
Training	(2)	(1)	0	(3)	(5)
Wellbeing	(2)	0	0	(2)	0
Christmas Events	(4)	0	0	(4)	(1)
Other	(17)	(15)	0	(32)	(50)
Total staff welfare and amenities	**(24)**	**(16)**	**0**	**(40)**	**(56)**
Medical and Rehabilitation Equipment	(16)	(73)	0	(89)	(129)
Furniture and Fittings	(15)	0	0	(15)	(11)
Other	0	0	0	0	(5)
Building Costs	0	0	0	0	0
Governance - Salaries & overheads	(19)	(21)	0	(41)	(84)
Governance - Audit Fees (external)	(1)	(1)	0	(2)	(2)
Total contribution to Maidstone and Tunbridge Wells NHS Trust	**(52)**	**(96)**	**0**	**(147)**	**(230)**
Total cost of charitable activities	**(93)**	**(117)**	**0**	**(210)**	**(323)**
Total resources expended	**(96)**	**(117)**	**0**	**(213)**	**(326)**

Employee Information

The Charity does not employ any staff directly, although members of the finance team support the governance and administration function of the Charity and a full time Fundraiser is employed by the Trust and recharged in full to the Charity. Their costs have been included in the table above.

During the year none of the members of the NHS Trust Board or senior NHS staff or parties related to them were beneficiaries of the Charity. Neither the Corporate Trustee nor any member of the NHS Trust Board has received honoraria, emoluments, or expenses in the year and the Corporate Trustee has not purchased trustee indemnity insurance.

4. Net Movements in Funds

				2021/22	2020/21
	Unrestricted Funds	Restricted Funds	Endowment Funds	**Total Funds**	Total Funds
	£000	£000	£000	**£000**	£000
Net Incoming/(outgoing) resources before other recognised gains and losses	120	(107)	0	**13**	218
Gains/Losses on Investments	3	4	0	**7**	104
Total net movement in funds	**123**	**(103)**	**0**	**20**	322
Funds transfers	0	0	0	**0**	0
Total net movement in funds after transfers	**123**	**(103)**	**0**	**17**	322
Fund balances at 1st April 2021	361	714	8	**1084**	762
Fund balances carried forward at 31st March 2022	**485**	**611**	**8**	**1,104**	1,084

5. Analysis of Movement of Fixed Asset Investments

5.1. Investments	Carrying value at 01/04/2021	Additions to investment at cost	Disposals at carrying value	Net gain / (loss) on revaluation	**Carrying value at 31/03/2022**
	£000	£000	£000	£000	**£000**
CAF Bond Income Fund (UK)	243	0	0	(17)	**226**
CAF Equity Growth Fund (UK)	384	0	0	24	**408**
Total Fixed Asset Investments	626	0	0	7	**634**

6. Current Assets

6.1. Cash and cash investments	**2021/22**	2020/21
	Total Funds	Total Funds
	£000	£000
Cash Investments:		
Santander	**82**	82
Clydesdale	**87**	87
Operational Bank Accounts:		
Government Banking Service (GBS) bank account	**304**	680
Nat West bank account	**19**	14
Total Cash and Cash Investments	**493**	**864**

6.2. Debtors	**2021/22**	**2020/21**
	Total Funds	**Total Funds**
	£000	**£000**
Amounts falling due within one year	21	0
Total Debtors due within one year	**21**	**0**

7. Current Liabilities

7.1. Creditors	**2021/22**	2020/21
	Total Funds	Total Funds
	£000	£000
Amounts falling due within one year:		
Trade Creditors	**(0)**	(0)
Other Creditors	**(0)**	(0)
Intercompany creditor between the charity and the Trust exchequer account	**(41)**	(406)
Accruals	**(2)**	(1)
Total Creditors due within one year	**(43)**	**(407)**

8. Details of Funds

Description	Fund number	Fund Type	Balance 01-Apr-2021	Incoming Resources	Resources Expended	Gain & (losses) on revaluation & disposal of investment assets	Balance 31-Mar-2022
			£000	**£000**	**£000**	**£000**	**£000**
A. Haines – Capital in perpetuity	67020	Endowment	7	0	0	0	7
E.C. Beedle Fund - Capital in perpetuity	67010	Endowment	1	0	0	0	1
Total Endowment Funds			**8**	**0**	**0**	**0**	**8**

Please note that there may be some rounding's within the following numbers:

Description	Fund number	Fund Type	Balance 01-Apr-2021	Incoming Resources	Resources Expended	Gain & (losses) on revaluation & disposal of investment assets	**Balance 31-Mar-2022**
			£000	£000	£000	£000	**£000**
Cardiac Equip Fd Ms Crow Legacy	65450	Restricted	19	0	(1)	0	**18**
Cardio Equip TW Hayling Legacy	65460	Restricted	104	0	(51)	0	**53**
E&M Dir Diabetes Fund Tw	65410	Restricted	50	0	(1)	0	**49**
Oncology Centrifuge Fund	61490	Restricted	21	0	(1)	0	**20**
Oncology Equipment Fund	67170	Restricted	49	0	(24)	0	**25**
Oncology Prostate Equip Fund P Ward Legacy	61310	Restricted	21	0	(9)	0	**12**
Pierre Fabre Grant Fund	61720	Restricted	51	0	(2)	0	**49**
E&M Directorate - Frances Gibson Legacy	65180	Restricted	21	0	(1)	0	**20**
Maskell Equipment Legacy Fund	69702	Restricted	81	0	5*	1	**87**
COVID-19 Trust Fund	69900	Restricted	260	9	(26)	2	**245**
Other Restricted Funds (closing balances <£10,000)			38	1	(7)	0	**32**
Total Restricted Funds			**715**	**10**	**(118)**	**3**	**611**

* The value of £5k appears as a positive balance in expenditure instead of a negative as the Trust was accruing for expenditure that was planned for at the end of 2020/21 which was released in 2021/22.

Description	Fund number	Fund Type	Balance 01-Apr-2021	Incoming Resources	Resources Expended	Gain & (losses) on revaluation & disposal of investment assets	Balance 31-Mar-2022
			£000	**£000**	**£000**	**£000**	**£000**
General Fund	61000	Unrestricted	92	84	(17)	1	**161**
Emergency & Medical Directorate	61020	Unrestricted	10	4	(0)	0	**14**
Critical care Dir Fund	61060	Unrestricted	35	24	(12)	0	**47**
Surgery Directorate Fund	61140	Unrestricted	10	37	(1)	0	**46**
Womens Directorate Fund	61320	Unrestricted	10	2	(1)	0	**11**
Cancer Services Fund	61350	Unrestricted	61	14	(11)	0	**64**
Sutcliffe Fund	61370	Unrestricted	23	0	(1)	0	**22**
Paediatric Dir Fund	61540	Unrestricted	6	15	(0)	0	**21**
Radiology Fund	61590	Unrestricted	12	1	(9)	0	**4**
Cardiac Fund	65400	Unrestricted	18	0	(1)	0	**17**
Special Care Baby Unit Fund	65660	Unrestricted	17	10	(18)	0	**9**
Equality + Diversity Fund	68900	Unrestricted	54	0	(19)	0	**35**
Other Unrestricted Funds (closing balances <£10,000)		Unrestricted	13	24	(6)	2	**34**
Total Unrestricted Funds			**362**	**215**	**(96)**	**3**	**485**

8.1. Nature and Purpose of Material Funds (Closing balance > £10,000)

Restricted Funds	**Nature and purpose of Fund**
Oncology Prostate Equipment Fund	Supports the purchase of prostate equipment for Cancer Services
Pierre Fabre Grant Fund	Supports the Oncology Department at Maidstone Hospital with specialist procedures
Oncology Centrifuge Fund	Supports the purchase of a centrifuge for the Oncology Centre
Cardio Equip Hayling Legacy Fund	Supports the Cardio Respiratory Unit at Tunbridge Wells Hospital
Cardiac Equip Crow Legacy Fund	Supports the Cardiac Unit at Maidstone Hospital
E&M Dir Diabetes Fund TW	Supports the Diabetic Unit at Tunbridge Wells Hospital
E&M Directorate Gibson Legacy	Supports the emergency & Medical Directorate
Oncology Equipment Fund	Supports the purchase of equipment for Cancer Services
Maskell equipment Legacy	Supports equipment purchases at Tunbridge Wells Hospital
COVID-19 Trust Fund	Donation from NHS Charities Together from money raised by Sir Tom Moore to support staff
Unrestricted Funds	**Nature and purpose of Fund**
General Fund	Supports Maidstone and Tunbridge Wells NHS Trust
Critical Care Fund	Supports the Critical Care Directorate
Cancer Services Fund	Supports the Cancer Services department
Emergency & Medical Dir Fund	Supports the Emergency & Medical Directorate
Cardiac Fund	Supports the Cardio Respiratory Unit at Tunbridge Wells Hospital
Surgery Directorate Fund	Supports the Surgery Directorate
Women's Directorate Fund	Supports the Women's Directorate
Paediatric Directorate Fund	Supports the Paediatric Directorate Department
Equality & Diversity Fund	Donation from NHS Charities Together from money raised by Sir Tom Moore to support staff
Sutcliffe Fund	Supports the purchase of medical equipment for the Haematology and Oncology departments

9. Charity Tax

Maidstone and Tunbridge Wells NHS Trust Charity is considered to pass the tests set out in Paragraph 1 Schedule 6 Finance Act 2010 and therefore it meets the definition of a charitable trust for UK income tax purposes. Accordingly, the charity is potentially exempt from taxation in respect of income or capital gains received within categories covered by Part 10 Income Tax Act 2007 or Section 256 of the Taxation of Chargeable Gains Act 1992, to the extent that such income or gains are applied exclusively to charitable purposes.

10. Related Parties

The Charity is established to hold the charitable funds of Maidstone and Tunbridge Wells NHS Trust.

During the year none of the NHS Trust Board or members of key management staff or parties related to them has undertaken any material transactions with Maidstone and Tunbridge Wells NHS Trust.

The Charity has made revenue and capital payments, in the form of grants, to Maidstone and Tunbridge Wells NHS Trust, the Corporate Trustee of the charity. In addition, £43k (in 2020/21, £86k) was payable by the Charity to the Trust in respect of contribution to salaries and overheads to support the administration and fundraising activities of the Charity. The amount owed at the balance sheet date to the Charity by the Trust was £21k, (in 2020/21, £0k). Total amount owed by the charity to the Trust for 2021/22 £43k (in 2020/21, £407k).

11. Events after the reporting year

The Charitable Fund does not have any events after the reporting period.

Our Ref: SO/jr

Steve Orpin
Deputy Chief Executive / Chief Finance Officer
Trust Management
Maidstone Hospital
Hermitage Lane
Maidstone
Kent ME16 9QQ

Grant Thornton UK LLP
30 Finsbury Square
London
EC2A 1AG

Dear Sirs

Maidstone and Tunbridge Wells NHS Trust Charitable Funds accounts for the year ended 31 March 2022

This representation letter is provided in connection with the independent examination of the accounts of Maidstone and Tunbridge Wells NHS Trust Charitable Fund for the year ended 31 March 2022 for the purpose of making of an independent examiner's report in accordance with Section 154 of the Charities Act 2011.

We confirm that to the best of our knowledge and belief having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

Accounts

i We have fulfilled our responsibilities, as set out in the terms of our engagement letter/contract dated 13 December 2016, for thepreparation of accounts in accordance with section 132 of the Charities Act 2011 and comply with the Statement of Recommended Practice for accounting and reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) ('Charities SORP (FRS 102)'), effective 1 January 2019, in particular the accounts give a true and fair view in accordance therewith.

ii We acknowledge our responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud.

iii The methods, the data and the significant assumptions used by us in making accounting estimates and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

v Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of the Charities SORP (FRS 102) and any subsequent amendments or variations to this statement.

vi All events subsequent to the date of the financial statements and for which the Charities SORP (FRS 102) and any subsequent amendments or variations to this statement require adjustment or disclosure have been adjusted or disclosed.

vii We have not adjusted the misstatements brought to our attention on the audit differences and adjustments summary, attached to this letter, as they are [**immaterial to the results of the company and financial position at the year-end / for the reasons noted on the schedule / other reasons**]. The financial statements are free of material misstatements, including omissions.

ix We can confirm that:

a. all income has been recorded;

b. the restricted funds have been properly applied;

c. constructive obligations for grants have been recognised; and

d. we consider there to be appropriate controls in place to ensure overseas payments are applied for charitable purposes.

x The charity has complied with all aspects of contractual agreements that could have a material effect on the accounts in the event of non-compliance. There has been no non-compliance with requirements of regulatory authorities that could have a material effect on the accounts in the event of non-compliance.

xi We have no plans or intentions that may materially alter the carrying value or classification of assets and liabilities reflected in the accounts.

xii Actual or possible litigation and claims have been accounted for and disclosed in accordance with the requirements of UK Generally Accepted Accounting Practice.

xiii The charity meets the conditions for exemption from an audit of the accounts as set out in section 145 of the Charities Act 2011.

xiv [Add any other matters that the independent examiner may consider appropriate].

Information Provided

xiv We have provided you with:

a. access to all information of which we are aware that is relevant to the preparation of the accounts such as records, documentation and other matters;

b. additional information that you have requested from us for the purpose of your examination; and

c. unrestricted access to persons from whom you determine it necessary to obtain evidence.

xv We have communicated to you all deficiencies in internal control of which we are aware.

xvi We have disclosed to you the results of our assessment of the risk that the accounts may be materially misstated as a result of fraud.

xvii All transactions have been recorded in the accounting records and are reflected in the accounts.

xviii We have disclosed to you our knowledge of fraud or suspected fraud affecting the charity involving:

a. management;

b. employees who have significant roles in internal control; or

c. others where the fraud could have a material effect on the accounts.

xix We have disclosed to you our knowledge of any allegations of fraud, or suspected fraud, affecting the charity's accounts communicated by employees, former employees, analysts, regulators or others.

xx We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing accounts.

xxi We have disclosed to you the identity of the charity's related parties and all the related party relationships and transactions of which we are aware.

xxii We have disclosed to you all known actual or possible litigation and claims whose effects should be considered when preparing the accounts.

xxiii We confirm that we have reviewed all correspondence with regulators, which has also been made available to you, including the guidance 'How to report a serious incident in your charity' issued by the Charity Commission (updated in June 2019) and the specific guidance on 'Reporting serious incidents to the Charity Commission during the coronavirus pandemic', issued in June 2020.

. We also confirm that no serious incident reports have been submitted to the Charity Commission, nor any events considered for submission, during the year or in the period to the date of signing of the balance sheet. [** tailor this representation where such reports have been made or considered, including details of matters reported on / considered **]

xxiv [Add any other matters that the independent examiner may consider appropriate (see Additional representations below for examples)].

Yours faithfully

Name……

Position……

Date……..

Signed on behalf Maidstone and Tunbridge Wells NHS Trust Charitable Fund