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

Thu 26 October 2023, 09:45 - 13:00

Pentecost-South rooms, The Academic Centre, Maidstone Hospital

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).

10-1
To receive apologies for absence

Neil Griffiths

10-2
To declare interests relevant to agenda items

Neil Griffiths

10-3
To approve the minutes of the 'Part 1' Trust Board meeting of 28th September 2023

Neil Griffiths

Board minutes, 28.09.23 (Part 1).pdf (16 pages)

10-4
To note progress with previous actions

David Highton

Board actions log (Part 1).pdf (2 pages)

10-5
Report from the Chair of the Trust Board

David Highton

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

10-6
Report from the Chief Executive

Miles Scott

Report from the Chief Executive - October 2023.pdf (4 pages)

Reports from Trust Board sub-committees

10-7
Quality Committee, 11/10/23

Maureen Choong

Summary of Quality C'ttee, 11.10.23.pdf (1 pages)

10-8
Finance and Performance Committee, 24/10/23

Neil Griffiths

Summary of Finance and Performance C'ttee 24.10.23.pdf (2 pages)

10-9
People and Organisational Development Committee, 20/10/23

Emma Pettitt-Mitchell

Summary of People and Organisational Development Cttee, 20.10.23 - updated.pdf (1 pages)

Integrated Performance Report

10-10
Integrated Performance Report (IPR) for September 2023

Miles Scott and colleagues

Integrated Performance Report (IPR) for September 2023 (with safe staffing) (updated).pdf (32 pages)

Quality Items

10-11
Annual Report from the Director of Infection Prevention and Control (including Trust Board annual refresher training)

Sara Mumford

Annual Report from the Director of Infection Prevention and Control 2022-23.pdf (56 pages)

10-12
Findings of the national inpatient survey 2022

Joanna Haworth

Findings of the national inpatient survey 2022 (updated - final).pdf (16 pages)

Workforce

10-13
To approve the Medical Workforce Strategy 2024 – 2026

Peter Maskell

To approve the Medical Workforce Strategy 2024 – 2026.pdf (17 pages)

Systems and Place

10-14
Update on the West Kent and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)

Rachel Jones

Update on the West Kent HCP and NHS Kent and Medway ICB - October 2023.pdf (6 pages)

10-15
To approve the plans for the development of the Kent and Medway Provider Collaboratives

Rachel Jones

To approve the plans for the development of the Kent and Medway Provider Collaboratives.pdf (31 pages)

Planning and strategy

10-16
Review of the draft winter plan for 2023/24

Sean Briggs

Review of the draft winter plan for 2023-24.pdf (14 pages)

Assurance and policy

10-17
Quarterly report from the Freedom to Speak Up Guardian

Sue Steen

Quarterly report from the Freedom to Speak Up Guardian - October 2023.pdf (5 pages)

Other matters

10-18
To consider any other business

David Highton

10-19
To respond to any questions from members of the public

David Highton

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

Members of the public should also take note that questions regarding an 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).

10-20
To approve the motion (to enable the Board to convene its ‘Part 2’ meeting) that...

David Highton

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

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 28TH SEPTEMBER 2023, 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)
	Steve Orpin	Deputy Chief Executive / Chief Finance Officer	(SO)
	Emma Pettitt-Mitchell	Non-Executive Director	(EPM)
	Miles Scott	Chief Executive (N.B. arrived during item 09-12 – refer to the specific minute for the relevant details)	(MS)
	Wayne Wright	Non-Executive Director	(WW)
In attendance:	Karen Cox	Associate Non-Executive Director (N.B. arrived during item 09-17 – refer to the specific minute for the relevant details)	(KC)
	Richard Finn	Associate Non-Executive Director	(RF)
	Rachel Jones	Director of Strategy, Planning and Partnerships	(RJ)
	Sue Steen	Chief People Officer	(SS)
	Jo Webber	Associate Non-Executive Director	(JW)
	Alex Yew	Associate Non-Executive Director	(AY)
	Kevin Rowan	Trust Secretary	(KR)
	Caroline Gibson	Trust Health and Safety Advisor (for item 09-21)	(CG)
	Kym Sullivan	Divisional Director of Operations, Women's Children's and Sexual Health (for item 09-17)	(KS)
	Rachel Thomas	Acting Director of Midwifery (for item 09-17)	(RT)
	John Weeks	Director of Emergency Planning and Response (for items 09-21 and 09-22)	(JWe)

09-1 To receive apologies for absence

No apologies were received, but it was noted that Sara Mumford (SM), Director of Infection Prevention and Control, would not be in attendance.

09-2 To declare interests relevant to agenda items

NG declared that he was the Managing Director of TeleTracking UK, which was referred to in the summary report from the Finance and Performance Committee.

AY declared that he was a member of the NHS Kent and Medway Integrated Care Board 's (ICB's) Productivity and Investment Committee, which was relevant for all the Integrated Care System (ICS)-related items on the agenda.

09-3 To approve the minutes of the 'Part 1' Trust Board meeting of 27th July 2023

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

09-4 To note progress with previous actions

The content of the submitted report was noted.

09-5 Report from the Chair of the Trust Board

DH referred to the submitted report and highlighted that there had been five consultant appointments, two of which were in paediatrics, which had been hard to recruit to in recent times, whilst there had also been an appointment in respiratory medicine, which had also been difficult to recruit to in the past.

DM observed that all five appointments had been to new consultant posts, but the Trust Board was not informed when a consultant post was eliminated, so asked whether the overall number of consultants was increasing, stable, or reducing. DH confirmed that the number was increasing, and some of the increase related to the Trust's plans to provide 7-day services, whilst some was related to reducing the use of locum consultants. PM added that the Trust was in the second phase of the increase in medical consultants, and that had had quite an impact on the "Reduce the amount of money the Trusts spends on premium workforce spend" Breakthrough Objective. PM continued that the Deputy Medical Director was developing a Medical Workforce Strategy, and consultant numbers would continue to increase for a while, but these would then plateau once the required numbers had been recruited. SO however added that there would also a third phase to the work, which had always been the intention, and a Business Case was being developed, so the increase would continue until that phase was completed. The point was acknowledged.

09-6 Report from the Chief Executive

In MS' absence, SO referred to the submitted report and highlighted the following points:

- There had been much media attention on Reinforced Autoclaved Aerated Concrete (RAAC), and it had been confirmed, following site surveys, that the Trust's buildings, and its leased buildings, had no such RAAC.
- The Inquiry into the Lucy Letby case was not completed, but the Trust wanted to ensure that staff were aware that they could speak up and be listened to, and a separate report would be considered later at the meeting.
- The Care Quality Commission (CQC) inspection report had been published and the Trust had been rated as "Good" for the Well Led domain. Steps had been, and would continue to be, taken to respond to the CQC's findings, but the report contained many positive comments. The Trust had also been subject to Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and maternity inspections by the CQC, and these would be discussed in future Trust Board meetings.

Questions were invited. None were received.

Reports from Trust Board sub-committees

09-7 Quality Committee, 09/08/23 and 13/09/23

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

- Two areas were considered in the 'deep dive' meeting: diabetes and tissue viability. Significant progress had been made to assure the Committee on the former issue, while good progress had also been made on the latter, and both areas had clear plans for continued progress.
- For the 'main' meeting, the mortality report had highlighted the further work required on social deprivation and ethnicity, to understand if there were any variations.

DH pointed out that the report from the 'deep dive' meeting had noted the impact of the Trust's new incident reporting system, InPhase, and DH observed that although the implementation of such systems was never easy, the outcome would mean that the Trust would be in a more positive position. MC agreed and noted that the quality of information within the Committee's reports had improved, and had helped the Divisions monitor and track performance more robustly. MC also acknowledged that although some of the InPhase operability could be quite challenging, the system offered huge potential.

09-8 Finance and Performance Committee, 26/09/23 (incl. approval of revised Terms of Reference)

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

- There had been an excellent presentation on Referral to Treatment (RTT) and elective activity that had given confidence that appropriate plans were in place.
- The Trust's performance was still strong despite pressures within the ICS, so thanks should be given to all staff for their continued hard work. However, the impact of industrial action,

payments for elective activity, and Cost Improvement Programme (CIP) performance continued to create pressure on the financial position.
- The Committee had reviewed the Business Case for the Nursing and Midwifery safer staffing review 2022/23, which would be considered under item 09-15. The Case had been very clear and the had been recommended for Trust Board approval but the Committee had asked for further details on the quantifiable benefits.
- The Committee had considered an update on developments within Estates.
- The Committee had agreed revised Terms of Reference, with no significant changes, and these had been submitted to the Trust Board, for approval.

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

09-9 <u>People and Organisational Development Committee, 21/07/23 (incl. quarterly report from the Guardian of Safe Working Hours)</u>

EPM referred to the submitted report and highlighted the following points:
- There had been a robust discussion about appraisals, and although some good progress had been made, more was needed to ensure that every voice was heard and everyone had an appraisal. SS and her team were aware and were working to achieve that aim.
- The Programme Director for Premium Staffing Spend had given an update on agency and bank staff expenditure and significant progress had been made, although more action was needed on the associated CIP target.
- Two of the Human Resources Business Partners had attended to give their insight.
- The Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) had been discussed, and both would be considered further at future meetings.
- The latest quarterly update from the Guardian of Safe Working Hours had been considered, and had been included in the report at Appendix 1.

09-10 <u>Patient Experience Committee, 07/09/23</u>

JW referred to the submitted report and highlighted the following points:
- Car parking at both main hospital sites had been considered, which had an impact on patient experience, particularly if patients missed their appointments due to not being able to park. The Committee would consider the issue again at its meeting in December 2023.
- The complaints annual report was considered, and the future changes arising from the new Parliamentary and Health Service Ombudsman were acknowledged. The changes would be explored in more detail at the December meeting.
- The Friends and Family Test (FFT) response rate was noted to be continuing to improve.
- A long discussion had been held about the Trust's new patient experience strategy, which would be developed during the autumn of 2023, with the involvement of service users and staff.
- A fascinating discussion had been held regarding dementia, and some of the issues would be considered further at the Quality Committee.

09-11 <u>Charitable Funds Committee, 26/07/23</u>

DM referred to the submitted report and highlighted the following points:
- Progress was being made in fundraising and disbursements, thanks to the work of the Head of Charity and Fundraising.
- Donations had reduced by approximately one third since the previous years, but the position was now expected to improve.
- The Mayor of Tunbridge Wells had appointed the Trust's Charitable Fund as their charity of the year.
- The Maggie's Centre had started to progress and the Trust Board would hear more about the project at future meetings.

DH reminded Trust Board members that the Trust Board was the corporate trustee of the Charitable Fund, but the Charitable Funds Committee took the lead on behalf of the Trust Board. DM added that the Charity Management Committee undertook much of the operational work.

Integrated Performance Report

09-12 Integrated Performance Report (IPR) for August 2023

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

- There were two areas for escalation. Firstly, the staff turnover rate was at 12.7%, which was a gradual reduction over the last 12 months; and the vacancy rate, which was now just over 8%, having reduced from over 15% from when the Breakthrough Objective had been set.
- The two areas of focus in relation to staff turnover were the departments where there was higher than Trust-average turnover, and where staff had left within two years of appointment. It was acknowledged that some turnover may be positive, and reflected internal promotion, but it could also be concerning. There was also a focus on Administrative & Clerical (A&C) staff and Healthcare Support Workers, and an A&C open day had been held recently where over 130 people attended, so there were clearly individuals who wanted to join the Trust.
- The other Breakthrough Objective that was in escalation was the "Percentage of AfC 8c and above that are BAME", as performance was below the target. However, an equality, diversity and inclusion (EDI) session was scheduled at a Trust Board Seminar later that day, which would set objectives and link into the NHS six high impact areas.
- The first EDI Steering Group meeting had been held earlier that week, and there had been good attendance and representation, including from NHS England (NHSE). The Steering Group would be a sub-committee of the Executive Team Meeting (ETM), but its output would also be reported to the People and Organisational Development Committee, for assurance. The Group would meet every six weeks, and the next meeting would focus on objectives.
- Work continued on recruitment, progression and development for Black and Asian Minority Ethnic (BAME) colleagues into senior leadership areas, and a development session with the Trust's senior leaders would be held in October, led by Brap, a leading anti-racist charity. The Chief Workforce, Training and Education Officer at NHSE would also speak to the EDI Steering Group; whilst the Trust was working with the ICB on a cross-ICS initiative to debias recruitment.
- The latest national NHS staff survey had launched that week and the survey would, for the first time, ask whether staff had experienced or witnessed any inappropriate sexual behaviour in the workplace.

WW welcomed the establishment of the EDI Steering Group but asked whether the Trust Board should be considering appraisal more at its meetings, given the need to ensure everyone had a voice and had 100% appraisals. SS firstly pointed out that the issue had not been discussed as it was not an escalation area, as the Trust had achieved the 95% target. SS however then elaborated on the work that had been done to increase the appraisal rate, and particularly focus on those that had not had an appraisal for two years. SS continued that there was still some data cleansing to be done, to remove the individuals that should not be included in the data, and a report would be considered at a future ETM. SS therefore gave assurance that there would be a continued focus on appraisal compliance, and confirmed she would report the issue via the usual channels. WW noted that 5% of the staff that had not had an appraisal equated to circa 350 individuals. WW also asked how many staff had not had an appraisal for two years and queried whether that should be a metric in the IPR. SS replied that the pre-cleansed data from circa two weeks ago had showed that circa 50% of those that had not had an appraisal in the current window had not had an appraisal for two years, although some may not have been at the Trust for long, so further work was needed to validate the data before SS could be certain on a number. SS however gave assurance that the information had been shared with the relevant managers and the appraisal window would remain open until 30/09/23, so the position would be clearer by mid-October. WW therefore queried whether the position would be clearer by the next Trust Board meeting and SS confirmed that would be the case.

AY then referred to the "Action Plan" for the "Reduce Turnover Rate to 12% Breakthrough Objective on page 9 of 31 and noted that many of the actions were due in August or September 2023, so asked whether there had been any useful insights arising from such actions. SS explained that a range of activity was taking place, such as stay interviews, leavers' questionnaires, the analysis of turnover rates for each area and staff survey data; while there was a specific retention team that focused on the issues. SS continued that the exit questionnaire would however be removed, as that had a very low response rate, so more insightful methods

would be considered instead. SS however confirmed that the initiatives would be more accurately reflected in the next IPR.

Action: Ensure that the Counter Measure Summary "Action Plan" for the "Reduce Turnover Rate to 12%" Breakthrough Objective within the Integrated Performance Report (IPR) for September 2023 more accurately reflected the range of initiatives being taken to deliver the Objective (Chief People Officer, September 2023 onwards)

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

- Mortality would be covered under item 09-17, but the Hospital Standardised Mortality Ratio (HSMR) had now reduced for the fourth consecutive month, to 96.8.
- The new Breakthrough Objective for Patient Safety & Clinical Effectiveness would be considered under item 09-13, and Trust Board members would recall that the falls objective had been moved to 'business as usual' monitoring, when the rate had reached 4.9 per 1000 bed days. That rate was now showing common cause variation.
- Although the Breakthrough Objective was listed as "To be Determined" on page 11 of 31, the new objective would be to reduce the incidents of moderate harm or above by 50%, which would, in turn, hopefully then achieve the "Vision Goal / Target" to reduce the rate of patient incidents resulting in "Moderate+ Harm per 1000 bd days" to 0.8, and then to 0.7.
- The other metrics were progressing as intended.

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

- Cancer performance had again been very strong.
- The Diagnostics Waiting Times and Activity (DM01) standard performance had continued to recover very well.
- Elective activity performance had also been strong, despite the recent strikes and continued pressures from other factors.
- The outpatient telephone call response times had continued to improve.
- Emergency Department (ED) demand had increased over the last four to eight weeks and the situation was very challenging. However, the teams had continued to work very hard, and the Trust's 4-hour waiting time target performance was still within the top three or four in the country. The increased demand was however a warning of what the forthcoming winter may hold.

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

DH commended the continued strong performance and congratulated SB, the operational teams, and clinical staff for their continued hard work.

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

- FFT response rate performance had continued to improve, particularly in the ED and inpatient areas. The maternity and outpatient areas response rates were stable, but they were slightly better than the national average. Further work was however needed in the ED as the performance was slightly below the national average response rate.
- The FFT recommendation rates were however above the national average which was a great testament to the teams.
- There had been a slight deterioration in the complaints response rate in August, due to staffing issues, but September's performance was expected to be better.

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

- The rate of discharges before noon had been stable at circa 15% for several months, but the challenges with patient flow remained so the two workstreams had been brought together.
- The A3 had therefore been reviewed, and some task and finish events had been held. The latest such event had been attended by several junior doctors and junior nurses, which had been very beneficial. RJ would therefore review the plans to achieve the 33% target.

DH noted that the Trust had introduced Electronic Discharge Notification (eDN) and asked whether that had been helpful. RJ replied that this had been expected to improve the situation, but that

improvement had not occurred which was why the A3 had been reviewed and the work was continuing with the junior doctors and others.

SO then referred to the “Sustainability” Strategic Theme and highlighted the following points:

- There were no areas for escalation but as NG had reported under item 09-8, the Trust had experienced financial pressures from the recent strikes, and was below its plan on the delivery of the CIP target.
- The elective activity position was relatively good, but that had been adversely affected by the aforementioned industrial action, and that reduced activity had limited the Trust’s opportunities to increase its income.
- A ‘deep dive’ on CIP would be considered at the Finance and Performance Committee in October, and that would include the actions intended to bring the position back into balance.
- However, the financial outlook remained very difficult.

EPM acknowledged SO’s eloquent description of the financial pressures faced, but asked SO whether he had heard anything further from the Trust’s teams. SO replied that the teams understood the position and the challenge, and the aforementioned ‘deep dive’ review of the CIP would consider the 2024/25 CIP, to help plan further ahead. SO however reiterated that the Trust was in a difficult place so anything that corporate areas could do to help would be welcome.

WW commended the work that SO had done on agency expenditure and also asked whether the under-performance on the CIP was linked to the strikes, or whether there were lessons to be learned. SO explained that the industrial action had limited the Trust’s ability to respond in-year, but SO felt that the largest learning point was that the CIP schemes that had been identified at the start of 2023/24 had not delivered the expected return, and had had to be replaced, so work was required to plan further ahead.

WW asked whether an approach had been considered whereby a higher CIP target would be set for internal purposes i.e. beyond the target and performance that was reported to the Trust Board. SO confirmed that such an approach had been taken in the past and would be borne in mind for the 2024/25 CIP. MS added that there was a major issue for the Trust Board to contemplate the future outlook, particularly as the ICS was in significant financial deficit and not delivering its plan. MS continued that the outlook for the wider NHS looked exceptionally tough too, so the Trust needed to engage in the longer-term work to try and address the issues, although much would depend on whether the Trust could deliver the plan it had set. NG highlighted that the issues referred to by SO and MS were already discussed at the Finance and Performance Committee, and the ‘stop-start’ nature of the CIP had been recognised. NG also noted that the Committee had acknowledged that the novel areas of income generation that Foundation Trusts, such as Northumbria Healthcare NHS Foundation Trust, were deploying were not available to the Trust. SO agreed and added that the Trusts that had varied income streams were better able to buffet the challenges, and that position was more difficult to achieve as an NHS Trust. DH commented that the Trust would need to take some tactical steps in 2023/24, as well as consider longer-term sustainability, and DH was pleased that there had been recognition of the Trust’s over-delivery of elective activity. DH however emphasised that the Trust must not forget that its baseline funding was still not based on a logical methodology, as there had still not been any reflection of the Trust’s four-year growth in non-elective admissions. DH continued that the Trust should continue to pursue the ICB’s recognition of that growth, despite the ICB’s inability to pay. The point was acknowledged.

Planning and strategy

09-13 <u>Confirmation of the updated Vision Goals, Vision Targets, Breakthrough Objectives and Corporate Projects</u>

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

- The mid-point review of the Objectives had been undertaken, as these had now been in place for almost 18 months.

- The only Breakthrough Objective with significant proposed changes was within the Patient Safety and Clinical Effectiveness Strategic Theme, where the Breakthrough Objective had now become “Reducing Deteriorating patients and sepsis by 50%”.
- The Breakthrough Objective under the “People” Strategic Theme would now reflect a stretch target and become “Reduce turnover to 12% by March 2024”.
- For complaints, the “Target” had been slightly changed to become “To reduce the overall number of complaints or concerns each month to a target of 24 by March 2024” and the Breakthrough Objective was “To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients “experience”, which were more realistic.
- The Corporate Projects were covered on page 4 of 13, and included a focus on mental health, EDI and workforce efficiencies.
- Two Corporate Projects that were being considered for ‘business as usual’ monitoring were the implementation of the Patient Portal, although more work was required to embed that; and the Electronic Prescribing and Medicines Administration (EPMA) project, which was not completely finished but was within the final stages.
- More resources were required, as the list contained two more projects than had been supported to date, but the additional resource was not significant.

MC referred to the “Direct Access” corporate project and asked if that related to increasing clinical activity, delivering faster patient access, or both. RF also asked how that project would relate to the Community Diagnostic Centre (CDC) service i.e. was it associated with making the CDC work better, or completely separate. RF also acknowledged that the “Mental Health in Acute Care” project intended to “Agree governance structure for the oversight of the holistic care of mental health patients…”, but queried whether the quality of care to mental health patients also needed to be considered. JW also asked for further details of what the “Mental Health in Acute Care” project would be expected to cover. RJ clarified that each project listed on page 4 of 13 were projects, not objectives; each project would have a ‘beginning, middle and end’; and had not yet been finalised.

RF also referred to the “EDI Strategy Implementation” corporate project and asked whether there was a conflict between the six pillars in the Trust’s EDI strategy and the national six high impact areas. SS replied that the national output had been compared to the Trust’s EDI strategy and the two were essentially complementary, although there were some differences.

DM asked how the Trust Board would maintain oversight of the corporate projects, as these were not covered within the IPR. RJ explained that the IPR covered improvements and objectives, and the corporate projects were designed to deliver the Trust’s objectives.

WW noted that there was a statutory element to issues such as staff wellbeing and Freedom to Speak Up, sexual harassment in the workplace, and bullying and harassment, so queried whether these should be reflected in the Trust’s objectives. RJ pointed out that there had not been a project or objective identified in relation to such issues. WW clarified that he understood there had been some cultural aspects identified so queried whether that should be covered. RJ suggested that WW’s points would likely be covered in the aforementioned EDI-related Trust Board Seminar to be held later that day, which would be covered by a corporate project. SS confirmed that would be the case, and WW confirmed he was content with that approach.

DH referred to the “Mental Health in Acute Care” project and noted that the Mental Health, Learning Disability & Autism Provider Collaborative had a specific objective to improve the mental health resource for acute trusts so it would be ideal if all acute Trusts could be aligned on their approach. The point was acknowledged.

RJ then continued that the further work would be able to be shared with the Trust Board at its meeting in either October or November 2023.

Action: Submit a report on the further work being undertaken in relation to the corporate objectives to the Trust Board in October or November 2023 (Director of Strategy, Planning and Partnerships, October or November 2023)

09-14 Self-certification to deliver elective and cancer recovery ambitions, high-quality waiting list management and ambitious outpatient transformation

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

- The self-certification was to ensure that Trusts stayed in control of their elective activity during the current challenging times.
- The Trust was on track with the "Validation" and "First Outpatients" steps.
- It was acknowledged that further work was required for the "Outpatient Follow Ups" area, but that was an area of focus.
- The Trust was also in a good position in relation to the "Support Required" section.

DH noted that the Trust did not have any patients that had waited 65 weeks or more for treatment, but the end of March 2024 was several months away and patients may therefore be waiting 65 weeks by that point. DH therefore asked what assurance could be given to the Trust Board on that position. SB confirmed that he was very confident that the position would not deteriorate to the point where the Trust had patients who would wait 52 weeks. SB also noted that the relevant teams were clear on the adverse patient experience that resulted from long waiting times. SB therefore gave assurance that he had no concerns that the Trust would be compliant at the end of 2023/24.

DH asked whether a "Yes" response was required in the "Assured?" column for each point on pages 14 to 16 of 16. SB confirmed that was correct.

The Trust Board then confirmed it had been "Assured" for all the points listed in the table in "Appendix A: self-certification", on pages 14 to 16 of 16, and therefore agreed that the self-certification could be "signed off" by DH and MS.

09-15 To approve a Business Case for the Nursing and Midwifery safer staffing review 2022/23

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

- The Business Case had been considered by the Finance and Performance Committee on 26/09/23, and had been considered by the ETM before that.
- The Trust was expected to undertake a nursing establishment review twice a year and the last review had resulted in recommendations that were approved by the Trust Board in December 2022. The Trust Board approved an increase in 65.22 Whole Time Equivalents, which would result in an £800k cost pressure and an ongoing cost of £3m per year. There would however be considerable benefits for patient safety.
- The Finance and Performance Committee had asked JH and SO to provide further details of the financial benefits, and a supplementary report had therefore been submitted in response. There was also a potential for further savings in the cost of recruiting nurses; whilst there would be reductions in enhanced care requirements and using temporary staff to support patients.
- A number of Serious Incidents (SIs) over the year related to staffing and a reduction in SIs and associated savings were expected.
- The Business Case therefore had financial benefits and benefits in patient and staff experience.
- The Trust Board was asked to approve the Case.

DM noted that he had asked for the additional information on benefits, and he then commended the work that SO and JH had done to quantify the benefits in the supplementary report. DM however suggested that it would be helpful if further context be included in the future, for example in relation to the nursing recruitment, to understand the overall numbers planned. JH welcomed DM's comments and noted that one of the reasons the information had not been developed previously was that efforts had been focused on identifying a specific figure rather than a range. JH also thanked SO and his team. WW confirmed his support for the Case but noted that SIs and other indicators could be quantified. The point was acknowledged and DH welcomed the method of quantifying the benefits.

The Trust Board then approved the Business Case for the Nursing and Midwifery safer staffing review 2022/23 as submitted.

Quality Items

09-16 <u>The Trust's well-led inspection by the Care Quality Commission (CQC)</u>

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

- The Well Led inspection had been undertaken at the same time as an inspection of one core service, End of Life Care.
- The main maternity service had been inspected since, but an inspection of the Birth Centres was still expected.
- An inspection of the radiology service had also been held and the report of that had now been received.
- The Well Led inspection had identified some EDI issues and some other issues about which the Trust was aware, such as Estates and the functioning of the Quality Committee. The latter issue was being addressed via an external governance review which was nearing completion.
- The governance of the End of Life Steering Committee had been strengthened, and the responsibility for certain aspects of the service, such as risk, would be supported by input from subject matter experts.
- The next steps were described on page 12 of 13.

DH noted that the radiology inspection was related to the Ionising Radiation (Medical Exposure) Regulations, and asked for an update. JH noted that an Improvement Notice had been issued, which related to policies and the submission of serious incidents, but a swift response had been submitted, although some further work was still required. DM commended the rapidity of the response.

09-17 <u>Quarterly mortality data</u>

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

- The HSMR had reduced for four consecutive months. Although the submitted report stated that the latest HSMR was 97.8, it was in fact 96.8, and that had been validated at an extra Mortality Surveillance Group (MSG) meeting held on 27/09/23.
- Septicaemia had been listed in the "CUSUM breaches" and "Significant Diagnosis Groups", and PM believed that reflected a genuine issue. Work was underway to strengthen the Sepsis Committee and the Breakthrough Objective, which was about deteriorating patients and sepsis.
- "Peritonitis and intestinal abscess" had been listed for the first time in the "Significant Diagnosis Groups", so Telstra-Health had been asked to undertake a 'deep dive' into the issue, and the report was awaited.
- For the Summary Hospital-level Mortality Indicator (SHMI), it was interesting to note that palliative care was not coded as well as it could be, and that the depth of clinical coding could be better. PM had therefore met with the Trust's Head of Clinical Coding and PbR Assurance within the last month to agree an action plan for them and their team, which included teaching within ED, as well as inserting the past medical history from the Kent and Medway Care Record into the Trust's clerking proforma.
- The Medical Examiner (ME) service had reviewed 99% of all the deaths that occurred within the Trust, although it had been difficult to conduct this within three days, partly because of the recent strike action.
- The implementation of the community ME service, which was hosted by the Trust, had continued, and all but three GP practices had engaged with the service, which was required to be in place by April 2024.
- The number of deaths to be scrutinised by the ME service would increase by 150% in April, so plans were being developed to ensure there was sufficient capacity.

[N.B. KC joined the meeting at this point]

- The purpose of the Medical Examiners' reviews was to refer deaths where there was a quality of care question for a Structured Judgment Review (SJR), and although a modified SJR could be used in the community, further engagement would be required with primary care to understand how they would want to proceed if the Medical Examiner identified there may be an issue with the quality of care.

- An extra MSG meeting had been held on 27/09/23, as the meeting scheduled for August 2023 had to be cancelled because of the aforementioned strike. The meeting had been clinically-focused and considered the cases where care had been assessed as “adequate” or worse, as well all patients with a mental health or learning disability diagnosis. The MSG was not however able to review the good care or learn from, and celebrate, the care that had judged to be “excellent”, so that needed to be considered.
- The SJR backlog was now at 21. The trajectory was to clear the backlog by October 2023, and although good progress had been made, the backlog still existed. A new process was however being introduced whereby less experienced staff were undertaking an initial SJR.
- A link had been established with women’s services. Link consultants were in place in three of the remaining four clinical divisions and efforts were being made to establish a link consultant for Cancer Services. Work was also taking place with the Patient Safety Team, who attended the MSG meeting, to try and disseminate lessons learned via the Patient Safety Hub.

DH welcomed the comprehensive report and observed that the extension of the ME service into the community would be an interesting development.

09-18 <u>Quarterly Maternity Services report (incl. a review of the Trust’s response to non-compliance with the Swab Count policy)</u>

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

- Between April and June 2023, four SIs had been reported, two of which were Healthcare Safety Investigation Branch (HSIB) cases. One of the two non-HSIB SIs pertained to monofer staining, and it had been investigated and closed within the quarter. It had led to more information for patients regarding monofer use and a proforma for staff to use.
- Two other SIs had been closed, one of which had been a Never Event that related to a swab count SI. The service was halfway through a pilot on the delivery suite to introduce a Local Safety Standard for Invasive Procedures (LocSIPP), which was similar to a WHO checklist, and that was being monitored daily. Staff had also been asked to provide feedback on its use and compliance on its effective completion was measured. A report would be produced at the end of the pilot and recommendations would be made after that.
- Further action in the relation the Never Event included that the coordinator in the delivery suite would have sight of every person that had suturing in the room. Training for Maternity Support Workers also continued, and they had stated that they would like to be involved more in instrumental deliveries, so training was being devised to support such involvement.
- Staff had also asked for new trollies and lights for suturing. The trollies had arrived and the lights were on order.
- A stillbirth had been reported as an SI because it was believed that there had been a potential omission to act on an abnormal result. However the investigation had revealed that there had been a transcription error, and the result was not abnormal. The case had however identified some other issues about contemporaneous documentation and Wi-Fi access in GP surgeries, which meant that midwives could not enter data into the E3 IT system in real-time. Work was therefore underway to resolve such issues.
- Of the two HSIB cases, one involved a shoulder dystocia and there were no safety recommendations. The other case involved a baby who had been injured during a caesarean section. There were no criticisms of the clinical management but some recommendations had been made regarding the holistic assessment prior to the caesarean section.
- Four cases had been reviewed in the Perinatal Mortality Review meeting, but three of the cases involved no care issues while the fourth case was the aforementioned case that involved a transcription error.
- The submitted report included a summary of the CQC maternity survey from 2022, and one issue that had been raised from that related to information on induction of labour (IOL), which was a nationwide issue and an issue for the Local Maternity & Neonatal System (LMNS). Many Trusts did not conform to the National Institute for Health and Care Excellence (NICE) guideline that had reduced IOL from 42 weeks to 41 weeks, as this was a major change. A project was however underway, and a new leaflet had been produced for women and birthing people that had been co-produced with the Maternity Voices Partnership (MVP), and this would be shared across the LMNS, as the Trust was the first in the LMNS to produce such a document. The IOL

project was included in the maternity services' Strategy Deployment Review (SDR) process, and would be focused on once one of the other projects had been completed.

- Another issue arising from the maternity survey was the information that was given to women and birthing people regarding feeding. The Trust had its Baby Friendly Initiative level 3 assessment in w/c 02/10/23, and antenatal education was being reviewed, while virtual feeding sessions had also been scheduled.
- The survey also showed that the Trust was below average on whether staff spoke to people in a way that they could understand. Work was therefore underway in response, which included work on personalised care plans.
- The submitted report covered the Saving Babies Live care bundle, and version 3 had now been launched, which was a key component of the NHS Resolution for Maternity Incentive Scheme. The criteria for that Scheme had however increased significantly, and only half of NHS Trusts had achieved the Scheme for the previous year. The Saving Babies Lives involved 70 criteria and the Trust needed to be 50% compliant in each element, and demonstrate 70% compliance overall. At present, the service was rated at 40% compliance, so it would therefore be very difficult to achieve the Scheme that year. The service was however committed to achieving the safety actions.

DH referred to the reduction in IOL and asked what the national position was in relation to compliance with the NICE guideline. RT reported that most Trusts, and all the Trusts within the LMNS, would continue to induce labour at 42 weeks, because of capacity, and the Trust had a derogation from the NICE guidance, following a risk assessment and significant discussion within the department. DH asked RT to elaborate on the capacity issues and RT explained that this related to the number of midwives and the number of beds. MS asked whether RT knew the number of additional inductions that would need to be brought forward by one week to conform to the NICE guideline. RT agreed to provide the details outside the Trust Board meeting.

Action: Provide the Trust Board with details of how many additional induction of labour cases would need to be brought forward by one week to conform to the National Institute for Health and Care Excellence's (NICE's) "Inducing labour" guideline (Acting Director of Midwifery, September 2023 onwards)

MS then acknowledged the work being done on breastfeeding but asked whether a virtual focus group would be held with the women that had declared an intention to breastfeed, but were not then able to do so, to identify what their specific issues were. RT noted that an infant feeding specialist was in place, so they may have already undertaken such work, so RT confirmed she would check and provide the requested information.

Action: Provide the Trust Board with details of the specific issues that had prevented the women who had declared an intention to breastfeed from not doing so (Acting Director of Midwifery, September 2023 onwards)

MC referred to the baby losses that had occurred, and noted the demand for mental health support within the maternity services team, so asked that the next report included details on that aspect i.e. whether that demand had been met, and whether there needed to be further consideration of future demand. RT noted that there was a full-time midwife that focused on mental health, so agreed to include the requested information within next quarterly report.

Action: Ensure that the next "Quarterly Maternity Services report" to the Quality Committee and Trust Board included details of the mental health support available within the maternity services' team following the loss of a baby (Acting Director of Midwifery, November 2023)

JW referred to the "GAP & Grow – e-Learning" and observed that improvement had not been achieved, so asked for a comment. RT explained the factors that had affected performance and noted that the situation had been exacerbated by the fact that the staff training requirements were very onerous, although efforts were being made to make the training as easy as possible.

09-19 <u>Safeguarding update (Annual Report to Board, incl. the Trust Board refresher training)</u>

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

- The report covered the 2022/23 year and provided assurance that the Trust was meeting statutory requirements.
- Safeguarding supervision for named professionals and practitioners was now in place as a provider has been identified.
- All relevant policies were up to date, or in the process of being updated.
- Oliver McGowan Learning Disability and Autism training had been introduced, following a national mandate.
- The Trust continued to participate with in the Safeguarding Adults and Children's Board; and had participated in several multi-agency reviews.
- The designated nurses from the ICB now attended the Trust's Safeguarding Committee.
- From a children's safeguarding perspective, there had been increased activity, with over 100 more referrals than the previous year. There had been a strong theme of mental health, related to both the ED and maternity service.
- Last summer the Trust had two complex paediatric patients in inpatient wards. An external review was subsequently commissioned by the ICB, to explore a system-wide approach that included partnership working, and multiple recommendations were made New pathways had since been developed and there was now a much more responsive approach from the Trust's partners.
- The Trust had increased its children's safeguarding training compliance, but more was required, so a different approach was being explored.
- There had also been increased activity within adults safeguarding, and an increase in Deprivation of Liberty Safeguards referrals was being explored.
- The Trust had introduced a Health Independent Domestic Violence Adviser, after being the last Trust within Kent and Medway to receive funding for the post.
- The uptake of adults safeguarding training was good apart from Mental Capacity Act training, so that would be an area of focus.
- Overall, there had been improvement in the adult safeguarding position, but JH wanted to see further improvement on the audit results.
- Learning disability-related activity had also increased, but the Trust had become a victim of its own success, as it had a very strong practitioner, with very strong links within the community, so the Trust was being asked to accept patients because of the pathways that had been created. The Patient Experience Committee had heard some good strong case studies.

JH then summarised that it had been a very busy year, with risks that focused on capacity, although an additional safeguarding practitioner would be covered by the Business Case that had been approved under item 09-15; and JH wanted to thank the team for their work.

EPM referred to the "Reason for the referral" chart on page 16 of 51, and asked whether JH knew why "Mental Health" referrals were higher in quarters 1 and 2, but lower in quarters 2 and 3. JH speculated on the potential reasons and acknowledged the need to triangulate the data with external partners.

JW asked whether JH was confident that the services in East Sussex were as good as they were for Kent. JH acknowledged the challenge and noted that the lead nurse for Kent and Medway was also the lead nurse for East Sussex, but the team was conscious that more was required. JW emphasised the need to ensure there were good communication links and welcomed JH's awareness.

WW noted that last year, EPM, the then Freedom to Speak Up Guardian and WW had visited Hedgehog Ward and noted the need to support the staff who were caring for patients with mental health needs, so asked if JH was comfortable with the support. WW also noted that 104 children had been admitted to Hedgehog Ward with mental health needs and asked whether that represented an increase. JH confirmed that that was a slight increase. JH also confirmed that support was available for staff and WW's visit may well have been when the aforementioned two complex patients had been on the ward. JH elaborated on the available support but acknowledged that more could be done, and referred back to the "Mental Health in Acute Care" corporate project that had been discussed under item 09-13. WW also asked whether there was support in relation to staff who had experienced physical assault. JH explained that each patient would have

dedicated support, which could include a Registered Mental Health Nurse and security, and in some cases, beds had had to be closed, but there was good support from the security team.

DH commended the comprehensive nature of the report.

Systems and Place

09-20 Update on the West Kent Health and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)

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

- The Acute Provider Collaborative had now held several meetings and workshops. MS, SO and SB were all involved. The report contained details of the key dates, although these may change. Additional information would however be submitted to the Trust Board in future.
- A flow diagram on establishing Integrated Neighbourhood Teams had been included.
- The primary care 'digital front door' initiative would be a significant scheme for the Trust and the Tunbridge Wells Primary Care Network. The initiative had only been funded in part, but RJ had now received confirmation that the ICB would fund the initiative at risk. RJ was therefore very hopeful that that would have a beneficial effect.

NG commended the work, but asked about the extent to which the ICS was considering its financial challenges, and where these were considered. RJ confirmed that there was a significant financial recovery programme in place across the ICS, but the HCP did not have a large budget, although it had been delegated some budget for health inequalities, and all partners were contributing. RJ continued that the financial challenge was however very considerable and it had taken months to address the HCP funding gap, which had only been £92k. SO added that the slight change was that the ICS was trying to mitigate all the financial risk within the ICS, which was a helpful approach, as this encouraged all organisations to work together.

RF noted that the ICB was creating a lot of work and asked whether RJ felt the Trust was sufficiently resourced to enable it to contribute as effectively as required. RJ replied that she was more confident with the position with regards to the HCP and Provider Collaboratives, but there was more resource being added and providers were being encouraged to participate in discussions regarding such resourcing. RJ summarised that the overall position was therefore 'work in progress'.

Assurance and policy

09-21 Responsible Officer's Annual Report 2022/23

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

- The report included the Statement of Compliance (Appendix D) that the Trust Board was asked to approve.
- There had been a new Trust medical appraisal lead, as the previous role holder was now the Director of Medical Education, but SM, PM and some of the Chiefs of Service had helped cover the role during the transitional period.
- Doctors had been asked what steps they had most wanted to see and they asked for a cloud-based system, so that had been introduced.
- The Trust had 77 appraisers and 590 connected doctors, and the appraisal rate had reached 98% at the end of July 2023.
- There was now rolling appraisal period throughout the year, rather than a fixed appraisal period, and that had worked well.
- Only five individuals had not been appraised.

WW asked what the plan was to achieve 100% compliance. PM explained that the Trust would invariably achieve 100% compliance, as appraisal was part of the medical revalidation process, although there were some exceptions. DH added that doctors were revalidated every five years.

The Trust Board then approved the Statement of Compliance (Appendix D), which confirmed that the Trust, as a designated body, was in compliance with the regulations governing appraisal and revalidation, as submitted.

09-22 Health & Safety Annual Report, 2022/23 and agreement of the 2023/24 programme (including Trust Board annual refresher training on health & safety, fire safety, and moving & handling)

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

- There had been a large increase in abuse, violence and harassment but JWe was very confident that this related to an increase in reporting, as staff were now reporting incidents in InPhase, to understand the different aspects of the incidents.
- The Trust's new security trainer was also undertaking significant work which was helping the increased reporting.

CG then drew the Trust Board's attention to Appendix A and highlighted the following points:

- There had been several prosecutions by the Health and Safety Executive and CQC and learning had been identified
- The Trust's Risk assessment policy and procedure been reviewed and updated. The Trust used the hazard profile checklist method, whilst unsafe conditions were also considered. The assessment considered hazards and control measures and these would then be used to determine the risk rating, using a 5 x 5 risk matrix. Risks would then be added to the risk register.
- There were specific risk assessments for certain types of hazards, which included Control of Substances Hazardous to Health Regulations (COSHH) and moving and handling.
- Risk assessments were reviewed annually, recorded on the Symbiotix system and reported to the Health and Safety Committee. Any significant changes would lead to a re-assessment.

DM referred to the risk evaluation and judgement of risk severity, and noted that some risk assessments were considered in the context of the individual area rather than the Trust as a whole. DM therefore asked CG how consistency was ensured when rating the severity of a risk. CG acknowledged that individuals would have a different perception, but noted that if a risk was rated as 'amber' or above, the Risk and Compliance Manager would review the risk and liaise with the relevant individual to ensure it had been accurately assessed. CG added that any risks assessed below 'amber' would not therefore be reviewed by the Risk and Compliance Manager, although there was oversight via the Symbiotix system.

RF remarked that he had understood that the Symbiotix system was intended to be replaced by InPhase, but that would not now be the case. CG explained that the InPhase system did not offer a Health and Safety module, so the either the functionality of Symbiotix would try to be improved, or the Trust would need to use an alternative system. RF asked whether a system was available that covered all aspects the Trust required. CG confirmed that was not the case at present, so the Trust would explore what was feasible with Symbiotix. RF asked for a timescale on that and CG stated that she expected to hear from Symbiotix later that week.

09-23 Approval of Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment

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

- The assessment was undertaken annually, in response to a requirement within the NHS standard contract.
- The evidence to support the assessment was uploaded to NSHE. The ICB then conducted an independent review and the ICB had informally confirmed their agreement with the Trust's assessment, although formal confirmation was awaited.
- The assessment had confirmed that the Trust fully complied with the required standards.

DM noted that the Trust did not have any RAAC on its sites, as had been reported under item 09-6, but asked if JWe believed the Trust's EPRR plans would have been sufficient, had any RAAC had been identified. JWe gave assurance to that effect, and noted that the Trusts that did have

RAAC on their sites had used the Trust's plans, including those for evacuation. DM welcomed JWe's reassurance.

WW asked whether cyber security was included within the assessment. JWe confirmed it was and that a statement of compliance had been obtained by the Director of IT and Head of Information Governance and ICT Risk Management.

WW noted that there had been a major cyber attack at Barts Health NHS Trust and WW had attended a recent event regarding that attack, so asked if the Trust had conducted a cyber-attack exercise. JWe confirmed that some exercises had been conducted but a further exercise would be planned and the Trust's Non-Executive Directors would be very welcome to attend. JWe added that other exercises, including for a fire incident, were planned and any Trust Board member was welcome to participate. MC noted that she had attended such exercises before and had found these to be beneficial, so encouraged Trust Board members to take part.

MS the thanked JWe and his team for their work, particularly in relation to the strength of the Trust's plans.

The Trust Board then approved the Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment as submitted.

Corporate governance

09-24 <u>The NHS England Fit and Proper Person Test Framework for board members</u>

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

- On 02/08/23, NHSE published a new Fit and Proper Person Test ("FPPT") Framework for NHS board members, which was the culmination of work to respond to the recommendations in the "Review of the Fit and Proper Person Test" undertaken by Tom Kark KC in 2019.
- The background to the work was explained in full on page 2 of 20, while the main aspects of the new Framework were described on page 3. The underlying regulations, which had been in force since 27/11/14, remained unchanged, but the new Framework primarily introduced two new elements: A Board Member Reference (BMR) document; and a formal process for the storing of relevant information within the Electronic Staff Record (ESR).
- The information that would be held in the ESR was listed on page 4 of 20, whilst the new BMR was shown in Appendix 2.
- Many aspects of the new Framework were already included within the Trust's procedures, so the implementation would not require a significant shift in approach. However, some aspects were new, so those procedures would need to be updated to ensure they reflected the new Framework in full. It was therefore proposed that the revised procedures, which were an Appendix to the Standing Orders, be submitted to the Audit and Governance Committee meeting on 09/11/23, for approval, and then be submitted to the Trust Board, for ratification.

DH noted that the new Framework would seek to address concerns regarding Trust Board members moving to join other NHS Trust Boards, and confirmed he would work with KR on the Framework over the coming months.

09-25 <u>Response to NHS England's "Verdict in the trial of Lucy Letby" letter</u>

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

- Trust Board members would likely be familiar with the Lucy Letby case, given the significant media attention the case had received since the trial verdict was announced on 18/08/23.
- NHSE had issued a "Verdict in the trial of Lucy Letby" letter on 18/08/23 and the submitted report aimed to provide the Trust Board with assurance in relation to the issues covered in that letter.
- The government had since announced a statutory inquiry into the case, which would be chaired by Lady Justice Thirlwall, so caution should be exercised against making assumptions about what had occurred at the Countess of Chester Hospital NHS Foundation Trust before the statutory inquiry had reached its conclusions.
- NHSE's letter had referred to the FPPT Framework that had been discussed under item 09-24.

09-26 Annual review of the Trust Board's Terms of Reference

KR referred to the submitted report and highlighted that the Trust Board's Terms of Reference were due their annual review, and the proposed amendments were shown as 'tracked'. KR then confirmed that all the proposed changes were non-material and reflected 'housekeeping'.

Questions or comments were invited. None were received. The revised Terms of Reference for the Trust Board were therefore approved as submitted.

Other matters

09-27 To consider any other business

There was no other business.

09-28 To respond to questions from members of the public

KR confirmed that no questions had been submitted.

09-29 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]
09-13	Submit a report on the further work being undertaken in relation to the corporate objectives to the Trust Board in October or November 2023.	Director of Strategy, Planning and Partnerships	October or November 2023	The item has been scheduled for the Trust Board meeting in November 2023.
09-18a	Provide the Trust Board with details of how many additional induction of labour cases would need to be brought forward by one week to conform to the National Institute for Health and Care Excellence's (NICE's) "Inducing labour" guideline.	Acting Director of Midwifery	September 2023 onwards	The requested information will be included in the next "Quarterly Maternity Services report", which is scheduled to be considered by the Trust Board in November 2023.
09-18b	Provide the Trust Board with details of the specific issues that had prevented the women who had declared an intention to breastfeed from not doing so.	Acting Director of Midwifery	September 2023 onwards	The requested information will be included in the next "Quarterly Maternity Services report", which is scheduled to be considered by the Trust Board in November 2023.

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
09-12	Ensure that the Counter Measure Summary "Action Plan" for the "Reduce Turnover Rate to 12%" Breakthrough Objective within the Integrated Performance Report (IPR) for September 2023 more accurately reflected the range of initiatives being taken to deliver the Objective.	Chief People Officer	October 2023	This has been reflected in the IPR submitted to the October 2023 Trust Board meeting.

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
05-16	Liaise with the Executive Directors to undertake a light-touch review of the Trust's compliance with the new NHS Provider Licence conditions.	Trust Secretary	October 2023	It was subsequently agreed with the Chair of the Trust Board to submit a report to the Trust Board meeting in September 2023 (having been reviewed at the Executive Team Meeting (ETM)

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

Ref.	Action	Person responsible	Original timescale	Progress
				beforehand). However the Chair of the Trust Board subsequently requested a deferral to October 2023, due to the size of the agenda for the September 2023 Trust Board meeting; and then to November 2023, because of the volume of work involved in the review (which is considerable, despite the light touch' label).
09-18c	Ensure that the next "Quarterly Maternity Services report" to the Quality Committee and Trust Board included details of the mental health support available within the maternity services' team following the loss of a baby.	Acting Director of Midwifery	November 2023	The next report is due at the 'main' Quality Committee meeting and Trust Board in November 2023.

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

Consultant appointments

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

Date of AAC	Title	First name/s	Surname	Department	Potential / Actual Start date	New or replacement post?
22/09/2023	Consultant	Andrew	Hartopp	Anaesthetics	20/02/2024	New
27/09/2023	Consultant	Sridhayan	Mahalingam	ENT	23/10/2023	Replacement post

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

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

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

Report from the Chief Executive **Chief Executive**

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

- Joint industrial action was taken for the first time by consultants and junior doctors on 2-4 October. This period was the most challenging yet, due to it affecting a larger group of our workforce. During this time, our Operational Pressures Escalation Level (OPEL) was raised from level three to four - this enabled us to effectively manage any surge in demand during this time and maintain quality of care and patient safety. The level returned to three at the end of the industrial action period. To ensure teams had the best possible support during the action, we coordinated greater senior management and tactical commander presence onsite, and implemented additional services, including phlebotomy and pharmacy. This enabled us to reduce any delays, both in attendances at our front door and during patient discharge processes. Our clinical and administrative teams worked hard to minimise the impact of the industrial action on our patients. On behalf of the Trust, I would like to thank the teams for their continued hard work and commitment to providing outstanding care to our patients in challenging circumstances.

- Our teams have been focussing on the colder months ahead as we continue to finalise our winter plans. With increased respiratory conditions in our communities and other seasonal challenges, each year we need to continuously improve our services, develop new pathways and revise our processes so we can manage spikes in attendances. A key part of this is maximising flow to make sure we get patients in the right bed and then discharged home or to their next place of care, as soon as possible. Part of our winter plans include:

  - Additional recruitment in our discharge lounges.
  - Extended hours and additional training for colleagues in our Care Coordination Centre helping with discharges earlier in the day.
  - Growing our capacity levels by increasing our Same Day Emergency Care pathways and also looking at out of hospital capacity/increased bed space with partners.
  - Expanding our virtual ward service; over the last six months, we've seen positive progress and now have six live virtual ward pathways, giving us the option to monitor appropriate patients at home, and freeing up space in our hospitals.
  - Working with partners to support joint decision-making including a new clinical pathway hub in partnership with South East Coast Ambulance Service (SECAmb) and Kent Community Health NHS Foundation Trust (KCHFT). This involves MTW and KCHFT staff working alongside ambulance crews to consider whether patients require transport to the Emergency Department (ED) or could receive more appropriate treatment elsewhere.
  - Stepping up plans for winter flu and COVID-19 vaccinations to ensure patients and staff are safe. Our MTW winter vaccination programme for staff is already underway, with vaccination clinics open at both Maidstone and Tunbridge Wells sites.

- Our online patient portal, Patients Know Best (PKB), launches this month. This service will enable patients to access their healthcare records and manage their own hospital appointments. This will help to reduce the number of calls our patients need to make to our hospitals and decrease the number of missed appointments, freeing up clinical spaces for other patients. MTW is the third hospital trust in Kent and Medway to launch the new portal. As it develops, the portal will give patients access to test results, questionnaires, and symptom trackers, and will also eventually enable them to monitor their own glucose levels, weight or heart readings, and share them with their health teams to avoid extra hospital visits. Patients can register for the portal now via our MTW website or the NHS app and they will then be

contacted to sign-up in early November. Those not wishing to use the portal will continue to be contacted as normal.

- The National Staff Survey opened at the end of September, and was sent to all Trust colleagues by email/letter. The survey will close at the end of November, and the results will help us to better understand what we are doing well and where we need to make improvements. We will be encouraging staff over the next couple of months to complete the survey and give us their thoughts on what it's like to work at MTW. We have also created additional guidance for managers, to help them support their teams in completing the survey.

- To ensure all colleagues across our diverse workforce are supported, we approved our first Equality, Diversity and Inclusion (EDI) strategy earlier this year. This reviewed our achievements to date and the role of our staff networks, which have gone from strength to strength in recent years. It also set out an ambitious plan for the next three years. The focus is now on:
  - Providing transparent and inclusive recruitment practices.
  - The development and management of our staff.
  - Creating a kinder workplace for everyone.
  - Having a culture that values the views, thoughts and opinions of all.
  - Developing our leaders as role models.
  - Developing a culture where supportive challenge is the norm and discrimination is eradicated.

  To drive our EDI strategy, we have set up a senior leadership steering group with senior representation from clinical and non-clinical departments across the Trust. The group recently met for the first-time, led by our Chief People Officer and our Head of EDI, Engagement and Retention, who were joined by senior leaders, our networks and patient experience representatives. The group took time to focus on their own EDI objectives, taking into consideration the lived experiences of our staff and patients. Although the objectives are now being refined and will be published soon, some of our initial visions include the use of shadow boards which can help provide staff with a forum to voice their ideas, insights and concerns, to bring about change and help them feel seen. We're also exploring fellowship programmes to provide opportunities for staff from minority groups to join a training programme that can give them experience in a range of areas, building on similar programmes implemented in nursing. The importance of working closely with our various networks to foster an environment at the Trust where everyone feels heard and valued was strongly emphasised. As part of this, I was delighted to be invited to the Cultural and Ethnic Minorities Network's meeting at the end of September, where I spoke about our EDI strategy and our commitment to ensuring we actively promote diversity and inclusion across our work and the wider Trust.

- As part of Black History Month and its theme 'Saluting our Sisters', a number of events have been held throughout October to celebrate the invaluable contributions of black people to British Society. Staff were invited to Kent and Medway system wide online events, which celebrated the exceptional achievements of black women and the crucial role they have played in shaping history, inspiring change and building communities in areas such as healthcare, literature and sport. An MTW staff event is also taking place on 30 October which will look at the MTW EDI Plan and engage attendees in vital conversations about equality, diversity and inclusion at the Trust.

- This year's Women in Medicine International Network (WIMIN) conference recently took place in Tunbridge Wells and was organised by two of our fantastic Consultant Anaesthetists, Dr Kate Stannard and Dr Helen Burdett. The two-day event welcomed over 120 professionals from our local healthcare systems and further afield, with a number of speakers travelling from as far as New Zealand. Attendees were brought together for talks and workshops on a range of important subjects such as equal pay, misogyny in medicine and also the recent sexual misconduct in surgery study. I had the pleasure of attending the conference, and spoke about embracing a

culture which calls out poor behaviour. In this way, we can work together to ensure any forms of misogyny, harassment, abuse, sexism and discrimination are called out and addressed.

- Our Paediatric Gastro team recently hosted their first Inflammatory Bowel Disease (IBD) activity days, which were held at the Hollywood Bowl centres in Maidstone and Tunbridge Wells. The events were organised by a parent in the Paediatric Gastro Support Group, with Hollywood Bowl kindly providing VIP places at each venue for families to enjoy a game of bowling. Our young guests were able to meet other children of all ages who are also living with IBD, and mix with staff from our Paediatric Gastro team. The events were a huge success, with a young patient commenting: “It was great to meet other children the same as me”. Parents were also able to mingle and meet with other families, to share their experiences and provide support to one another.

- Our surgical teams in the Maidstone Orthopaedic Unit at Maidstone Hospital recently performed seven hip replacements on a single list – the most our Trust has ever performed in this timeframe. All the patients were able to go home within 24 hours, thanks to minimally invasive surgery which meant less pain after the operation and a shorter recovery time. The surgical team were supported by our pharmacists, radiologists, physiotherapists, and the anaesthetic team, whose expertise meant that patients were awake and on their feet as soon as possible after the operation. Known as HIT (High Intensity Theatre) lists, the approach used for the hip surgery day focuses on just one type of procedure and minimises the turnaround time between operations. The method was inspired by Formula 1 pitstop techniques, aiming for maximum efficiency and safety by minimising delays – in this case, by shortening the turnaround time between patients. This is in turn gives the surgeon as much time as possible to operate and enables more procedures to be completed in one day, therefore benefiting more patients. Trauma and Orthopaedics Consultant, Mr Syed Ahmed is an advocate for day case hip replacements. He said the aim will be to treat nearly 10% of patients as day case procedures in the new Kent & Medway Orthopaedic Centre once it opens next year.

- As part of National Hereditary Cancer Awareness Week, we recently worked alongside NHS South East Genomics to raise awareness of the role genes play in our risk of developing cancer. Hayley Tillett, a Wellbeing Partner in our People and OD Department who worked for 18 years as a therapeutic radiographer, shared her story to highlight the importance of genetic testing. Hayley sadly lost her mum to cancer at a young age, and both her aunts were also diagnosed. As a result, Hayley underwent genetic testing for the BRCA gene, which is proven to increase your risk of developing cancer. Hayley tested positive and subsequently underwent a double mastectomy in her early 20s and the removal of her fallopian tubes in her 30s, to reduce her risk of developing cancer. Genetic testing is supported by the South East NHS Genomic Medicine Service which covers Kent, Medway, Sussex, Surrey and South London. Their role is to embed genomics and genetic testing into routine NHS care and ensure everyone can benefit from the new research and technology that is now available. On behalf of the Trust, I would like to thank Hayley for sharing her story and supporting the invaluable work of NHS South East Genomics.

- We are continuously looking for ways to reduce our carbon footprint, in line with the wider Greener NHS Programme. Part of this work includes the recent introduction of a carbon neutral clog for our clinical staff, as a way of integrating environmental responsibility into all areas of the Trust. Made of 51% waste sugar cane, the green clogs achieve an impressive negative carbon emission factor, while still providing safe footwear that meets healthcare industry regulations. The incorporation of sustainable materials and manufacturing practices ensure the clogs offset the carbon dioxide emitted during production, so each step our clinical staff take is one step closer to a greener and more sustainable future.

- Congratulations to the winner of the Trust’s Employee of the Month award for September, Juanita Caseley, an Advanced Nurse Practitioner in the Cancer Division. Juanita is always coming up with ideas to improve and develop the care that the Open-Access Follow-Up team

provides. She has been described by her colleagues as a ‘role model’, with patients being at the heart of everything she does.

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, 11/10/23 Committee Chair (Non-Exec. Director)

The Quality Committee met (face-to-face / in-person) on 11th October 2023 (a 'deep dive' meeting).

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

- The **actions from previous meetings** were reviewed and it was agreed that the Deputy Chief Nurse, Quality and Experience should provide Committee members with details of the timeline for the 'go live' of the Pressure Ulcer Risk Primary or Secondary Evaluation Tool (PURPOSE-T)).
- The Named Nurse for Safeguarding Adults and Mental Capacity Act (MCA) Lead; and Deputy Chief Nurse, Quality and Experience presented an **in-depth review of safeguarding training and compliance at the Trust** which provided Committee members with details of the increase in challenging behaviours; the safeguarding competencies required by each staffing group; the various training formats which had been developed to improve the Trust's compliance; and the benefits associated with the Named Doctor for Safeguarding Children role at the Trust. The Committee acknowledged that the Trust's safeguarding training compliance had been reset to zero following the publication of the revised Adult Safeguarding Intercollegiate Document in 2022; however, emphasised the importance of ensuring Trust staff, particularly in those in high risk environments such as the Trust's Emergency Departments, were compliant with the safeguarding training requirements and the following actions were agreed:
  - The Named Nurse for Safeguarding Adults and Mental Capacity Act (MCA) Lead should liaise with Trust's Learning and Development Team to identify those members of staff whose adult safeguarding training was most out of date.
  - The Deputy Chief Nurse, Quality and Experience should ensure that the safeguarding competency compliance data which was supplied to the Divisional and Directorate Triumvirates included the date of last completion for safeguarding competencies.
  - The Deputy Chief Nurse, Quality and Experience should check, and confirm to the Divisional Head of Quality and Governance for Core Clinical Services, the arrangements in relation to the provision of level 3 Children's Safeguarding qualified staff at the Community Diagnostic Centre (CDC).
  - The Chief Nurse should liaise with representatives from the Trust's Wellbeing Team to investigate what, if any, additional signposting could be implemented in relation to available internal and external support mechanisms for staff and members of the public (e.g. the utilisation of posters within the Trust's cafeterias).
  - The Chief Nurse should ensure that a discussion was held at a future Joint Safeguarding Committee meeting regarding which safeguarding competencies were required by each staffing group to reflect 'best practice' nationally.
- The Committee reviewed the **items scheduled for scrutiny at future Quality Committee 'deep dive' meetings**; however, it was agreed that the Chair of the Committee and the Chief Nurse should consider, and confirm to the Trust Secretary's Office, the topics for scrutiny at the December 2023 Quality Committee 'deep dive' meeting, to ensure the key areas of focus at the Committee addressed any potential current concerns at the Trust.

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

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

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

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

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

Summary report from the Finance and Performance Committee, 24/10/23	**Committee Chair (Non-Exec. Director)**

The Committee met on 24th October 2023, face-to-face/in-person.

1. **The key matters considered at the meeting were as follows:**
   - Two of the **actions from previous meetings** were discussed in detail, and it was agreed to schedule the Committee's 2024 meetings using the same scheduling model used in 2023. It was also agreed that the Trust Board should be asked to consider the Committee's recommendation that monitoring reports relating to the extended software and consultancy agreement with TeleTracking UK be received by the Trust Board rather than by the Committee; and that a report be considered at the Board every six months in the first instance. The Trust Board is therefore asked to consider this.
   - A **review of compliance with the Committee's Terms of Reference** was undertaken and several additional items were agreed to be scheduled at future meetings. It was however also agreed to seek the Board's approval to remove the duty "To review and assess the effectiveness of financial information systems and monitor development plans, including the development of Service Line Reporting (SLR)", as the vast majority of the Trust's clinical income was based on a fixed-income model. The Board is therefore asked to approve this change.
   - The 'deep dive' item focused on a **review of the Trust's Cost Improvement Programme (CIP) for 2023/24 and 2024/25**, and a helpful discussion of the Trust's underlying financial challenge was held. It was also agreed to schedule a "Review of the Model Hospital Benchmarking Opportunity within the Medicine & Emergency Care Division" as a 'deep dive' item at the Committee's meeting in November 2023.
   - The **Patient Access strategic theme metrics for September** were reviewed, which highlighted the continued improvement in outpatient telephone call response times, and the continued strong performance on the Emergency Department 4-hour waiting time target, despite the significant pressures faced.
   - The Chief Operating Officer gave a brief **update on the plans regarding the non-emergency patient transport service**.
   - The review of **financial performance for September** highlighted that the Trust had a £2.9m deficit for the year-to-date, which was £1.6m adverse to plan; and also discussed the year-end forecast, and the risks to that forecast, in some detail.
   - The Committee considered the **plan for the forthcoming winter period**, and heard about the schemes intended to address the current shortfall between the available number of inpatient beds and the number that were forecast to be required. It was agreed that a 'deep dive' item should be scheduled on one such scheme, the utilisation of the virtual ward.
   - The Director of Strategy, Planning and Partnerships attended to give an update on the **emerging financial risks regarding the Kent and Medway Medical School accommodation project**, and it was agreed to schedule a further update in November.
   - The content of the **summary report from the People and Organisational Development Committee** meeting in September 2023 was noted, as was the latest **use of the Trust Seal**.
   - The Committee's **forward programme** was 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:**
   - The Trust Board is asked to consider the recommendation that monitoring reports relating to the extended software and consultancy agreement with TeleTracking be received by the Trust Board rather than the Committee (given the Chair of the Committee's role with TeleTracking); and that a report be considered at the Board every six months in the first instance.
   - The Trust Board is asked to approve the removal of the duty "To review and assess the effectiveness of financial information systems and monitor development plans, including the development of Service Line Reporting (SLR)" from the Committee's Terms of reference, as the vast majority of the Trust's clinical income was based on a fixed-income model.

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

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

1. Information and assurance.
2. To consider the Committee's recommendation that monitoring reports relating to the extended software and consultancy agreement with TeleTracking UK be received by the Trust Board, rather than by the Committee; and that a report be considered at the Board every six months in the first instance.
3. To approve the removal of the duty, from the Committee's Terms of Reference, "To review and assess the effectiveness of financial information systems and monitor development plans, including the development of Service Line Reporting (SLR)".

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

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Summary report from the People and Organisational Development Committee, 20/10/23	**Committee Chair (Non-Exec. Director)**

The People and Organisational Development Committee met (virtually) on 20th October 2023 (a 'deep dive' meeting).

The key matters considered at the meeting were as follows:

- The **actions from previous 'main' meetings** were reviewed.
- The Committee considered a detailed **review of the Trust's appraisal compliance for 2023,** which highlighted the significant increase in appraisal completion (to 97%). The Committee commended the overall achievement but particularly wanted to commend the Estates Division, which achieved 100% compliance among its 41 staff. The quality of appraisals was also discussed, as was appraisal for medical staff.
- The Head of Leadership Development gave a very assuring report on the **mechanisms which should be implemented to provide Trust Staff who had attended the Exceptional Leaders programme**.
- The Committee conducted the latest **monthly review of the "Strategic Theme: People" section of the Integrated Performance Report (IPR)**, and a detailed discussion on the Trust's high staff turnover rate was held.
- The Committee conducted an **evaluation of the meeting** wherein Committee members gave their perspective on what had worked well, and what aspects could be improved.

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

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

- The Committee agreed to highlight the Estates Division's 100% appraisal compliance rate at the Trust Board meeting on 26/10/23, given the exceptional improvement in performance.

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

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

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Integrated Performance Report (IPR) for September 2023	Chief Executive / Executive Directors

The IPR for month 6, 2023/24, is enclosed, along with the monthly finance report and latest "Planned verses Actual" Safe Staffing data.

Which Committees have reviewed the information prior to Board submission?
Finance and Performance Committee, 24/10/23

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

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Integrated Performance Report

September 2023

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

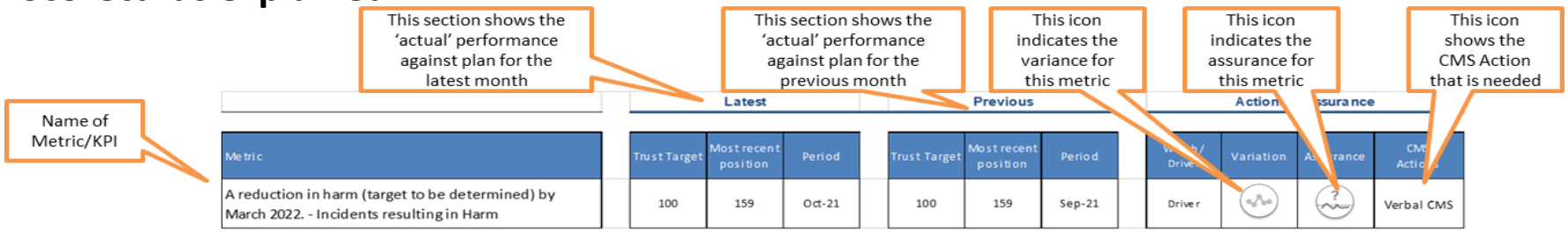
Escalation Rules:

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

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Forecasts

				Latest			Previous			Actions & Assurance				Forecast		
Metric Type	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Well Led	Reduce the Trust wide vacancy rate to 12%		12%	8.6%	Aug-23	12%	9.5%	Jul-23	Driver			Note Performance	9.2%		
Breakthrough Objectives	Well Led	Reduce Turnover Rate to 12%		12%	12.7%	Aug-23	12%	12.5%	Jul-23	Driver			Full CMS	12.1%		

A three month forward view forecast has been included in the IPR for the Vision and Breakthrough metrics. Variation and Assurance icons being generated for the forecasted position to give an indicative view of performance at that point. There are varying approaches being used to generate these forecasts. Some are statistical and others based on detailed plans and / or upcoming known events. These are signed off by Exec. SROs.

Data Quality Kite Marks explained

Metric Type	CQC Domain	Metric	DQ Kite Mark
Vision Goals / Targets	Well Led	Reduce the Trust wide vacancy rate to 12%	
Breakthrough Objectives	Well Led	Reduce Turnover Rate to 12%	

A Kite Mark has been assigned to each metric in the report. This has been created by assessing each source system against the criteria shown in the table (right). A point has been assigned for each of the criteria met. The maximum score is ten. There are ten segments in the Kite Mark image and the corresponding number of segments are shaded blue based on those marked as met by the source system manager. In this example the Electronic Staff Record system scores 8 out of 10. Implementing this system of rating is an audit recommendation.

Data Quality Kite Mark Criteria

1.	System Training / SOPs in place
2.	Subject to internal / external audit / benchmarking
3.	Data collected within 5 days of occurring
4.	Validation processes built into system
5.	Data included in Divisional reports
6.	Data has no more than 5% missing values
7.	Information Processes Documented and Validated
8.	Metric Definition Documented
9.	Metric Owned by one individual or service
10.	Clinical / Expert input in capture / validation process

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Executive Summary

Executive Summary: The Trust Vacancy Rate continues to experience special cause variation of an improving nature and passing the target for more than six months. The Trust is therefore introducing a new stretch target of 8% from October 2023. Turnover Rate continues to experience common cause variation and consistently failing the target. Agency spend did not achieve the target for August 23 but remains in common cause variation and variable achievement of the target. Sickness levels continue to experience special cause variation of an improving nature and have achieved the target for more than six consecutive months. The Trust Appraisal window officially closed at the end of July 2023, with a performance of 91.6%, however the window had been left open until the end of September for some late data to be entered and performance as at September 23 was above the 95% target at 96.8%. Statutory and Mandatory Training remains in common cause variation and variable achievement of the target, achieving the target once again in September. The percentage of staff Afc 8a or above that are female or have a disability have achieved the target, whilst those that are BAME is consistently failing the target but is in special cause variation of an improving nature. The Trust was £0.6m in surplus in the month which was £0.2m adverse to plan. Year to Date the Trust is £2.9m in deficit which is £1.6m adverse to plan.

The Nursing Safe Staffing Levels has increased in September to slightly below target. It remains in common cause variation and variable achievement of the target. The rate of incidents causing patients moderate or higher harm achieved the new target of 0.90 in August and remains in common cause variation and variable achievement of the target. The new breakthrough indicator for the number of deteriorating patients with moderate or higher harm was above the target of 2 in August, experiencing common cause variation and variable achievement of the target. The rate of inpatient falls, C.Difficile and E.Coli are experiencing common cause variation and variable achievement of the target. The rate of C.Difficile and E.Coli are escalated due to being in Hit or Miss for more than six months. Complaints response times have failed the target for more than 6 months and therefore remain escalated. Friends and Family Response rates remain challenging.

Diagnostic Waiting Times achieved the recovery trajectory target set for September 23 at 96.8% (+9.2%). It now experiencing common cause variation and has achieved the recovery trajectory target for six months. RTT performance remains below the recovery trajectory, now experiencing special cause variation of a concerning nature and consistently failing the target. We remain one of the best performing trusts in the country for longer waiters but have reported one month end breach in September 23. Performance for First outpatient activity levels is expected to achieve plan for Sep-23 (once all cashing up has taken place) and is now experiencing common cause variation and variable achievement of the target. Outpatient Utilisation and Calls answered within 1 minute continue to experience special cause variation of an improving nature but remain consistently failing the target. Diagnostic Imaging activity levels remain below plan for September 2023, but remain above 1920 levels. Elective (inpatient and day case combined) activity was above plan for September 2023 and remains above plan year to date. This metric is now experiencing common cause variation and variable achievement of the target.

The number of patients leaving our hospitals before noon continues to experience common cause variation and consistently failing the target. A&E 4hr performance was just below trajectory for September 23 at 85.6%, experiencing common cause variation and variable achievement of the target. The Trust's performance remains one of the highest both Regionally and Nationally. Ambulance handovers remain in special cause variation of an improving nature and variable achievement. The Trust continues to achieve the Cancer Waiting Times (CWT) 62 Day and 2 Week Wait (2WW) standard, with the 62 day standard reporting it's best performance over the last five years at 88%. CWT performance is the Provisional reported monthly positions as per the CWT website. Finalised reports will be available after the 6 monthly refresh, so for April to September 2023 these will be available in January 2024 Initial results, following validation suggest that the 31 day standard may achieve the target for July and August 23 once the finalised positions are submitted in January but will need to be confirmed.

Escalations by Strategic Theme:

People:

- Turnover Rate (P.9)
- % of Afc 8c and above that are BAME (P.10)
- Statutory and Mandatory Training (P.10)*

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

Patient Safety & Clinical Effectiveness:

- Infection Control – Rate of C.Diff and E.Coli (P.12)*

Patient Access:

- RTT Performance (P.14)
- Outpatient Calls answered <1 minute (P.15)
- Outpatient Clinic Utilisation (P.15)
- Planned levels of Diagnostics activity (P.15)

Patient Experience:

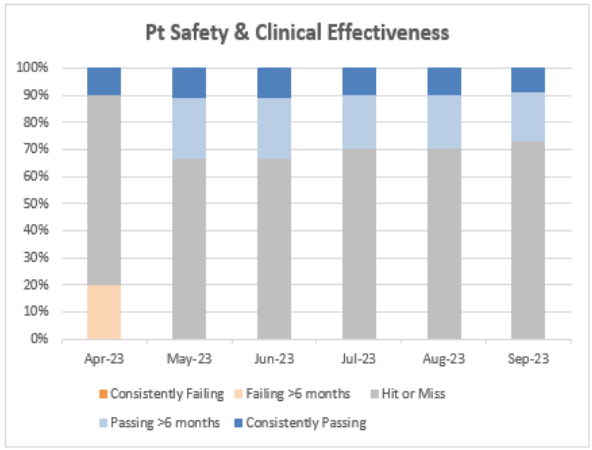
- New Complaints Received (P.17)*
- Complaints responded within target (P.18)
- FFT Response Rates: A&E, Outpatients & Maternity (P.18)

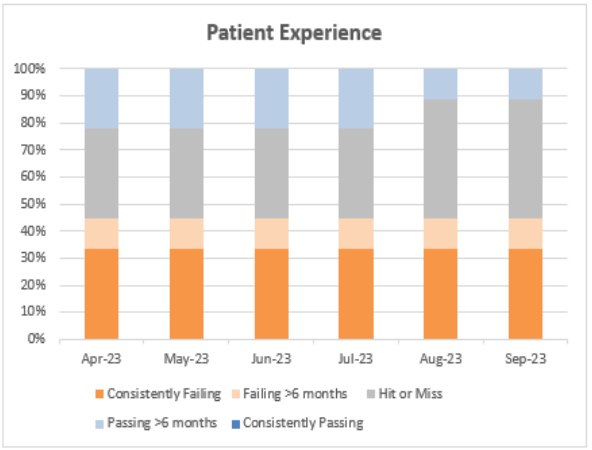
Systems:

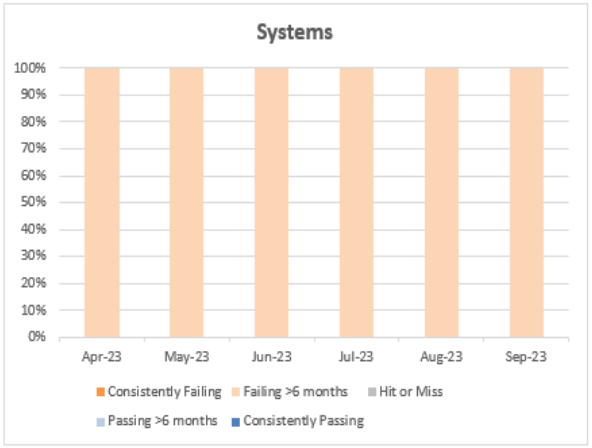
- Discharges before Noon (P.20)

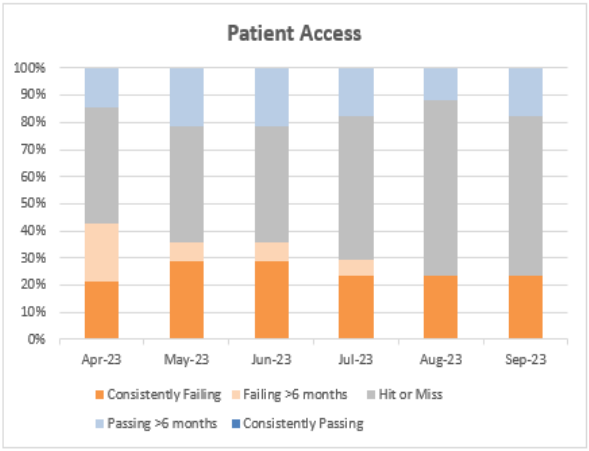
Sustainability: None

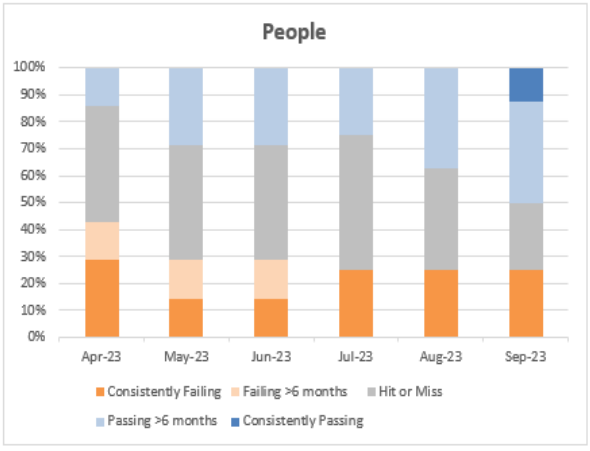
Assurance Stacked Bar Charts by Strategic Theme

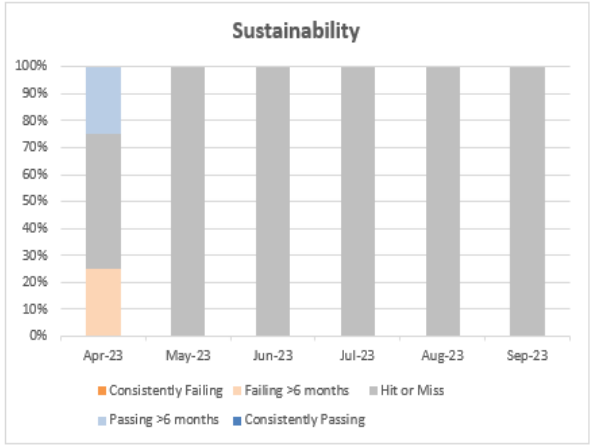












Matrix Summary

September 2023		Assurance				
		Pass ★	Pass	Hit and Miss	Fail	Fail -
Variance	Special Cause - Improvement	Percentage of AfC 8c and above that have a Disability Summary Hospital-level Mortality Indicator (SHMI)	Reduce the Trust wide vacancy rate to 12% Sickness Absence Percentage of AfC 8c and above that are Female Never Events		% complaints responded to within target	Percentage of AfC 8c and above that are BAME Transformation: % OP Clinics Utilised (slots) Transformation: CAU Calls answered <1 minute To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20) % complaints responded to within target Friends and Family (FFT) % Response Rate: A&E Friends and Family (FFT) % Response Rate: Maternity
	Common Cause		Number of New SIs in month Access to Diagnostics (<6weeks standard) Cancer - 2 Week Wait Cancer - 62 Day Complaints Rate per 1,000 occupied beddays	Appraisal Completeness Statutory and Mandatory Training Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind) Number of Deteriorating Patients with Moderate+ Harm (data runs one month behind) Standardised Mortality HSMR Safe Staffing Levels IC - Rate of Hospital E.Coli per 100,000 occupied beddays IC - Rate of Hospital C.Difficile per 100,000 occupied beddays IC - Number of Hospital acquired MRSA Rate of patient falls per 1000 occupied bed days To achieve the planned levels of new outpatients activity (shown as a % 19/20) A&E 4 hr Performance Cancer - 31Day First Cancer - 28 Day Faster Diagnosis Compliance Cancer - 28 Day Faster Diagnosis Completeness To achieve the planned levels of elective (DC and IP cobined) activity (shown as a %19/20) To achieve the planned levels of outpatients follow up activity (shown as a %19/20) To reduce the overall number of complaints or concerns each month To reduce the number of complaints and concerns where poor communication with patients and their families is the main issue affecting the patients experience		Reduce Turnover Rate to 12% Friends and Family (FFT) % Response Rate: Outpatients To increase the number of patients leaving our hospitals by noon on the day of discharge
	Special Cause - Concern			RTT Patients waiting longer than 40 weeks for treatment % VTE Risk Assessment (one month behind) Cash Balance (£k)		Achieve the Trust RTT Trajectory

Strategic Theme: People

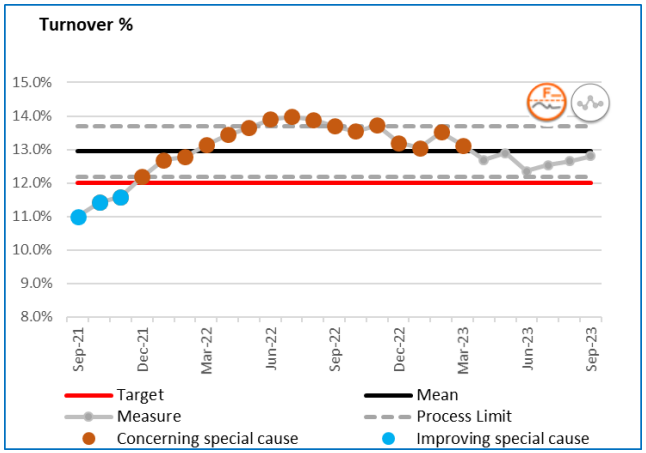
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Well Led	Reduce the Trust wide vacancy rate to 12%		12%	8.5%	Sep-23	12%	8.6%	Aug-23	Driver			Note Performance	8.1%		
Breakthrough Objectives	Well Led	Reduce Turnover Rate to 12%		12%	12.8%	Sep-23	12%	12.7%	Aug-23	Driver			Full CMS	12.7%		
Constitutional Standards and Key Metrics (not in SDR)	Well Led	Sickness Absence		4.5%	3.9%	Aug-23	4.5%	3.7%	Jul-23	Driver			Not Escalated			
	Well Led	Appraisal Completeness		95.0%	96.8%	Sep-23	95.0%	93.1%	Aug-23	Driver			Not Escalated			
	Well Led	Statutory and Mandatory Training		85.0%	85.6%	Sep-23	85.0%	84.4%	Aug-23	Driver			Not Escalated			
	Well Led	Percentage of AfC 8c and above that are Female		62.0%	68.5%	Sep-23	62.0%	67.5%	Aug-23	Driver			Not Escalated			
	Well Led	Percentage of AfC 8c and above that have a Disability		3.2%	3.8%	Sep-23	3.2%	4.0%	Aug-23	Driver			Not Escalated			
	Well Led	Percentage of AfC 8c and above that are BAME		12.0%	8.5%	Sep-23	12.0%	8.7%	Aug-23	Driver			Escalation			

Breakthrough Objective: Counter Measure Summary

Metric Name – Reduce Turnover Rate to 12%

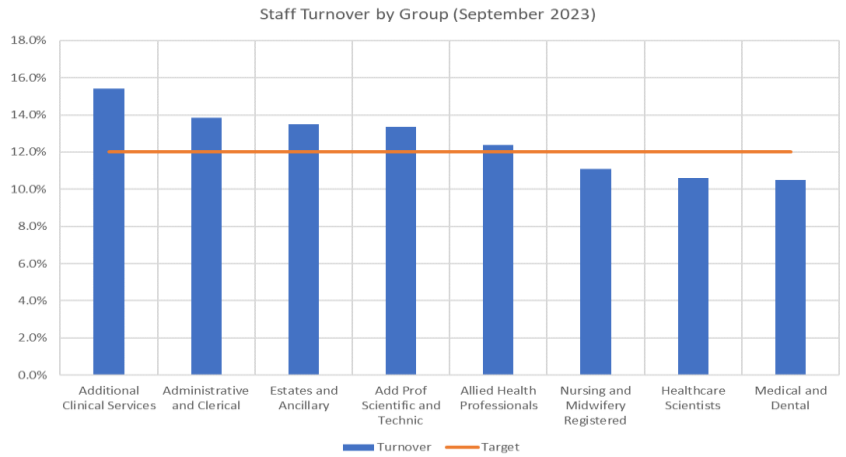
Owner: Sue Steen
Metric: Turnover Rate
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Sep--23
12.81%
Variance / Assurance
Metric is currently Common Cause variation and is consistently failing the target
Max Target (Internal)
12%
Business Rule
Full CMS as not achieved target

2. Stratified Data



3. Top Contributors

These are some of the main contributors of focus for the working groups

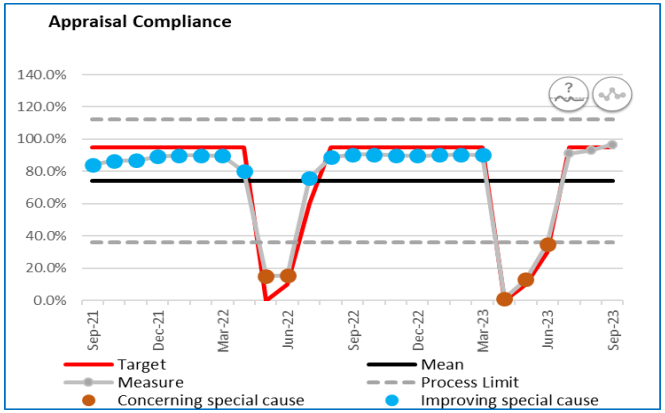
Attraction	Learning & Development
Flexible working can be too rigid / No free food / Increased cost of living at TW site / No USP staff benefits for working at MTW	No clear progression path / Upskilling does not lead to promotion
Inadequate break times / Poor wellbeing	Onboarding slow / Gaps in leadership capability
	Not enough locally trained staff / Lack of staff development
Processes	**Retention**
Retire and return policy out of date, putting people off returning	Not feeling valued, engaged, part of a team / Feedback from listening events taking too long to action
TRAC process takes too long, leading to delays / lack of transparency in recruitment	No outer London waiting, losing staff to Dartford / easier to find better pay elsewhere

4. Action Plan

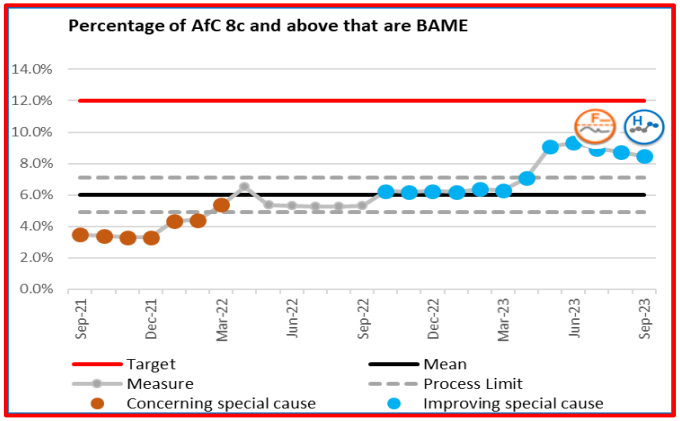
A full action plan by the working groups has been developed; some of the key actions shown:

Countermeasures	Completion Date
Agree a formal pathway for approval for all incentives scheme	Oct-23
Refer a Friend initiative	Nov-23
Decrease time to hire (conditional offer to sign off) to 25 working days by Dec-23 - currently at 30 (Sept), down from 43 days (July)	Dec-23
Deep dive into the average time candidates are in each stage of the recruitment process	Nov-23
Combining new starter, recruitment and induction surveys into one: the onboarding survey. Launching w/c 23rd Oct. Review data in six months to assess quality of responses	Apr-24
Develop new project specifically looking at reducing the number of leavers who have been with the Trust for 24 months or less	Mar-24
Admin and Clerical retention-deep dive	Dec-23
Set trajectories for all KPIs	Oct-23

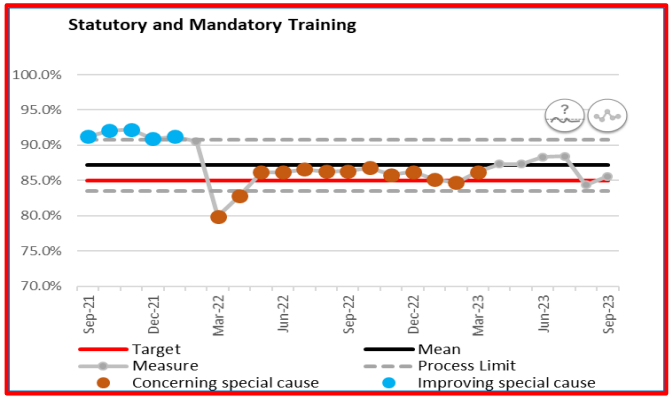
People – Workforce: CQC: Well-Led



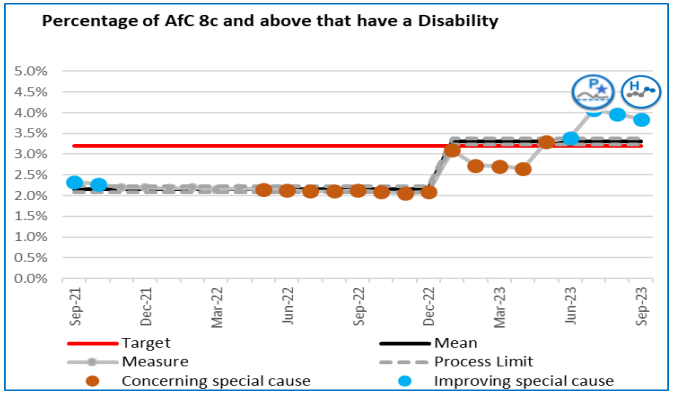
Sep-23
96.82%
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Max Target (Internal)
95%
Business Rule
For information as has now achieved the 95% target



Seo-23
8.5%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target
Target (National)
12%
Business Rule
Full Escalation



Sep-23
85.6%
Variance / Assurance
Metric is currently experiencing common cause variation and variable achievement of the target
Target (National)
85%
Business Rule
Escalated as in hit and miss for 6+ months



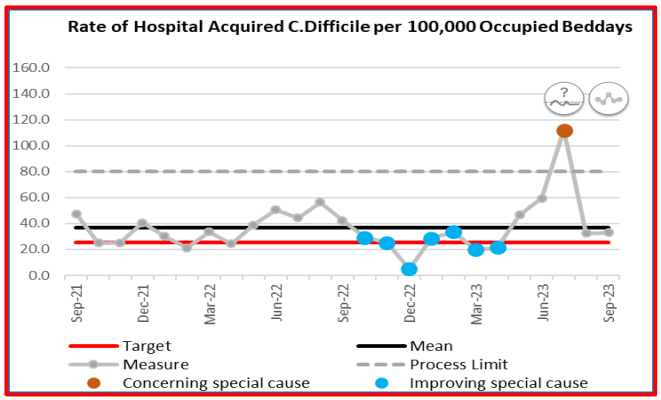
Sep-23
3.8%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently passing the target
Target (National)
3.2%
Business Rule
Not Escalated but shown for info as is now consistently passing the target

Summary:	Actions:	Assurance & Timescales for Improvement:
Appraisal % - This metric is experiencing Common Cause Variation and variable achievement of the target. Shown for information as now achieved above the 95% target as at end of September 2023 this this annual round of Appraisals. **% of AfC 8c and above that are BAME:** This metric is experiencing special cause variation of an improving nature and consistently failing the target. **Statutory and Mandatory Training:** This metric is experiencing common cause variation and variable achievement of the target for 6+ months but has achieved the target in September. **% of AfC 8c and above that have a Disability:** This metric is experiencing special cause variation of an improving nature and has now moved into consistently passing the target.	**% of AfC 8c and above that have a Disability and % of AfC 8c and above that are BAME:** (NB: These are not rapidly changing indicators). As at September 23 the current number of staff (WTEs) that are AfC 8c and above is 130. Of these 5 have a disability , 11 are BAME and 89 are female. **Actions:** • Mandate for EDI recruitment reps to be on all interview panels of 8C and above • EDI steering Board commenced October to drive improvement • Focus on anti racism for the senior leadership away day on 25/10/2023 • Second cohort of reverse mentoring launches in November with staff from ethnic minority backgrounds and those with long term health conditions as mentors and mentee pool being the Trust Board, including NEDs, plus Divisional triumvirates	**Statutory and Mandatory Training**: Following the dip in performance seen in August, due to the introduction of a new mandatory training course, the performance has returned to above the 85% target in September. A review of compliance against each separate statutory and Mandatory Training course is being undertaken. **% of AfC 8c and above that have a Disability and % of AfC 8c and above that are BAME:** Develop and deliver values based recruitment training will commence by November 2023, targeting recruiting managers in Divisions with high turnover. The Trust Board are in the process of agreeing EDI objectives which will be measured in April 2024.

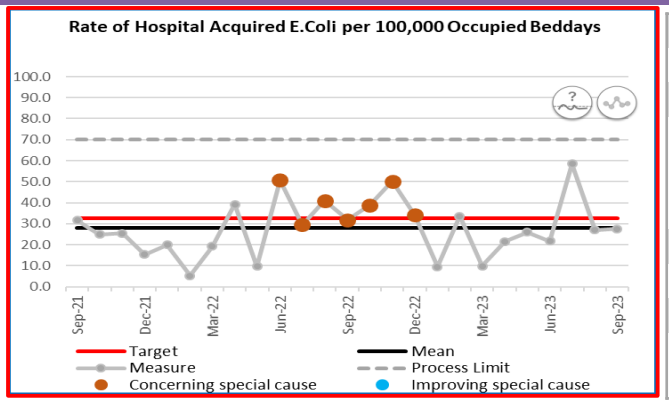
Strategic Theme: Patient Safety & Clinical Effectiveness

				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Safe	Reduction in rate of patient incidents resulting in Moderate+ Harm per 1000 bed days (data runs one month behind)		0.90	0.76	Aug-23	0.90	0.80	Jul-23	Driver			Verbal CMS	1.14		
Breakthrough Objectives	Safe	Number of Deteriorating Patients with Moderate+ Harm (data runs one month behind)		2	4	Aug-23	2	4	Jul-23	Driver			Verbal CMS	4		
Constitutional Standards and Key Metrics (not in SDR)	Safe	Number of New SIs in month		11	8	Sep-23	11	8	Aug-23	Driver			Not Escalated			
	Safe	Standardised Mortality HSMR		100.0	98.7	Jun-23	100.0	98.6	May-23	Driver			Not Escalated			
	Safe	Summary Hospital-level Mortality Indicator (SHMI)		100.0	90.9	Jun-23	100.0	91.3	May-23	Driver			Not Escalated			
	Safe	Never Events		0	0	Sep-23	0	0	Aug-23	Driver			Not Escalated			
	Safe	Safe Staffing Levels		93.5%	92.9%	Sep-23	93.5%	89.2%	Aug-23	Driver			Not Escalated			
	Safe	IC - Rate of Hospital E.Coli per 100,000 occupied beddays	TBC	32.6	27.5	Sep-23	32.6	27.0	Aug-23	Driver			Not Escalated			
	Safe	IC - Rate of Hospital C.Difficile per 100,000 occupied beddays	TBC	25.5	33.0	Sep-23	25.5	32.4	Aug-23	Driver			Not Escalated			
	Safe	IC - Number of Hospital acquired MRSA	TBC	0	1	Sep-23	0	0	Aug-23	Driver			Not Escalated			
	Safe	Rate of patient falls per 1000 occupied bed days		6.4	7.3	Sep-23	6.4	6.2	Aug-23	Driver			Verbal CMS			

Patient Safety and Clinical Effectiveness: CQC: Safe



Sep-23
32.97
Variance / Assurance
Metric is currently experiencing common cause variation and variable achievement of the target
Max Target
25.5
Business Rule
Escalated as in Hit & Miss for >6months



Sep-23
27.4
Variance / Assurance
Metric is currently experiencing Common Cause Variation and variable achievement of the target
Max Target (Internal)
32.6
Business Rule
Escalated as in Hit & Miss for >6months

Summary:

Rate of C.difficile: is experiencing special cause variation of a deteriorating nature and variable achievement of the target.

Rate of E.coli:: is experiencing common cause variation and variable achievement of the target.

Actions:

Infection Control:

Following the sharp rise in C diff cases in July, August saw a significant reduction in cases close to the expected rates which has continued into September.

- Two Trust wide C diff incident meetings have been held to identify and monitor areas for improvement.
- A deep cleaning task and finish group has been formed to co-ordinate the deep cleaning programme at TWH. Ward 12 and 10 have been deep cleaned W21 has been commenced.
- Enhanced cleaning is being undertaken on wards at MH where possible
- Key C diff information has been published on the Trust intranet page
- The IPC team continue to deliver additional ward-based updates, promoting the completion of the c diff risk assessment and C diff related documentation
- Weekly C diff round involving the Consultant Microbiologist and IPC team are held weekly
- Rapid C diff reviews are being undertaken by the IPC team with clinician involvement to support timely identification of learning

E coli blood stream infection were within the expected rates for August and September. All healthcare associated cases are subject to data collection by the IPCT and full RCA where lapses of care are identified

Assurance & Timescales for Improvement:

Infection Control:

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 and gram negative blood stream infections. Learning from RCAs is shared within the Directorate and via the HCAI weekly status

Actions will continue to be identified and monitored through the Trust wide incident meeting held in September

Plans are being developed to transition to PSIRF for IPC post infection reviews. A system wide process is being written.

Strategic Theme: Patient Access

				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Responsive	Achieve the Trust RTT Trajectory		72.7%	66.2%	Sep-23	72.1%	67.1%	Aug-23	Driver			Full CMS	68.3%		
Breakthrough Objectives	Responsive	To achieve the planned levels of new outpatients activity (shown as a % 19/20)		110.3%	116.6%	Sep-23	123.8%	123.6%	Aug-23	Driver			Verbal CMS	117.0%		
Constitutional Standards and Key Metrics (not in SDR)	Responsive	RTT Patients waiting longer than 40 weeks for treatment		637	1071	Sep-23	642	1017	Aug-23	Driver			Not Escalated			
	Responsive	Access to Diagnostics (<6weeks standard)		87.6%	96.8%	Sep-23	87.1%	97.1%	Aug-23	Driver			Not Escalated			
	Responsive	A&E 4 hr Performance		86.8%	85.6%	Sep-23	88.3%	84.7%	Aug-23	Driver			Not Escalated			
	Responsive	Cancer - 2 Week Wait *		93.0%	95.2%	Aug-23	93.0%	95.3%	Jul-23	Driver			Not Escalated			
	Responsive	Cancer - 31 Day First *		96.0%	95.5%	Aug-23	96.0%	95.2%	Aug-23	Driver			Not Escalated			
	Responsive	Cancer - 62 Day *		85.0%	88.0%	Aug-23	85.0%	85.0%	Jul-23	Driver			Not Escalated			
	Responsive	Cancer - 28 Day Faster Diagnosis Compliance *		75.0%	71.9%	Aug-23	75.0%	75.0%	Jul-23	Driver			Not Escalated			
	Responsive	Cancer - 28 Day Faster Diagnosis Completeness *		80.0%	86.5%	Aug-23	80.0%	85.1%	Jul-23	Driver			Not Escalated			
	Effective	Transformation: % OP Clinics Utilised (slots)		85.0%	82.3%	Sep-23	85.0%	83.3%	Aug-23	Driver			Escalation			
	Effective	Transformation: % of Patients Discharged to a PIFU Pathways		1.5%	5.4%	Sep-23	1.5%	5.5%	Aug-23	Driver	No SPC	No SPC	Not Escalated			
	Effective	Transformation: CAU Calls answered <1 minute		90.0%	72.7%	Sep-23	90.0%	70.5%	Aug-23	Driver			Escalation			
	Effective	Flow: Ambulance Handover Delays >30mins	TBC	5.0%	6.3%	Sep-23	5.0%	6.8%	Aug-23	Driver			Not Escalated			
	Effective	Flow: % of Emergency Admissions into Assessment Areas		65.0%	63.7%	Sep-23	65.0%	63.2%	Aug-23	Driver			Not Escalated			
	Responsive	To achieve the planned levels of elective (DC and IP cobined) activity (shown as a % 19/20)		98.8%	105.4%	Sep-23	111.0%	111.4%	Aug-23	Driver			Not Escalated			
	Responsive	To achieve the planned levels of outpatients follow up activity (shown as a % 19/20)		106.8%	107.0%	Sep-23	114.5%	112.9%	Aug-23	Driver			Not Escalated			
	Responsive	To achieve the planned levels of Diagnostic (MRI,NOUS,CT Combined) Activity (shown as a % 19/20)		145.1%	139.4%	Sep-23	153.4%	139.8%	Aug-23	Driver			Escalation			

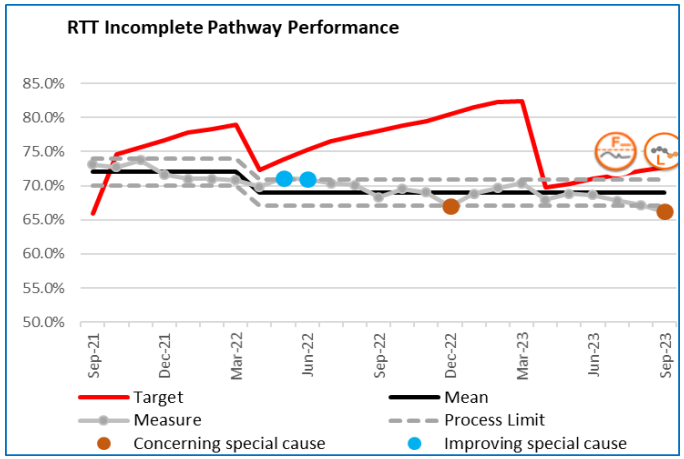
* CWT metrics are the Provisional reported monthly positions as per the Cancer Waiting Times website. Finalised reports will be available after the 6 monthly refresh in January 2024

Vision: Counter Measure Summary

Project/Metric Name – Achieve the Trust RTT

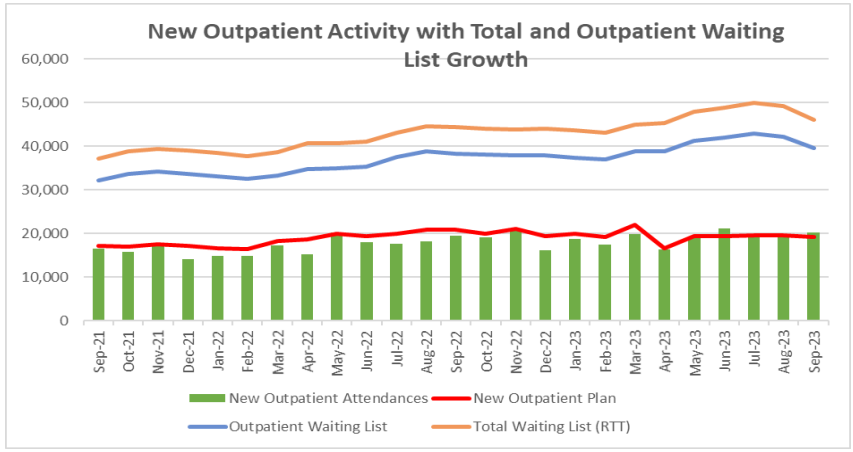
Owner: Sean Briggs
Metric: Referral to Treatment time Standard
Desired Trend: 7 consecutive data points above the mean

1. Historic Trend Data



Sep-23
66.18%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
72.7%
Target Achievement
Metric is consistently failing the target

2. Stratified Data



3. Top Contributors/Key Risks/Issues

Despite being above plan for our new outpatients. Although some of the key specialties with long waits are still under plan. The trust wide themes/top contributors are as follows:

- Long waits for 1st Outpatient appointment
- Achievement of activity targets for new outpatients and electives
- Follow ups without procedure above plan

BAU actions continue and focussed clinical engagement with Further Faster GIRFT Programme.

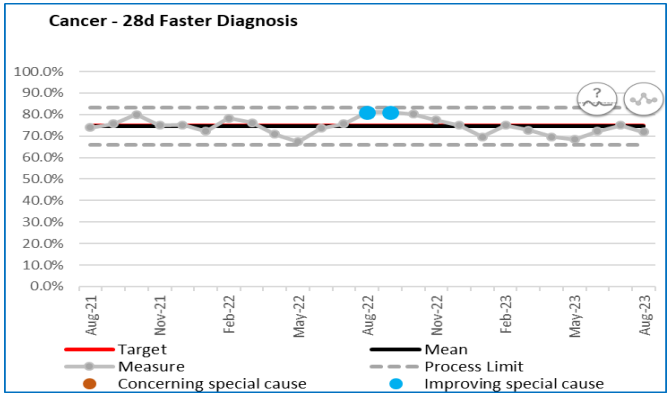
Key Risks:

- There is a risk that medical industrial action will affect achievement of the planned trajectory for activity affecting RTT.
- Waiting list growth could be affected due to increase in referrals and systems pressure.

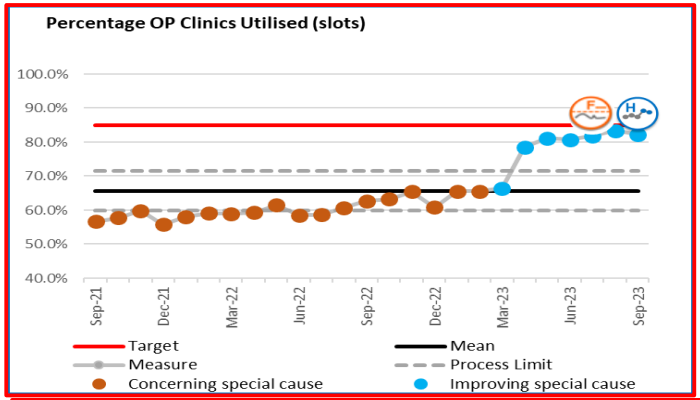
4. Action Plan/Next Steps

Countermeasures	Action	Who / By when	Complete
Improved New Outpatient Activity	Focussed work on GIRFT Further Faster initiatives,. Clinical validation standardisation pilots	SC	Oct/Nov
	Pre-appointment expanding use of A&G/Smart Pathways via EROS	SC	May 24
	Review of DOS with clinical teams	AC	Oct 23
DNA Reduction	Two Way Text roll out for adults and paeds	SC	Sept 23✓
	Trust wide DNA Task and Finish group looking at GIRFT recommendations and Patient Engagement	SC	March 24
Close monitoring of all patients over 40 weeks	Tuesday PTL and Trust Access Performance meeting Additional PTLs for Gastro, Gynae, Neurology and Surgery	RTT Lead and PAT team	Weekly and in progress

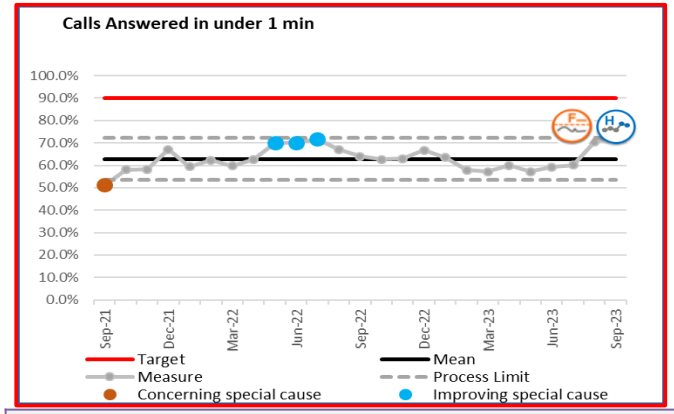
Patient Access: CQC: Responsive



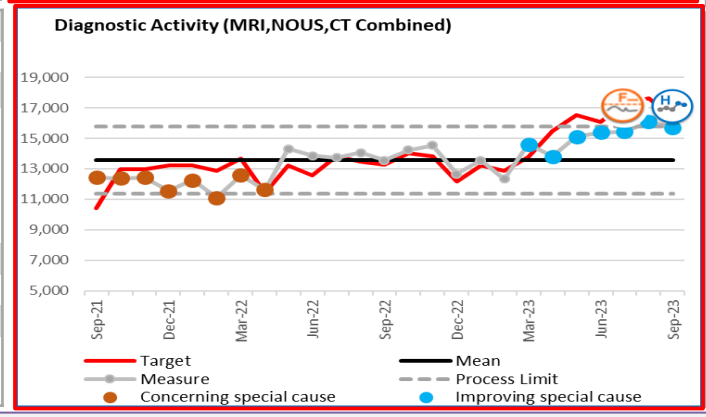
Aug-23
75%
Variance / ,Assurance
Metric is currently experiencing common cause variation and variable achievement of the target
National Target
75%
Business Rule
For info as new metric



Sep-23
82.3%
Variance / Assurance
Metric is currently experiencing Special Cause Variation of an improving nature and consistently failing the target
Target (Internal)
85%
Business Rule
Full Escalation as consistently failing the target



Sep-23
72.7%
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 as consistently failing the target



Sep-23
15,712
Variance / Assurance
Metric is currently experiencing special cause variation of an improving nature and consistently failing the target
Target
16,354
Business Rule
Full Escalation as consistently failing the target

Summary:

CWT – 28 Day Faster Diagnosis Compliance: is experiencing common cause variation and variable achievement of the target. However the Trust achieved the 75% national target for the first time in July 23.

Calls Answered <1 min: is experiencing special cause variation of an improving nature and remains consistently failing the target. An improvement was seen in September 23. The areas with the lowest rate is Women & Children, Surgical Specialties and General Surgery.

Outpatient Utilisation: is experiencing special cause variation of an improving nature and consistently failing the target. The Divisions below 75% are Medicine, Pre-Op and Women & Children's Services.
Diagnostic Activity: Activity levels are currently above 1920 levels for MRI, CT and NOUS and are now experiencing special cause variation of an improving nature. However, the metric continues to be consistently failing the target. Echocardiography is above the revised trajectory and is now experiencing common cause variation and variable achievement of the target.

Actions:

CWT – 28 Day Faster Diagnosis Compliance: Newly Cancer Alliance Funded roles are undergoing recruitment to support the delivery of the 28 day Faster Diagnosis Standard. These roles will support the manual process of recording FDS dates and developing diagnostic pathways within 28 days.

Performance against the under 1 minute KPI: Plan to increase trained admin staff on bank to cover CAU vacancies. Daily report by hour and by speciality are circulated to the General Managers and team leaders to highlight peaks and troughs of performance. The team are working with CAUs to review phone rotas and ensure all hours are covered - working with specialities to design a rota based on busiest call times.

Outpatient Clinic Slot Utilisation: The OPD team have worked with the CAU's on their clinic templates to improve utilisation by 20%. Next, the focus is on planned elective clinics with utilisation below 85%. Slot utilisation is discussed with specialities at the weekly RTT meeting.
Diagnostic Activity: MRI and CT activity is below plan for September 23 due to equipment issues; planning is in place to divert activity to the more resilient scanners. Reprofiled internally for recovery info.
Echocardiography Activity: was above the recovery trajectory for September 2023. Activity being monitored weekly,

Assurance & Timescales for Improvement:

CWT – 28 Day Faster Diagnosis Compliance: Data completeness (number of pathways with a recorded FDS date) remains above the 80% threshold. As completeness rises, performance (number of patients with an FDS date within 28 days) is likely to decrease, however individual pathway tumour site working groups are set up to ensure diagnostic pathways can reach the 28 day standard. Despite this, in July and August, we achieved the 75% target for 28 day FDS performance.
Calls Answered within 1 minute in the CAUs: All vacancies are now filled in the OPD contact team. Many speciality CAUs are reporting short staffing, however, an admin specific recruitment event took place on Saturday 16th September to support CAU recruitment. We achieved our interim target of 70% in August and September and new starters should help maintain that through further periods of Industrial Action.
Outpatient Slot Utilisation The aim is to ensure that no planned elective clinic is under 85% utilised. The OPD team have worked to identify 'planned elective' vs. 'emergency / hot clinics'. Supporting specialties to reduce the amount of retrospective work required post month end to reach 80%. Currently mapping a Trust wide trajectory to improve to 85%

Strategic Theme: Patient Experience

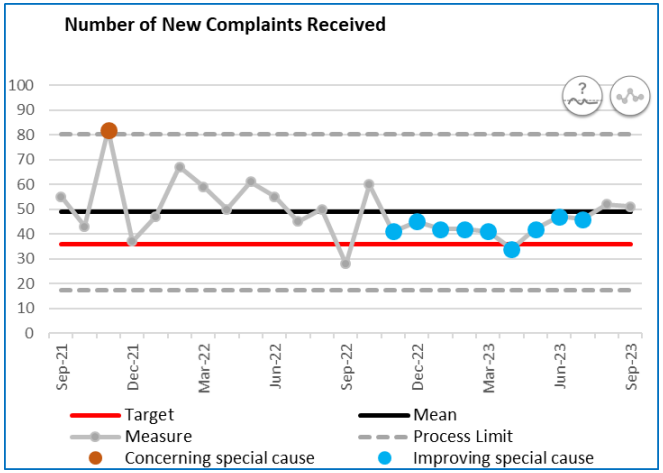
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Caring	To reduce the overall number of complaints or concerns each month		36	51	Sep-23	36	52	Aug-23	Driver			Verbal CMS	48		
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	34	Sep-23	24	34	Aug-23	Driver			Verbal CMS	32		
Constitutional Standards and Key Metrics (not in SDR)	Caring	Complaints Rate per 1,000 occupied beddays		3.9	2.8	Sep-23	3.9	3	Aug-23	Driver			Not Escalated			
	Caring	% complaints responded to within target		75.0%	73.2%	Sep-23	75.0%	56.8%	Aug-23	Driver			Escalation			
	Caring	% VTE Risk Assessment (one month behind)		95.0%	95.4%	Aug-23	95.0%	95.4%	Jul-23	Driver			Not Escalated			
	Caring	Friends and Family (FFT) % Response Rate: Inpatients		25.0%	25.8%	Sep-23	25.0%	29.8%	Aug-23	Driver			Not Escalated			
	Caring	Friends and Family (FFT) % Response Rate: A&E		15.0%	8.1%	Sep-23	15.0%	7.6%	Aug-23	Driver			Escalation			
	Caring	Friends and Family (FFT) % Response Rate: Maternity		25.0%	19.6%	Sep-23	25.0%	19.8%	Aug-23	Driver			Escalation			
	Caring	Friends and Family (FFT) % Response Rate: Outpatients		20.0%	8.1%	Sep-23	20.0%	8.3%	Aug-23	Driver			Escalation			

Vision: Counter Measure Summary

Metric Name – To reduce the overall number of complaints or concerns each month

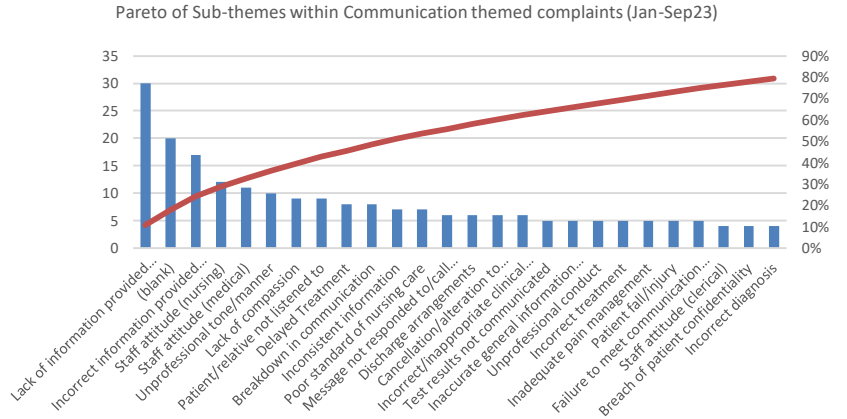
Owner: Joanna Haworth
Metric: Number of Complaints Received Monthly
Desired Trend: 7 consecutive data points below the mean

1. Historic Trend Data



Sep-23
51
Variance Type
Metric is currently experiencing Common Cause Variation
Max Limit (Internal)
36
Target Achievement
Metric is in variable achievement of the target for 6+ months

2. Stratified Data



3. Top Contributors and Key Risks

A3 Thinking currently underway to understand the themes of complaints and concerns where poor communication is the main issue affecting patient experience

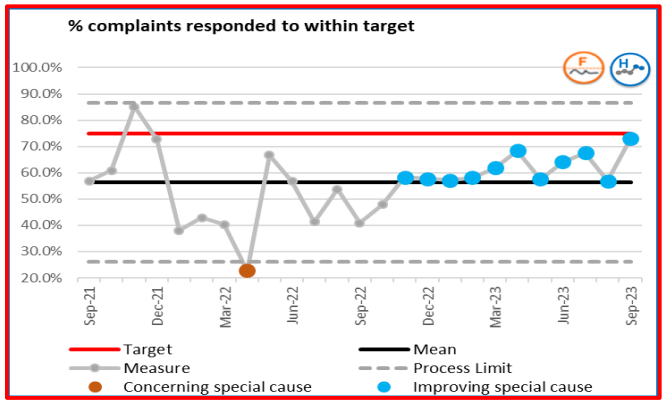
Key Risks:
1. Industrial action leading to reduced clinician availability

Horizon Events:
1. Impact of PKB once launched end of October
2. Formulation of Patient Experience Strategy

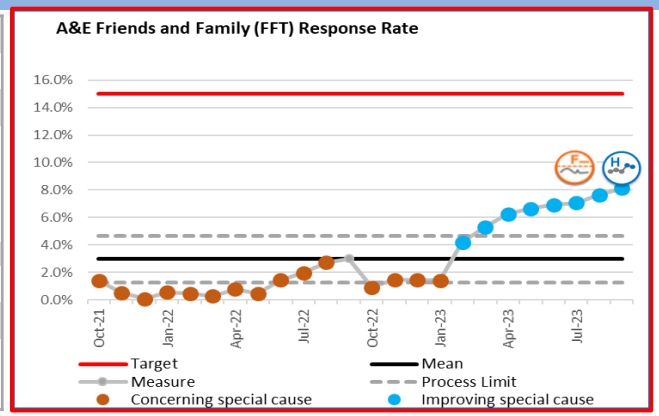
4. Action Plan

	Action for A3	Timeline	Progress
Define	Method to collect data from InPhase to be defined and agreed	August	Complete
	Current state of play being analysed	September	Complete
	Audit of complaints to be completed	October	In Progress
Measure	Root Cause being identified	October	In progress
	Patient Voice being collected using an overall Patient Experience survey to inform part of Patient Experience Strategy	Sep-Oct	In Progress

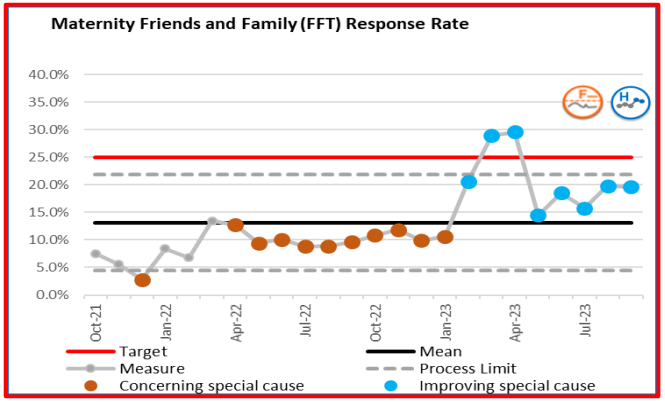
Patient Experience: CQC: Caring



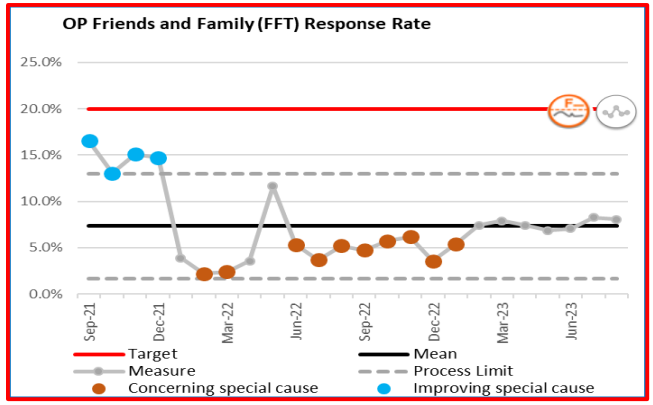
Sep-23
73%
Variance / Assurance
Metric is in special cause variation of an improving nature and failing the target for 6+ months
Target (Internal)
75%
Business Rule
Full Escalation as failed the target 6+ months



Sep-23
8.1%
Variance / Assurance
Metric is currently experiencing special cause variation of an improving nature and is consistently failing the target
Target (Internal)
15%
Business Rule
Full Escalation as consistently failing the target



Sep-23
19.6%
Variance / Assurance
Metric is currently experiencing special cause variation of an improving nature and is consistently failing the target
Target (Internal)
25%
Business Rule
Full Escalation as consistently failing the target



Sep-23
8.1%
Variance / Assurance
Metric is currently experiencing common cause variation and is consistently failing the target
Target (Internal)
20%
Business Rule
Full escalation as is consistently failing the target

Summary:

% Complaints responded to within target: this indicator is experiencing special cause variation of an improving nature and has failed the target for >6months, noting the target has not been met since November 2021

Friends and Family Response Rate - A&E: Is experiencing Special Cause Variation of an improving nature, but is consistently failing the target.

Recommended Rate is 98.6%

Friends and Family Response Rate - Maternity: Is experiencing Special Cause Variation of an improving nature, but is consistently failing the target.

Recommended Rate is 100%

Friends and Family Response Rate - Outpatients: Is experiencing special cause variation of a concerning nature and is consistently failing the target

Recommended Rate is 95%

Word clouds being reviewed for key sentiments and shared with divisions

Actions:

Complaints Response Rate: Complaints performance recovery and stabilisation actions include;

- Weekly oversight meetings led by CN and DQG
- Business case for revised complaints model submitted
- 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

A&E: ED is an improving picture. Continue with current methodology. Hybrid method using text, QR code and online. Currently in the process of reviewing providers and to re-review the internal target of 15% (based on NHSE/I recommendations)

Maternity: Meetings held with the directorate to support improvements to FFT responses. Volunteers are supporting with FFT collection.

Outpatients: SMS text messaging underway. QR Codes have been published. Problem identified with mapping text messaging and linking to PAS OP clinic codes. Outpatients have a issue with mapping of all clinic codes. Netcall meeting is in progress to discuss issues with mapping the data. Recent IT issues have also impacted in the delay.

FFT Response All: Response rate consistently over >7,000 since April 2023. Word clouds being compiled between and feedback received and what good looks like

Assurance & Timescales for Improvement:

% Complaints responded to within Target:

- Trust aiming to hit sustained delivery of the target response (75%) by September 2023, increasing to 90% by December 2023

Friends and Family (FFT) response Rates: Continue monthly review. Meetings with Netcall, ED and OP to monitor and review. Improvements identified to mapping for Netcall to implement for OP texts. Further meeting in June planned with ED and OP to work through concerns.

Meetings held with ED and Maternity to review FFT and actions put in place including updating IQVIA hierarchy, printing and supplying FFT posters, using iPads and volunteers supporting with FFT collection. Updated FFT reports circulated to staff.

Imperial Research project

Comms put out reminding staff about FFT. Internet page updated to include more information about FFT and accessibility information.

We will continue to monitor all aspects of FFT.

Strategic Theme: Systems

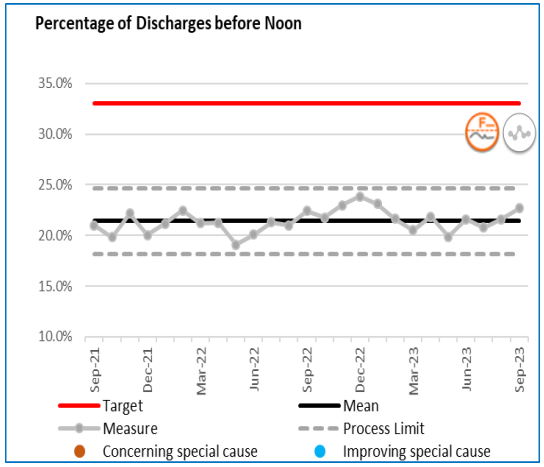
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Effective	Decrease the number of occupied bed days for patients identified as medically fit for discharge (shown as rate per 100 occupied beddays)		3.5	9.2	Sep-23	3.5	6.9	Aug-23	Driver	No SPC	No SPC	Note Performance	TBC	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%	22.7%	Sep-23	33.0%	21.6%	Aug-23	Driver			Full CMS	22%		

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%

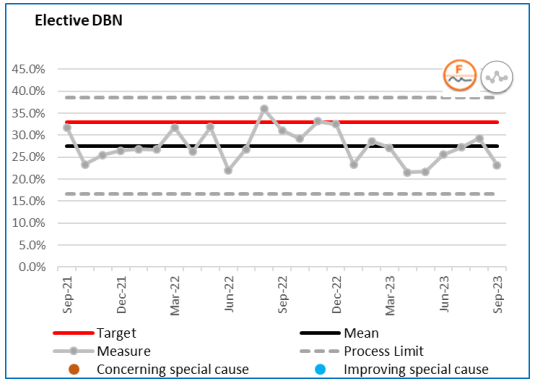
Owner: Rachel Jones
Metric: Discharges before Noon
Desired Trend: 7 consecutive data points above the mean

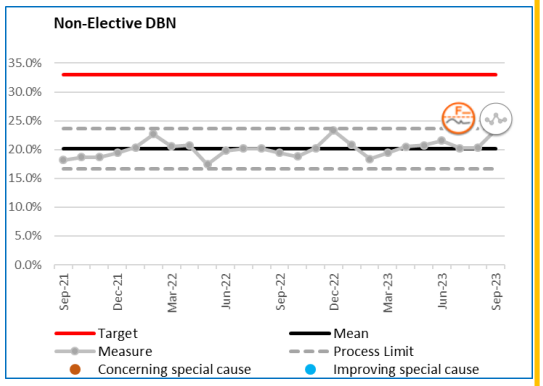
1. Historic Trend Data



Current Data Source: Teletracking
Sep-23
22.7%
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
33%
Target Achievement
Metric is consistently failing the target

2. Stratified Data





3. Top Contributors and Key Risks

Area of Analysis	Considered a Top Contributor?
EDN	EDNs are a top contributor in delays in discharge time. There is a clinically led EDN project group focusing on expediting the completion of EDN to ensure discharges are completed before noon.
	A focus group working on EDN proforma to align with the clerking model to facilitate quicker completion on EDNs
Criteria Led Discharge	Data shows Criteria led discharge was only utilised 1.3% of all discharges – hence focus around identifying patients with CLD and recording them on Sunrise, have been identified.

Key Risks:

1. Continued disruption to a focus on EDN as a result of industrial action.
2. Clinical buy-in to manage EDN and CLD processes differently
3. Sunrise change freeze – Timeline will affect implementation of the changes and Sunrise data from HISBI – Report extraction

4. Action Plan

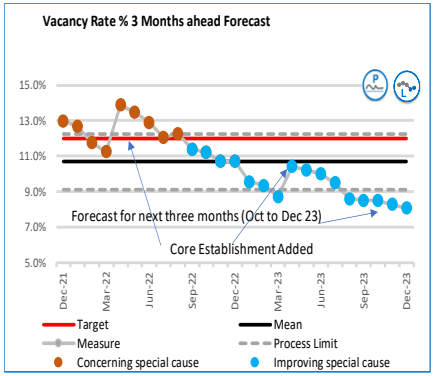
CM	Action	Who	When	Complete
Criteria Led Discharge	• Clinical Engagement with Med Specialties and Surgery • Discharge policy to be updated to include CLD. • Competencies and E-learning uploaded to L&D (MTW learning) for Matrons and Band 7s to complete and training to be disseminated across all wards for CLD. • Changes in Sunrise to identify patients with CLD, on the taskbar and reports to be extracted from Sunrise (When the sunrise upgrade is completed)	NP/SF/ Divisional CDs NP NP/RS/RT	End of Oct 23 Oct 23 Dec 23	In Progress Complete In Progress In Progress Delayed – early 2024
EDN	• Trial different Jr Dr allocation model specifically to deliver EDNs on two wards (one medical base ward, one surgical) • Agree ward and firms testing (meet ward 21 to confirm support w/o 23rd) • Agree roll out plan if test successful • Change EDN structure in Sunrise to align with clerking model • Change EPMA & Sunrise TTO module to reduce time taken to complete medicines element of EDN (requires planned Sunrise upgrade completion first)	BC CoS, MD BC JS JS	1/11/23 24/10/23 5/12/23 11/23 3/24	In Progress In Progress In Progress In Progress In progress
Delay Reason	• Develop data export from Teletracking to BI warehouse to enable in house bespoke reporting • Develop data migration from Sunrise to Teletracking	RS JS		In Progress In Progress

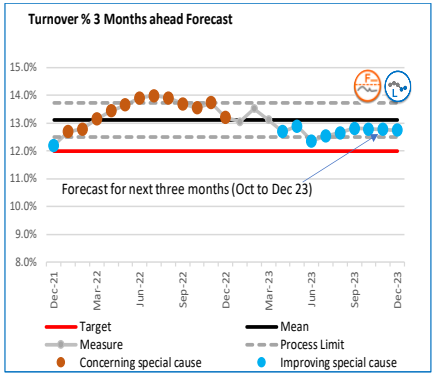
Strategic Theme: Sustainability

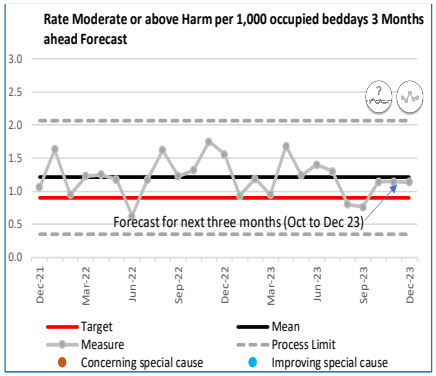
				Latest			Previous			Actions & Assurance				Forecast		
	CQC Domain	Metric	DQ Kite Mark	Trust Target	Most recent position	Period	Trust Target	Most recent position	Period	Watch / Driver	Variation	Assurance	CMS Actions	3 Month Forecast	Variation	Assurance
Vision Goals / Targets	Well Led	Delivery of financial plan, including operational delivery of capital investment plan (net surplus(+)/net deficit (-) £000)		748	588	Sep-23	977	1055	Aug-23	Driver			Verbal CMS	-1168		
Breakthrough Objectives	Well Led	Reduce the amount of money the Trusts spends on premium workforce spend: Monthly Agency Spend - £000		935	1451	Sep-23	968	1324	Aug-23	Driver			Verbal CMS	1338		
Constitutional Standards and Key Metrics (not in SDR)	Well Led	CIP		2851	2590	Sep-23	2922	1309	Aug-23	Driver	No SPC	No SPC	Not Escalated			
	Well Led	Cash Balance (£k)		18277	15756	Sep-23	18768	17266	Aug-23	Driver			Not Escalated			
	Well Led	Capital Expenditure (£k)		4091	3975	Sep-23	5907	991	Aug-23	Driver			Not Escalated			
	Well Led	Delivery of the variable Elective Recovery Funding (ERF) plan - £000		60746	62775	Sep-23	50718	51545	Aug-23	Driver	No SPC	No SPC	Not Escalated			
	Well Led	Delivery of Other Variable Income (Non-ERF) plan - £000		10256	9852	Sep-23	8539	8415	Aug-23	Driver	No SPC	No SPC	Not Escalated			

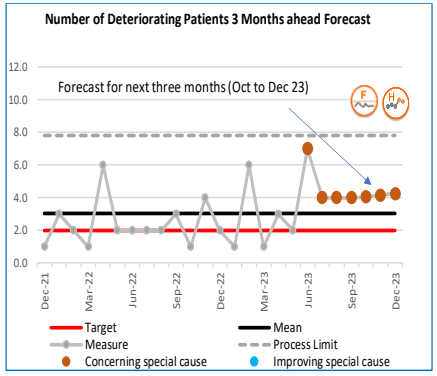
Appendices

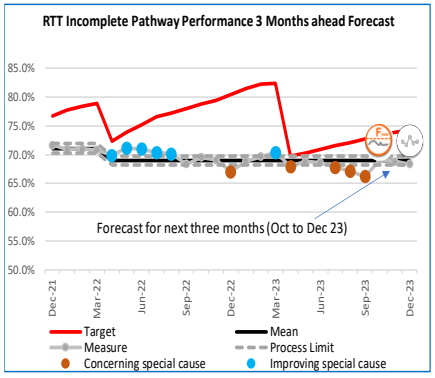
Forecast SPCs (3 month forward view) for Vision and Breakthrough Objectives

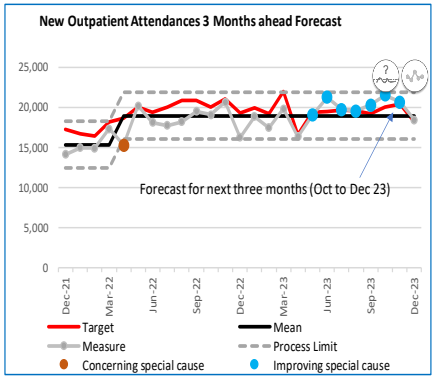


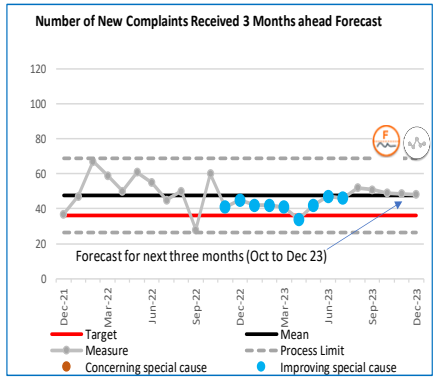


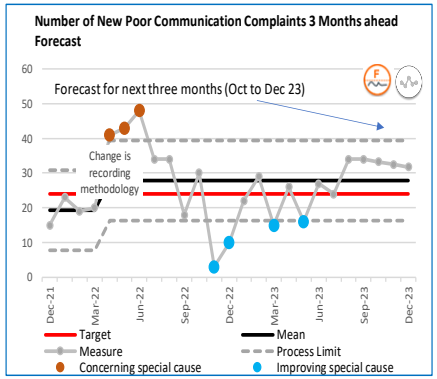


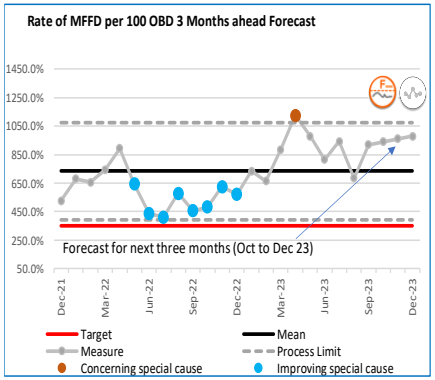


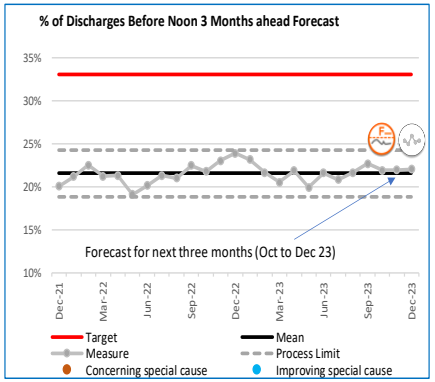


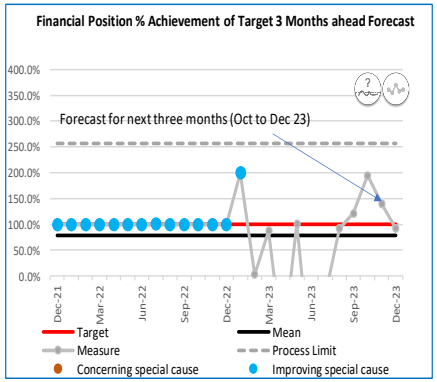


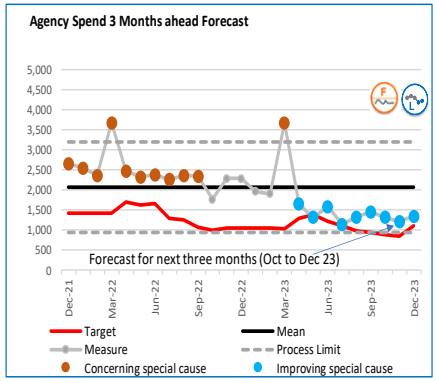






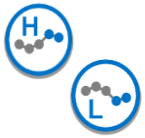






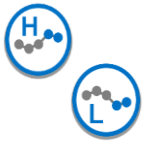
SDR Business Rules Driven by the SPC Icons

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. 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. Consider next steps.
		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

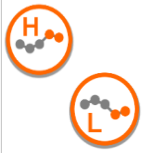
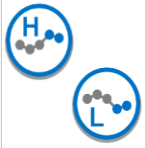
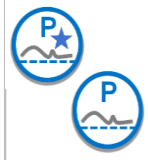
SDR Business Rules Driven by the SPC Icons

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 improvement	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 improvement	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.	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**
Any		Assurance indicates inconsistently hitting or missing the target.	A Driver Metric that remains in Hit & Miss for 6 months or more will need to complete a **full CMS**	N/A

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:

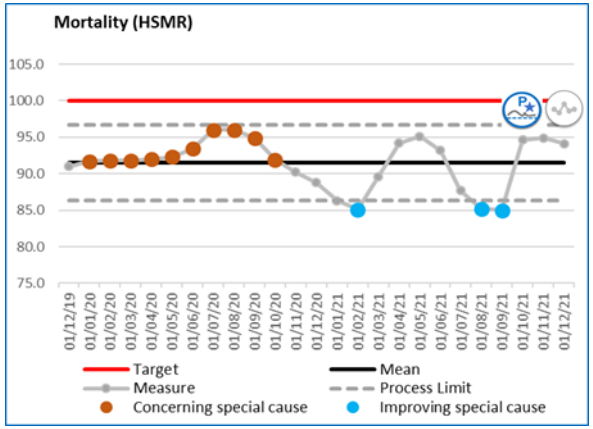
The **target** line **between** the **upper** and **lower** control limit for all metric types

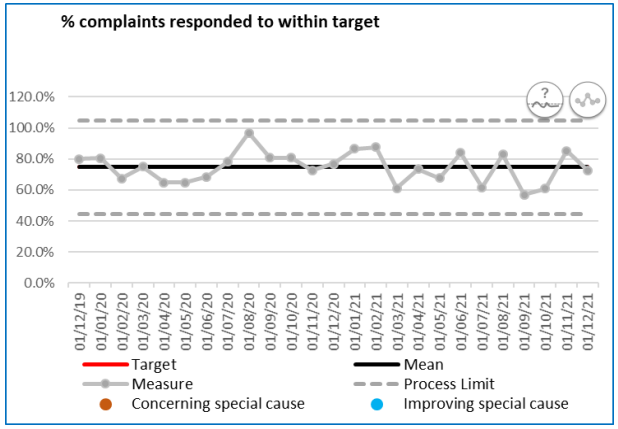
Metrics that consistently **fail** have:

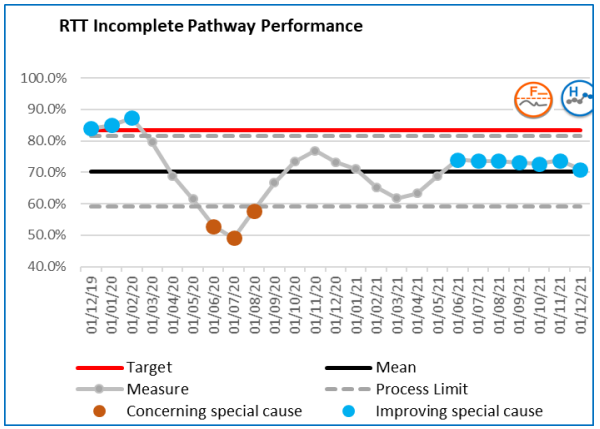
The **lower** control limit **above** the target line for metrics that need to be **below the target**

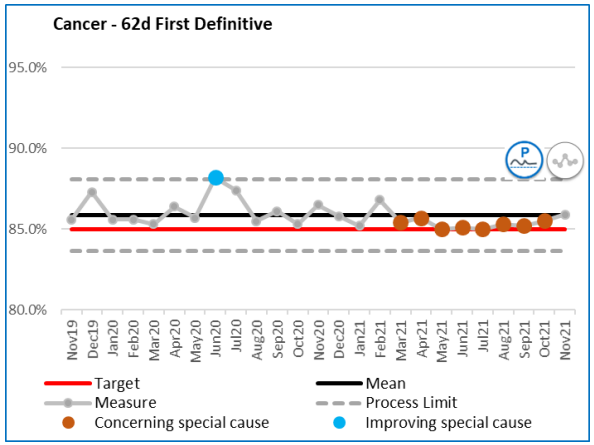
The **upper** control limit **below** the target line for metrics that need to be **above the target**

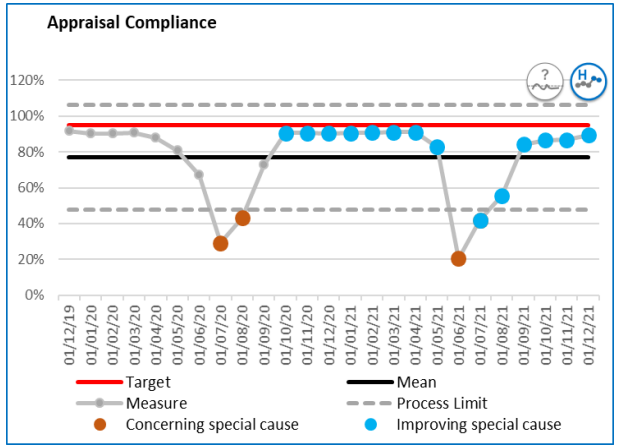
A metric not achieving the target for 6 months or more will be flagged as failing

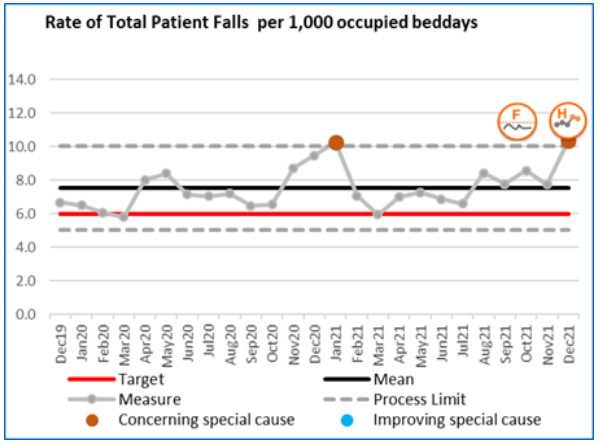


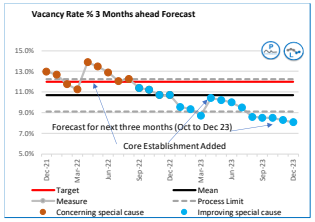


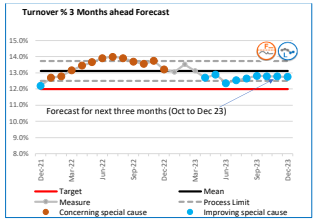


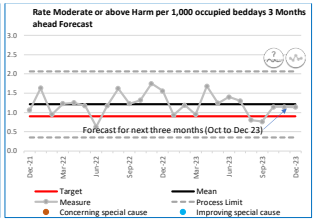


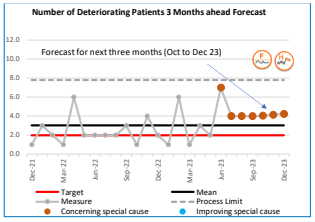


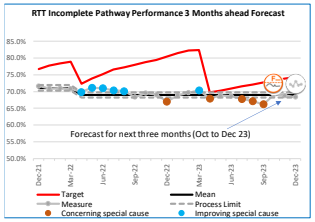


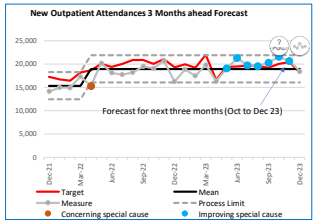

Vacancy Rate % 3 Months ahead Forecast
Forecast for next three months (Oct to Dec 23)
Core Establishment Added
Target
Mean
Measure
Process Limit
Concerning special cause
Improving special cause

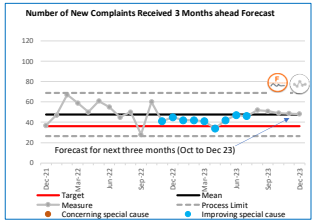

Turnover % 3 Months ahead Forecast
Forecast for next three months (Oct to Dec 23)
Target
Mean
Measure
Process Limit
Concerning special cause
Improving special cause

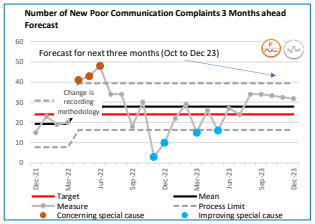

Rate Moderate or above Harm per 1,000 occupied beddays 3 Months ahead Forecast
Forecast for next three months (Oct to Dec 23)
Target
Mean
Measure
Process Limit
Concerning special cause
Improving special cause

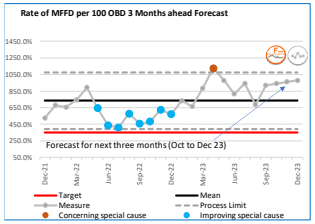

Number of Deteriorating Patients 3 Months ahead Forecast
Forecast for next three months (Oct to Dec 23)
Target
Mean
Measure
Process Limit
Concerning special cause
Improving special cause

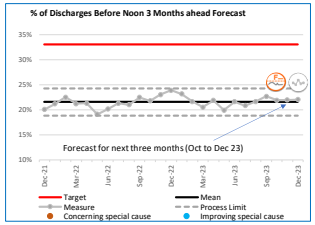

RTT Incomplete Pathway Performance 3 Months ahead Forecast
Forecast for next three months (Oct to Dec 23)
Target
Mean
Measure
Process Limit
Concerning special cause
Improving special cause

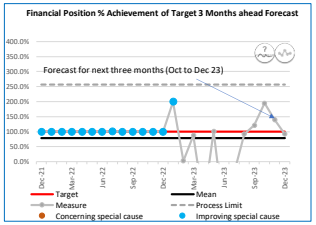

New Outpatient Attendances 3 Months ahead Forecast
Forecast for next three months (Oct to Dec 23)
Target
Mean
Measure
Process Limit
Concerning special cause
Improving special cause

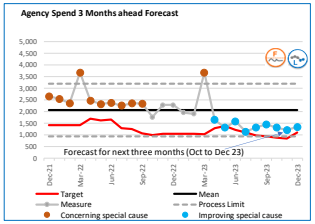

Number of New Complaints Received 3 Months ahead Forecast
Forecast for next three months (Oct to Dec 23)
Target
Mean
Measure
Process Limit
Concerning special cause
Improving special cause


Number of New Poor Communication Complaints 3 Months ahead Forecast
Forecast for next three months (Oct to Dec 23)
Change is recording methodology
Target
Mean
Measure
Process Limit
Concerning special cause
Improving special cause


Rate of MFFD per 100 OBD 3 Months ahead Forecast
Forecast for next three months (Oct to Dec 23)
Target
Mean
Measure
Process Limit
Concerning special cause
Improving special cause


% of Discharges Before Noon 3 Months ahead Forecast
Forecast for next three months (Oct to Dec 23)
Target
Mean
Measure
Process Limit
Concerning special cause
Improving special cause


Financial Position % Achievement of Target 3 Months ahead Forecast
Forecast for next three months (Oct to Dec 23)
Target
Mean
Measure
Process Limit
Concerning special cause
Improving special cause


Agency Spend 3 Months ahead Forecast
Forecast for next three months (Oct to Dec 23)
Target
Mean
Measure
Process Limit
Concerning special cause
Improving special cause

Maidstone and Tunbridge Wells NHS Trust

Finance Report

Month 6
2023/24

Maidstone and Tunbridge Wells NHS Trust

Summary

September 2023/24

	Current Month					Year to Date					Annual Forecast / Plan		
	Actual	*Plan*	*Variance*	Pass-throug	*Revised Variance*	*Actual*	*Plan*	*Variance*	Pass-throug	*Revised Variance*	*Forecast*	*Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income	57.6	57.4	0.2	(0.2)	0.3	343.5	341.3	2.3	(0.4)	2.6	698.2	687.1	11.1
Expenditure	(52.8)	(52.4)	(0.4)	0.2	(0.5)	(321.1)	(317.2)	(3.9)	0.4	(4.3)	(647.7)	(635.0)	(12.6)
EBITDA (Income less Expenditure)	4.8	5.0	(0.2)	0.0	(0.2)	22.4	24.1	(1.7)	0.0	(1.7)	50.5	52.0	(1.5)
Financing Costs	(4.3)	(4.3)	0.0	0.0	0.0	(25.7)	(25.7)	0.0	0.0	0.0	(69.6)	(69.3)	(0.2)
Technical Adjustments	0.0	0.0	0.0	0.0	0.0	0.3	0.3	0.0	0.0	0.0	17.3	17.3	0.0
Net Surplus / Deficit	**0.6**	**0.7**	**(0.2)**	**0.0**	**(0.2)**	**(2.9)**	**(1.3)**	**(1.6)**	**0.0**	**(1.6)**	**(1.7)**	**0.0**	**(1.7)**
Cash Balance	15.8	18.3	(2.5)		(2.5)	15.8	18.3	(2.5)		(2.5)	2.0	2.0	0.0
Capital Expenditure (Incl Donated Assets and IFRS16)	4.0	4.1	0.1		0.1	14.4	27.7	(13.3)		(13.3)	63.8	68.0	4.1
Cost Improvement Plan	2.6	2.9	(0.3)		(0.3)	9.0	11.4	(2.4)		(2.4)	17.8	33.3	(15.5)

Summary Current Month:
- The Trust was £0.6m in surplus in the month which was £0.2m adverse to plan. The Industrial action in September led to a £0.2m increase in temporary staffing and lost income due to cancelled elective activity of £0.3m.

Key Favourable variances in month are:
- Variable related activity overperformance net of estimated cost (£0.4m)
- Year to date review of ICT contracts (£0.5m) and bank staff reconciliation to payroll (£0.5m)
- Reinstatement of year to date Trust contingency (£0.5m)

Key Adverse variances in month are:
- Impact of Industrial action (£0.5m)

Year to date overview:
- The Trust is £2.9m in deficit which is £1.6m adverse to plan, the Trusts key variances to the plan are:

Adverse Variances:
- CIP Slippage (£2.4m)
- CDC delay to full capacity and also due to under utilisation of the CT capacity (£1.5m)
- Additional Costs associated with Industrial Action (£1.8m) and Medical pay award pressures (£0.4m)
- Other pressures mainly pay related (£1.1m)

Favourable Variances
- Variable activity overperformance including change to ERF target (£3.2m)
- Non recurrent benefits (£2.3m)

CIP (Savings)
- The Trust has a savings target for 2023/24 of £33.3m and has delivered £9m year to date which is £2.4m adverse to plan.

Risks
- **Community Diagnostic Centre (CDC) delay to full occupancy** – financial risk has arisen due to the delays in opening additional capacity in the CDC. Year to date there is under-performance against the income plan causing a net £1.4m pressure which is in part due to the delay to full capacity and also due to under utilisation of the CT capacity. There is a risk that costs won't be reduced to fully offset the loss in income.
- **CIP Delivery -** The Trust has a large CIP target for 2023/24 and there is £15.5m of unidentified CIP. The PMO continues to work with Divisions to improve CIP delivery.
- **Industrial Action** - The Trust will incur unfunded costs / loss in variable related income associated with future Industrial actions.
- **Kent and Medway Medical School (KMMS)** – The forecast includes £0.9m of liquidated damages.

Sep-23		DAY				NIGHT				TEMPORARY STAFFING		Bank / Agency Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand Unfilled - RM/N (number of shifts)	Overall Care Hours per pt day	Nurse Sensitive Indicators					Financial review		
Hospital Site name	Health Roster Name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Bank/ Agency Usage	Agency as a % of Temporary Staffing					FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Medical Unit (M) - NG551	96.1%	111.1%	-	-	98.3%	134.8%	-	-	30.5%	34.7%	80	5.73	25	9.3	27.8%	96.9%	3	0		186,226	189,654	(3,428)
MAIDSTONE	Stroke Unit (M) - NK551	93.0%	76.0%	-	100.0%	97.2%	94.7%	-	-	31.5%	10.7%	262	18.61	50	8.3	8.3%	100.0%	5	0	Falls data also includes Foster Clark	390,815	343,797	47,018
MAIDSTONE	Cornwallis - NS251	181.0%	160.1%	-	-	93.5%	92.1%	-	-	7.9%	5.3%	84	5.18	12	15.2	#N/A	#N/A	2	0		0	86	(86)
MAIDSTONE	Culpepper Ward (M) - NS551	100.0%	98.1%	-	100.0%	101.7%	155.5%	-	-	27.7%	39.3%	15	1.06	2	5.3	0.0%	100.0%	0	0		118,416	122,830	(4,414)
MAIDSTONE	Edith Cavell - NS459	102.1%	128.4%	-	100.0%	100.1%	173.3%	-	-	51.0%	7.7%	44	3.01	3	6.9	17.2%	100.0%	4	1		121,085	140,512	(19,427)
MAIDSTONE	John Day Respiratory Ward (M) - NT151	93.2%	106.0%	-	-	102.2%	116.7%	-	-	29.1%	11.2%	77	5.43	12	6.4	24.1%	100.0%	0	2		156,436	169,755	(13,319)
MAIDSTONE	Intensive Care (M) - NA251	84.3%	84.3%	-	-	89.7%	81.7%	-	-	5.5%	0.0%	39	2.70	12	52.5	533.3%	87.5%	0	0		240,066	224,924	15,142
MAIDSTONE	Lord North Ward (M) - NF651	96.0%	113.1%	-	100.0%	98.7%	100.0%	-	-	8.2%	0.0%	28	2.13	8	8.0	22.2%	100.0%	2	0		117,055	111,996	5,059
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	116.1%	43.7%	-	100.0%	83.6%	-	-	-	14.0%	0.0%	10	0.70	1	19.2	0.0%	97.0%	3	0		50,909	51,928	(1,019)
MAIDSTONE	Mercer Ward (M) - NJ251	102.2%	91.9%	-	100.0%	101.5%	110.5%	-	100.0%	13.0%	14.0%	20	1.46	4	5.6	29.4%	100.0%	2	1		114,115	132,319	(18,204)
MAIDSTONE	Peale Ward COVID - ND451	94.0%	119.9%	-	-	89.9%	164.1%	-	-	20.6%	29.2%	51	3.51	19	9.1	16.0%	100.0%	3	0		102,358	104,545	(2,187)
MAIDSTONE	Pye Oliver (Medical) - NK259	101.1%	100.1%	-	-	109.4%	132.6%	-	-	32.8%	26.3%	48	3.31	6	6.3	13.3%	100.0%	7	0		135,990	143,017	(7,027)
MAIDSTONE	Short Stay Surgical Unit (M) - NE751	92.6%	85.3%	-	-	81.2%	-	-	-	20.5%	0.8%	31	1.83	4	33.2	0.0%	99.5%	0	0		59,953	55,994	3,959
MAIDSTONE	Whatman Ward - NK959	96.7%	98.8%	-	100.0%	99.0%	124.1%	-	-	34.8%	18.6%	65	4.65	13	6.2	10.5%	100.0%	5	0		104,475	134,244	(29,769)
MAIDSTONE	Maidstone Birth Centre - NP751	108.8%	84.6%	-	-	100.1%	96.7%	-	-	19.9%	0.0%	39	2.33	0	31.0	0.0%	100.0%	0	0		77,570	92,016	(14,446)
TWH	Acute Medical Unit (TW) - NA901	94.2%	104.5%	-	100.0%	101.6%	117.9%	-	100.0%	23.5%	31.3%	137	9.80	41	8.7	13.5%	90.0%	7	0		254,957	245,839	9,118
TWH	Coronary Care Unit (TW) - NP301	97.9%	83.2%	-	-	98.9%	-	-	-	12.2%	0.0%	20	1.47	3	12.2	133.3%	95.8%	0	0		75,962	70,302	5,660
TWH	Hedgehog Ward (TW) - ND702	90.0%	111.8%	-	-	88.9%	152.6%	-	-	37.9%	30.1%	192	13.33	62	10.3	42.0%	95.5%	0	0		153,164	185,738	(32,574)
TWH	Intensive Care (TW) - NA201	102.9%	100.0%	-	-	102.9%	64.0%	-	-	3.4%	0.0%	37	2.27	3	34.1	200.0%	100.0%	0	1		381,661	386,878	(5,217)
TWH	Private Patient Unit (TW) - NR702	109.3%	102.4%	-	-	98.3%	99.7%	-	-	23.5%	0.0%	34	2.05	2	8.8	116.7%	95.2%	0	0		73,468	67,893	5,575
TWH	Ward 2 (TW) - NG442	92.7%	83.2%	-	100.0%	95.7%	126.0%	-	100.0%	22.3%	4.0%	73	5.36	34	6.4	72.0%	88.9%	9	0		183,318	166,297	17,021
TWH	Ward 10 (TW) - NG131	105.9%	101.0%	-	-	104.3%	139.0%	-	-	24.9%	1.8%	64	4.51	11	8.2	28.6%	100.0%	0	2		149,847	162,045	(12,198)
TWH	Ward 12 (TW) - NG132	109.0%	99.4%	-	100.0%	120.8%	104.1%	-	-	38.9%	41.0%	206	13.83	48.00	13.8	71.0%	100.0%	0	0		149,950	177,878	(27,928)
TWH	Ward 20 (TW) - NG230	97.1%	124.6%	-	100.0%	109.7%	123.9%	-	-	36.3%	31.7%	125	8.46	33	7.4	28.6%	78.6%	9	0		176,689	183,270	(6,581)
TWH	Ward 21 (TW) - NG231	91.6%	112.7%	-	100.0%	96.6%	132.2%	-	-	15.8%	9.5%	63	3.97	15	6.2	8.5%	100.0%	1	2		152,563	151,935	628
TWH	Ward 22 (TW) - NG332	85.0%	133.8%	-	-	102.3%	145.8%	-	-	44.8%	48.9%	139	9.75	35	7.0	40.0%	100.0%	24	4		150,276	157,363	(7,087)
TWH	Ward 30 (TW) - NG330	88.7%	89.2%	-	100.0%	93.1%	129.8%	-	100.0%	41.0%	2.5%	134	8.55	37	6.0	25.0%	80.0%	4	1		128,507	164,536	(36,029)
TWH	Ward 31 (TW) - NG331	91.5%	121.0%	-	100.0%	94.2%	136.7%	-	-	33.9%	1.2%	144	9.15	33	6.8	17.1%	83.3%	8	0		142,604	177,836	(35,232)
TWH	Ward 32 (TW) - NG130	85.7%	95.2%	-	100.0%	93.0%	104.8%	-	-	20.3%	1.6%	91	6.14	31	9.1	0.0%	100.0%	5	0		151,293	150,364	929
TWH	Ward 33 (Gynae) (TW) - ND302	92.9%	96.4%	-	-	100.0%	100.0%	-	-	39.0%	1.5%	69	4.34	7	7.0	27.0%	100.0%	0	1		102,927	99,758	3,169
TWH	SCBU (TW) - NA102	101.9%	155.0%	-	-	114.0%	50.0%	-	-	30.2%	5.4%	142	8.72	15	10.3	-	-	0	0		212,704	199,778	12,926
TWH	Short Stay Surgical Unit (TW) - NE901	89.1%	110.9%	-	100.0%	99.8%	103.8%	-	-	9.8%	3.2%	23	1.53	2	12.6	10.6%	100.0%	1	0		83,819	89,790	(5,971)
TWH	Surgical Assessment Unit (TW) - NE701	100.0%	98.0%	-	-	99.9%	100.0%	-	-	12.5%	0.0%	16	1.11	1	14.9	9.2%	100.0%	0	0		78,755	72,961	5,794
TWH	Midwifery (multiple rosters)	81.4%	73.5%	-	-	85.6%	87.5%	-	-	11.9%	3.3%	539	30.94	153	**11.1**	80.8%	99.5%	**0**	**0**		**865,985**	**843,111**	**22,874**
Crowborough	Crowborough Birth Centre (CBC) - NP775	77.4%	92.9%	-	-	43.3%	80.0%	-	-	13.0%	0.0%	51	3.03	19	221.5	60.0%	100.0%	0	0		-62,636	92,182	(154,818)
MAIDSTONE	Accident & Emergency (M) - NA351	98.9%	93.0%	-	-	102.1%	98.1%	-	-	44.6%	39.5%	479	33.16	33	-	0.0%	87.5%	0	0		386,824	475,877	(89,053)
TWH	Accident & Emergency (TW) - NA301	100.3%	77.5%	-	100.0%	100.7%	82.4%	-	100.0%	39.6%	42.4%	417	28.94	34	-	8.3%	90.2%	2	0		416,455	460,928	(44,473)

	Budget £	Actual £	Variance £ (overspend)
Total Established Wards	**6,384,561**	**6,800,175**	**(415,614)**
Additional Capacity bed Cath Labs	57,909	49,566	8,343
Whatman	317,342	245,051	72,291
Ward 11 (TW) NG144	0	-5,025	5,025
Other associated nursing costs	5,362,019	4,978,871	383,148
Total	12,121,831	12,068,638	53,193

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

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

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

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

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

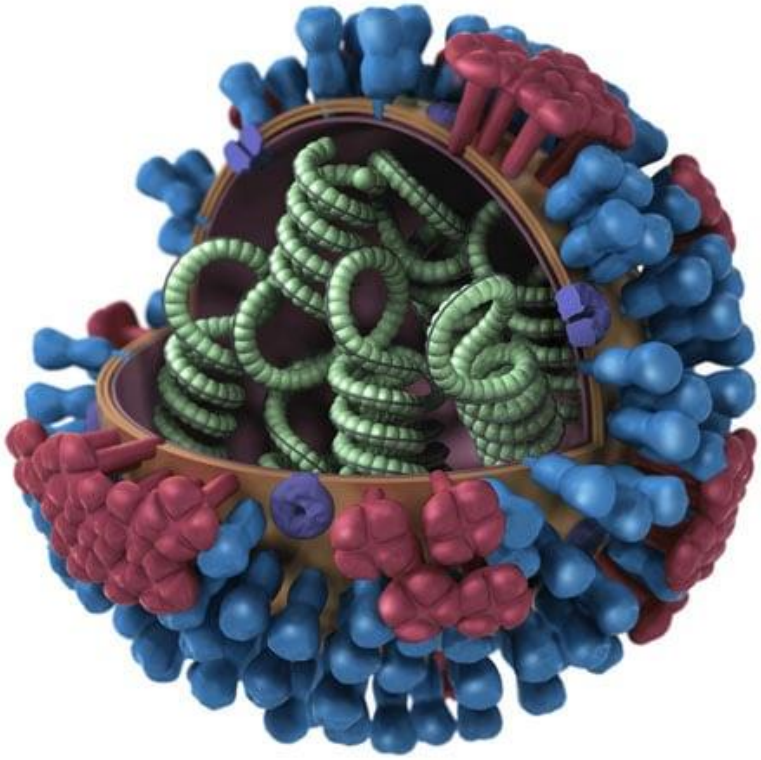
[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making;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

Maidstone and Tunbridge Wells NHS Trust

2022/23 Infection Prevention and Control Report

and

2023/24 Healthcare Associated Infection Reduction Plan



2022/23 Annual Infection Prevention and Control Report and 2023/24 Healthcare Associated Infection Reduction Plan

Introduction

This is a two-part document; a report on the developments and performance related to Infection Prevention and Control (IPC) during 2022/23 and the broad plan of work for 2023/24 to reduce the risk of healthcare associated infections (HCAIs). The report outlines the challenges faced in-year and the Trusts approach to reducing the risk of HCAI for patients.

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

The report acknowledges the hard work and diligence of all grades of staff, clinical and non-clinical who play a vital role in improving the quality of patient and stakeholder experience as well as helping to reduce the number of infections.

The Trust continues to work collaboratively within the Kent and Medway Integrated Care System (K&M ICS) to improve antimicrobial stewardship and reduce the incidence and impact of healthcare associated infections.

Executive Summary

The annual report for Infection Prevention and Control outlines the Trust's IPC activity in 2022/23. In addition, it highlights the role, function and reporting arrangements of the Director of Infection Prevention and Control (DIPC) and the Infection Prevention and Control Team (IPCT).

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

Prevention and control of healthcare associated infections (HCAIs) is a key priority for Maidstone and Tunbridge Wells NHS Trust which has an infection prevention and control annual programme of work, based on local priorities and incorporating the K&M ICS HCAI strategy and national initiatives for the reduction of infection rates.

The Infection Prevention and Control Team (IPCT) advises and co-ordinates activities to prevent and control infection; however, it is the responsibility of all staff in the organisation to comply with Trust policies and implement guidelines in their local area. The IPCT also works closely with other stakeholders in relation to strategies for prevention of infection including NHS England, K&M ICS and NHS Sussex, UK Health Security Agency (UKHSA) and Regional Specialist Laboratories.

There are national contractual reduction objectives for *Clostridioides difficile* infections (CDI) and gram-negative blood stream infections (GNBSI), with mandatory reporting in place for the following infections:

Clostridioides difficile infections

Meticillin Resistant *Staphylococcus aureus* (MRSA) bloodstream infections

Meticillin Sensitive *Staphylococcus aureus* (MSSA) bloodstream infections

Eschericia coli (E. coli) bloodstream infections

Klebsiella spp blood stream infections

Pseudomonas aeruginosa blood stream infections

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

2022/23 has seen the beginning of the recovery from the COVID-19 pandemic with lessening of restrictions on patient and staff testing and Personal protective equipment (PPE).

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

The ten criteria referenced here were updated and published in December 2022 following a consultation exercise in which MTW participated.

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

Governance and Monitoring

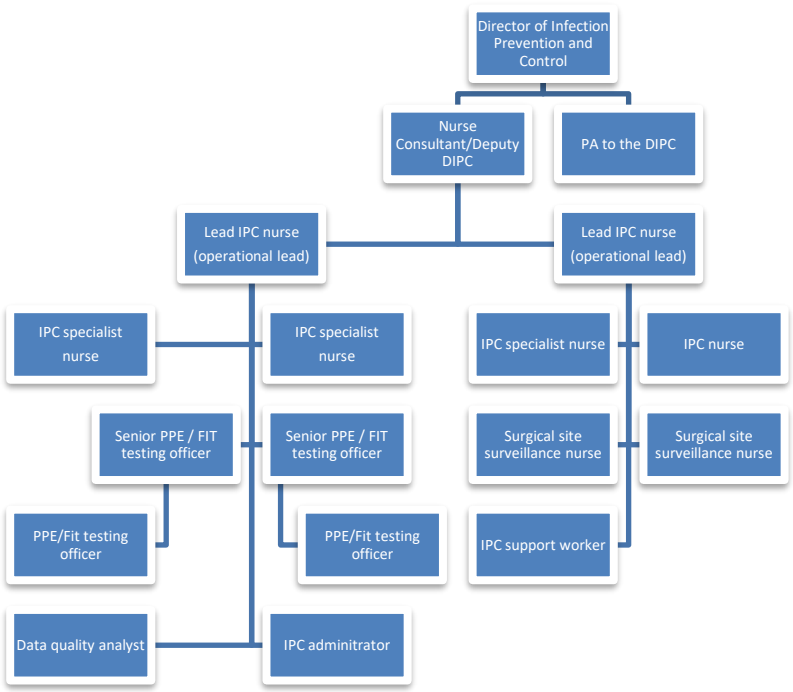
1.1 IPC Governance

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

The Director of Infection Prevention and Control (DIPC) is a consultant microbiologist with specific training and experience in infection prevention and control and reports directly to the Chief Executive Officer.

The DIPC is supported by the Deputy DIPC (Nurse Consultant in Infection Prevention and Control) and the IPCT (Fig 1).

Fig 1: Structure of the Infection Prevention and Control Team 2022-2023



The Trust Board receives a monthly IPC update as part of the SDR process. *C. difficile,* COVID-19 and MRSA and *E. coli* blood stream infection numbers and rates are detailed on the Board level dashboard together with non-elective MRSA screening rates. Since June 2020, the board has also received the COVID-19 IPC Board Assurance Framework on a monthly basis or more latterly at times of change due to updated guidance.

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

Kent and Medway ICB were MTW's main commissioning organisation during 2022/23. IPC is a key element of quality commissioning and forms part of quality schedule 4. The MTW DIPC has been Senior Responsible Officer for IPC in Kent and Medway since September 2021.

The *C. difficile* and MSSA root cause analysis reports from Trust attributable cases of *C. difficile* and MSSA blood stream infections are reviewed by the IPCT a root cause agreed and learning identified. A bi-annual summary report of outcomes of HCAI RCA is

reported to the IPCC. Learning is shared through directorate clinical governance meetings.

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

1.2 Infection Prevention and Control Committee

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

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

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

The objectives of the IPCC include:

- To advise and support the Infection Prevention and Control Team.
- To provide assurance to the Quality Committee with respect to infection prevention and control structure, processes and outcomes and compliance with CQC requirements as set out in the 'Hygiene Code' (The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance).
- To inform the Quality Committee in a timely manner of any serious problems or hazards relating to infection control.
- To receive reports from the Infection Prevention and Control Team.
- To monitor Healthcare Associated Infection against key performance indicators including receiving reports on compliance data from Directorate representatives.
- To discuss and approve Infection Prevention and Control policies.
- To review the annual infection control programme and audit programme.
- To ensure the implementation of national guidance, and action plans arising from Patient Safety alerts relating to Infection control
- To monitor progress against CQUIN targets related to infection control
- To provide assurance that in the event of a pandemic, national or regional outbreak of infection, the Trust has measures and training in place to maintain the safety of all staff and patients.

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

1.3 Surveillance

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

The IPCT uses the ICNet surveillance system.

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

MTW is a Sentinel site for reporting Influenza infection and also reports on cases of Respiratory Syncytial Virus (RSV) through the same reporting route. The Business Intelligence team took over the data gathering and submission for the 22/23 winter period.

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

1.3.1 Alert organisms

MRSA	*Salmonella* spp	Group A *Streptococcus*	*Aspergillus*
Clostridioides difficile infection (CDI)		Glycopeptide-resistant *Enterococci*	*Influenza*
Campylobacter spp	*Mycobacterium tuberculosis*	*Neisseria meningitidis*	*Norovirus*
Multi-resistant gram-negative bacilli e.g. extended spectrum beta-lactamase (ESBL)producers			
Carbapenem resistant and Carbapenemase-producing Enterobacteriaceae (CRE/CPE)			
Hepatitis A	Hepatitis B	Hepatitis C	

1.3.2 Alert Conditions

Measles	Mumps
Chicken pox and Shingles	Scabies
Two or more possibly related cases of acute infection e.g. gastroenteritis such as norovirus	

The national HCAI objectives for MTW for 2022/23 set by NHSE were:

- MRSA – a continued zero tolerance to all MRSA blood stream infections
- CDI – to have no more than 62 patients with Trust-attributable CDI.

In addition the HCAI action plan set out to:

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

1.4 *Staphylococcus aureus*

All *Staphylococcus aureus* blood stream infections, whether sensitive to Meticillin (MSSA) or resistant to Meticillin (MRSA), are reported on a mandatory basis through the UKHSA HCAI Data Capture System (DCS). The Trust's incidence of MSSA and MRSA cases is publicly reported on the fingertips data base together with other HCAI data AMR local indicators - produced by the UKHSA - Data - OHID (phe.org.uk)

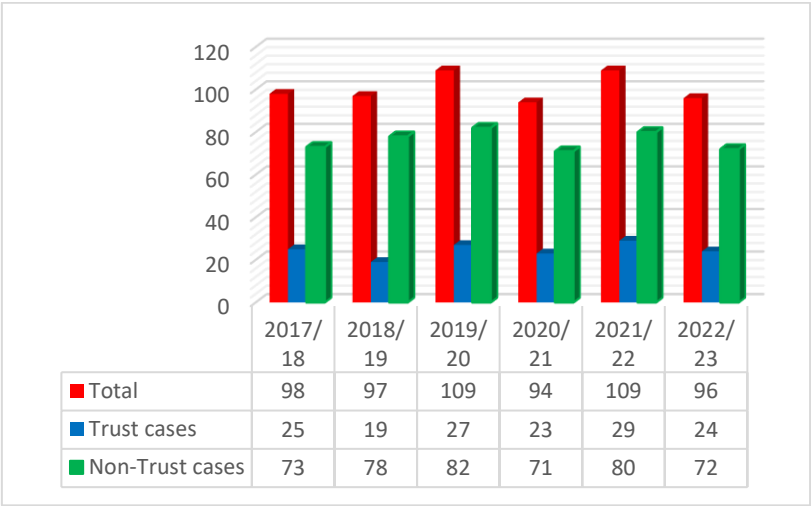
The incidence of these cases is reported publicly as acute Trust attributable or otherwise. The reduction of all avoidable blood stream infections including MSSA and MRSA continues to be an aim of the Trust

1.4.1 MSSA

There is no national objective set for MSSA bacteraemia.

All Trust-attributable (those occurring from day 2 after admission) cases of MSSA blood stream infection have a post–infection review including root cause analysis and review by the Infection Control table top exercise, feeding back learning to ward teams and matrons.

Fig 2: MSSA bacteraemia cases

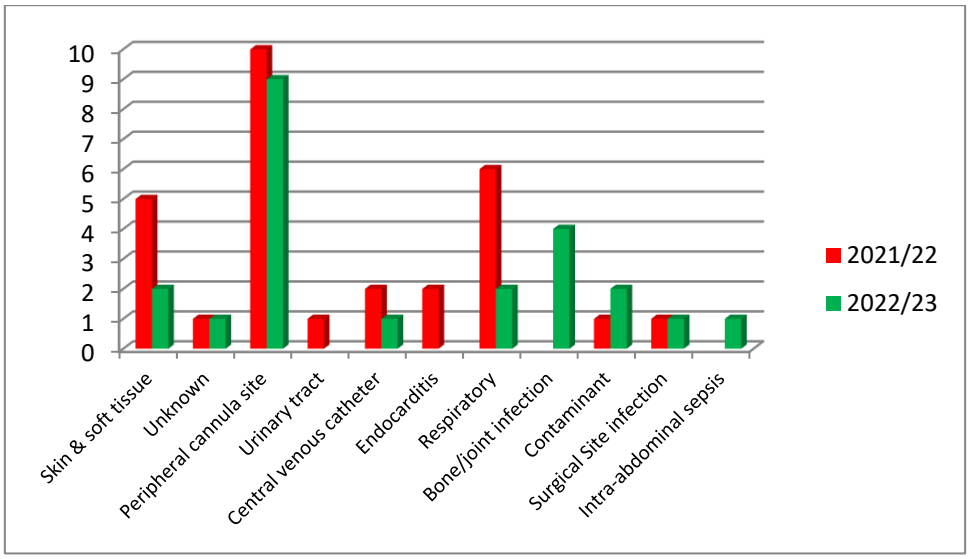


	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Total	98	97	109	94	109	96
Trust cases	25	19	27	23	29	24
Non-Trust cases	73	78	82	71	80	72

The numbers of hospital attributable cases seen decreased to 24 over the year, a rate of 9.6 per 100 000 bed days compared with an England benchmark rate of 11.0. Of the 24 cases, 10 were avoidable and 8 of these associated with peripheral and central line infections.

A Quality Improvement project will be undertaken in 2023/24 to improve cannula care. A successful bid for funding for a project nurse has been made to the K&M ICB.

Figure 3: MSSA bacteraemia root cause 2021/22 – 2022/23



1.4.2 MSSA screening

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

1.4.3 MRSA

There was no national HCAI objective for MRSA blood stream infections for 2022/23. However there was an expectation that no avoidable infections would be seen.

Cases are initially defined as non-trust apportioned if blood cultures are collected on the day of admission or the next day. All other cases are apportioned to the Trust. A Post Infection Review (PIR) is carried out on all cases and the Trust investigates every MRSA blood stream infection in collaboration with other care providers associated with the case. This process identifies lessons to be learned across the patient's pathway and determines the final assignment of the case to the ICB, Trust or Third Party.

The Trust has reported three non-Trust apportioned cases and three Trust apportioned cases for 2022/23.

One Trust-apportioned case appears in the data twice having an initially community acquired infection which required a prolonged stay in hospital and relapsed after 28 days.

The second case was deemed unavoidable on investigation as it related to a cannula placed in the community and removed appropriately after the patient was admitted. The patient later developed a cannula site infection.

The third case was thought to be a contaminant on further investigation

1.4.4 MRSA screening

The Trust continues to use a robust approach to screening the majority of patients, either pre-operatively or on admission. Since 2009, it has been Trust policy to screen all elective admissions (except for certain excluded groups) to comply with Department of Health and Social Care policy. The policy is reviewed when new guidance is published. Further guidance was published in December 2021: *Joint Healthcare Infection Society (HIS) and Infection Prevention Society (IPS) guidelines for the prevention and control of meticillin-resistant Staphylococcus aureus (MRSA) in healthcare facilities* which clarified earlier guidance but did not require any material changes to be made to the MTW policy.

Rates of MRSA infection and colonisation amongst elective patients have remained relatively low and a protocol is in place for decolonisation prior to admission and surgery.

Non-elective patients who are colonised are usually identified from screening swabs within 24 hours of admission. Some colonised patients are also identified as a result of clinical samples. Early detection allows effective decolonisation of the patient to be started in a timely manner, reducing the risk of infection and spread to other patients. Patients who remain in hospital for more than a week are rescreened on a weekly basis. Patients who are known to be colonised are commenced on the decolonisation protocol on admission.

Figure 4: New MRSA colonisations 2015-22

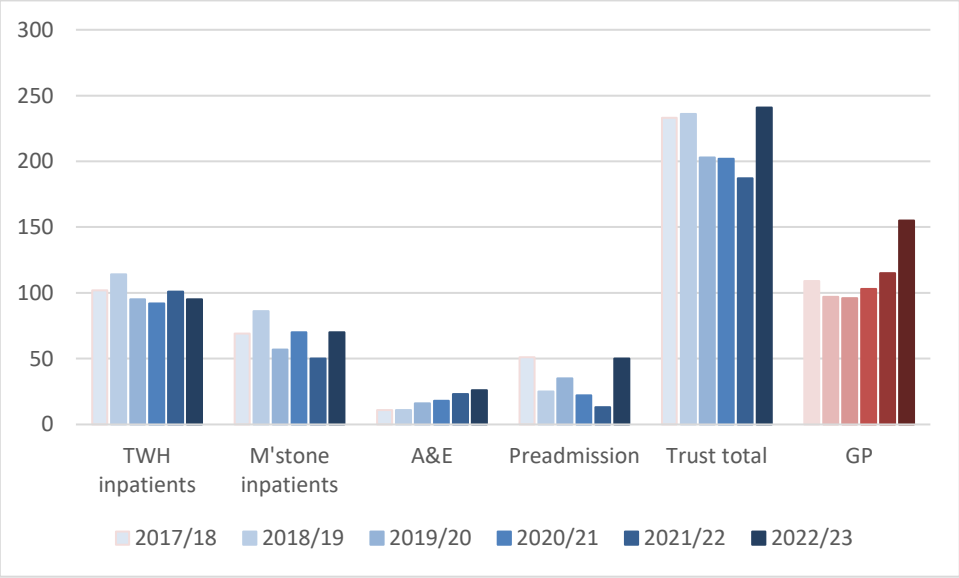
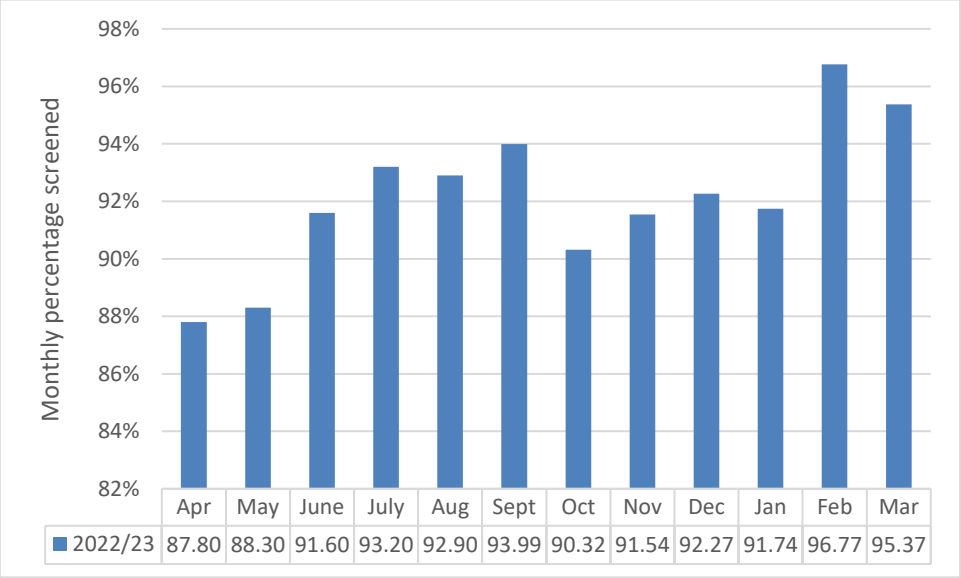


Fig 5: MRSA non-elective admission screening 2022/23v



The number of patients who may have acquired MRSA colonisation in hospital is also monitored and investigated. For 2022/23, 19 such cases were identified at Maidstone Hospital and 19 cases at TWH. There were several investigations into possible cross infection with one episode proven.

1.4.5 Periods of Increased Incidence

Where two or more new (post 48 hour) acquisitions (whether related or not) of MRSA colonisation are identified by screening on the same ward within 28 days, a Period of Increased Incidence (PII) is declared for the ward where the acquisitions occurred. A single case of MRSA bacteraemia will also trigger a PII.

When the PII is declared the following actions are taken:

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

1.5 *Clostridioides difficile* infection (CDI)

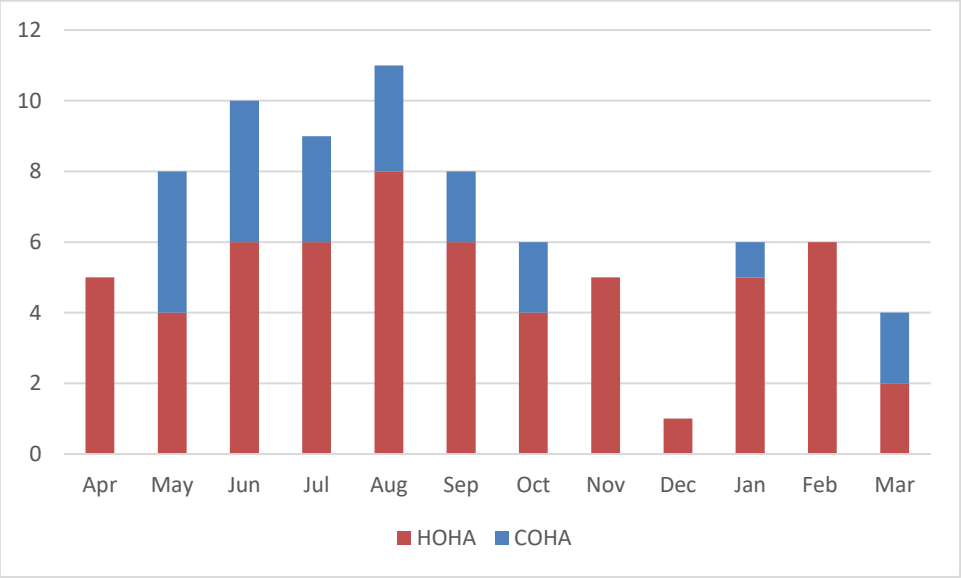
The CDI NHS standard contract objective for MTW for 2022/23 was to have no more than 62 cases.

Cases are designated into one of four groups:
Hospital-onset healthcare-associated (HOHA) - Date of onset is ≥ 2 days after admission (where day of admission is day 1)

Community-onset healthcare-associated (COHA) - Date of onset is < 2 days after admission and the patient was admitted to the trust in the 4 weeks prior to the current episode
Community-onset indeterminate association (COIA) - Date of onset is < 2 days after admission and the patient was admitted in the previous 12 weeks, but not the previous 4 weeks prior to the current episode
Community-onset community-associated (COCA) - Date of onset is < 2 days after admission and the patient had not been admitted to the trust in the previous 12 weeks prior to the current episode.

In 2022/23 a total of 79 Trust attributable cases were seen, 58 HOHA cases and 21 COHA cases, a rate of 24.5 HOHA cases per 100 000 bed days (compared with 17.3 for the previous year and an England rate of 20.3).

Figure 6: *C. difficile* HOHA and COHA cases

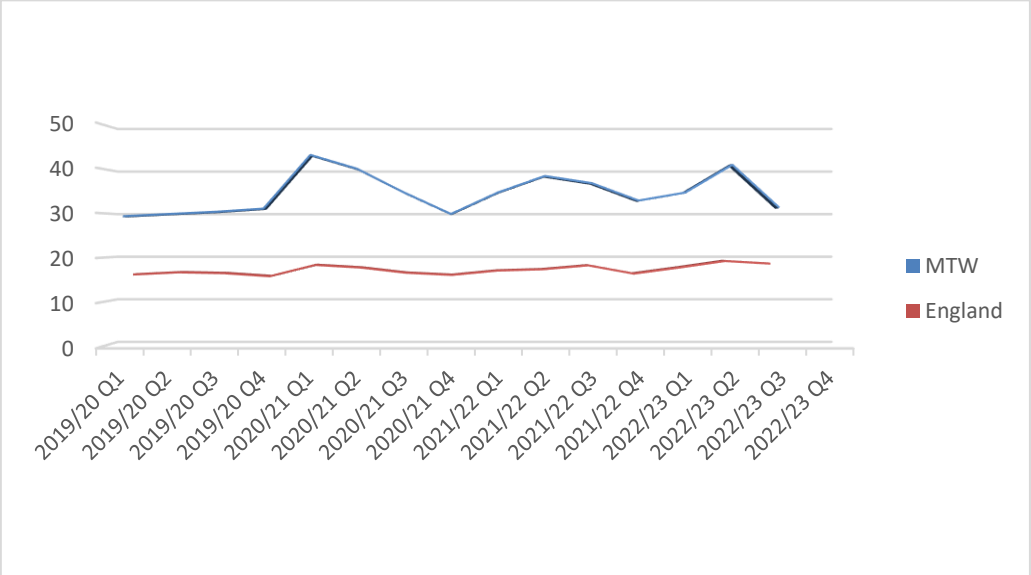


The increase in the rate of cases reflected a wider increase in cases across England and Kent and Medway in particular.

1.5.1 Laboratory Diagnosis

C. difficile tests are processed on diarrhoea samples according to national guidelines. During 2022/23, the microbiology laboratory processed 9174 samples for *C. difficile* including those from GP patients, inpatients in acute or community settings, MTW A&E and outpatient attenders.

Figure 7: *C. difficile* toxin tests per 1000 bed days compared with England average 2019/20 to 2022/23



168 patients were newly identified as carriers of toxigenic *C. difficile* (199 in 2021/22).

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

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

1.5.2 Case review

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

Root cause analysis multidisciplinary meetings are held for all HOHA and COHA cases. This enables any lessons associated with cases arising in the community to be learned and ensures that the impact of inpatient treatment on patients is understood.

Root causes are confirmed following a table top review exercise by senior members of the IPCT.

The outcomes of root cause analysis shown in the table below

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

Cross infection	Inappropriate antibiotics	Appropriate antibiotics	Relapse	Community antibiotics	Unknown
2	14	48	7	2	6

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

The root cause analysis process identifies if there are any lapses in care and the main areas for learning are:

- Delay in sending stool specimen
- Referral to microbiologist for prescribing advice
- Diarrhoea rapid risk assessment not completed
- Incomplete documentation on stool charts
- *C. difficile* risk assessment not completed

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

1.5.3 Periods of Increased Incidence

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

At MTW a PII is declared for the ward area whenever a new case of *C. difficile* is diagnosed.

In response to the PII declaration, several actions have to be taken including structured IPC audits, antimicrobial prescribing audits, additional cleaning and support and education from the IPCT

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

During 2022/23, fifty-one PIIs were declared for *C. difficile*, twenty-six at Maidstone and twenty-five at TWH. Three PIIs were re-declared due to standards not being maintained after initial closure. Eight wards had two PIIs during the year, five wards had three and three wards had four.

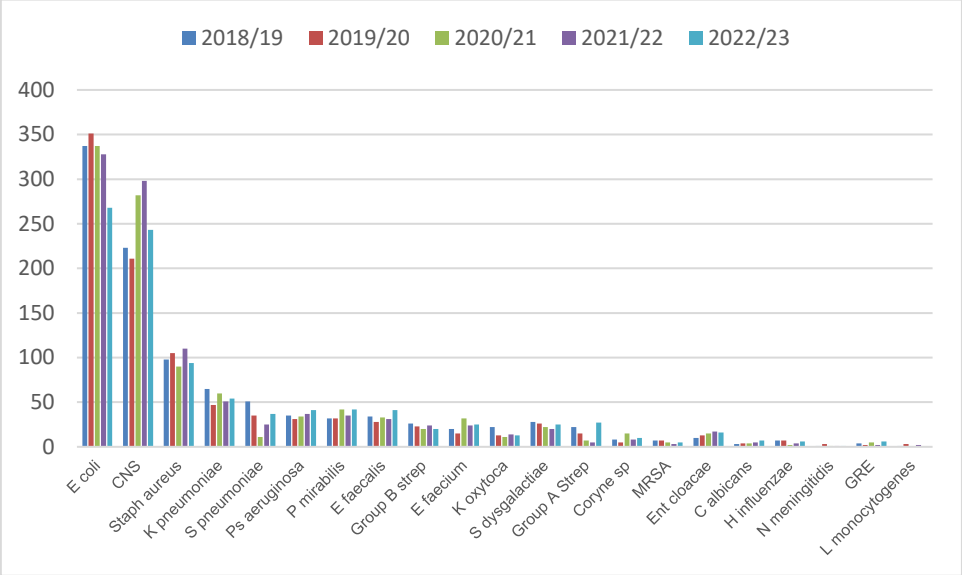
1.5.4 Non-Trust attributed CDI cases

There was a decrease in the number of patients with non-Trust attributable CDI from 65 cases in 2021/22 to 60 cases in 2022/2023

1.6 Blood stream infections

A total of 1026 patients had positive blood cultures during 2022/23, a decrease (of 90 patients) on the previous year. *E. coli* is the commonest organism causing blood stream infection in the Trust accounting for around 13% of all positive cultures.

Figure 8: Commonest significant isolates from Blood cultures 2018-2023



Some isolates are seen in small numbers but are highly significant for their ability to cause severe infection. They include *Neisseria meningitidis* (a cause of meningitis), MRSA and glycopeptide resistant *enterococcus.* Of note there was a significant increase in the number of Group A streptococcus blood stream infections (5 cases increased to 27) and this was reflective of the national outbreak at the end of 2022

1.6.1 Gram negative blood stream infections

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

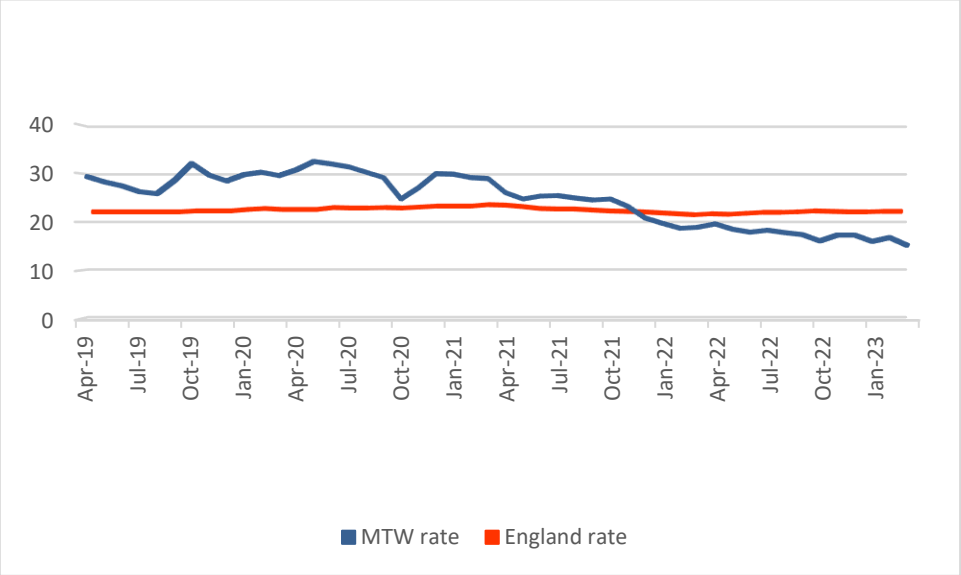
- *E. coli*
- *Klebsiella species*
- *Pseudomonas aeruginosa*

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

1.6.2 *Eschericia coli (E. coli)* bacteraemia

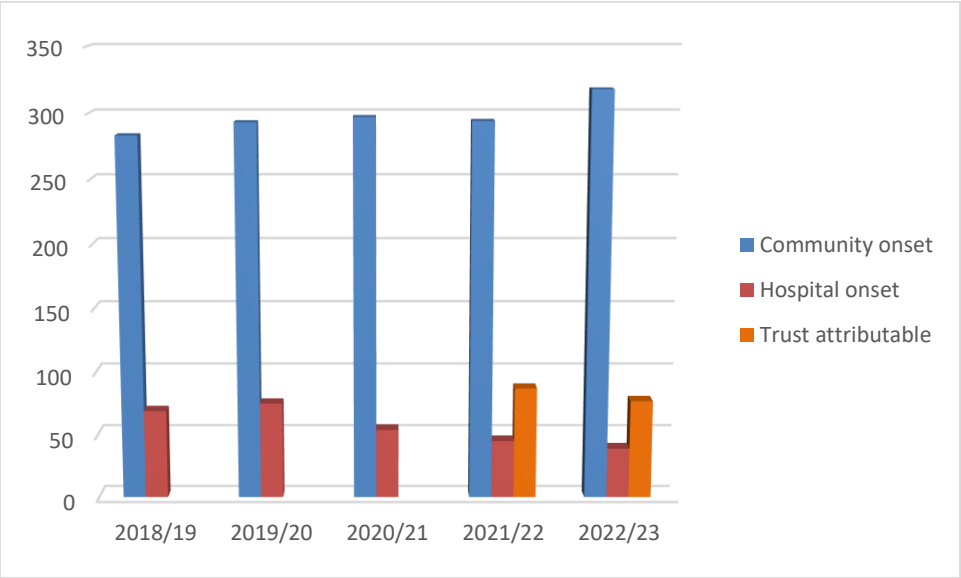
E. coli bacteria are frequently found in the intestines of humans and animals. There are many different types of *E. coli* and while some live harmlessly in the intestine, others may cause a variety of diseases. *E. coli* bacteraemia may be caused by primary infections such as urinary tract infections, biliary tract infections and others, spreading to the blood. The MTW rate of *E. coli* infections for 2022/23 was 15.2/100 000 bed days compared with an England rate of 22.2/100 000 bed days, a significant reduction from the rate in 2021/22 of 18.9/100 000 bed days.

Figure 9: Hospital onset rates of *E.coli* bacteraemia (12 month rolling rate)



The rate of *E. coli* bacteraemia in hospital and in the community has decreased following interventions such as improvements in urinary catheter management.

Figure 10: Cases of *E. coli* bacteraemia 2016-2022



For 2022/23, UKHSA began to apply the same definitions to cases of blood stream infection as for C. difficile depending on when the cases arise. Cases arising in the community which occur within 28 days of discharge from the reporting Trust are classified as Community onset healthcare associated and are Trust attributable. This is demonstrated in Figure 10.

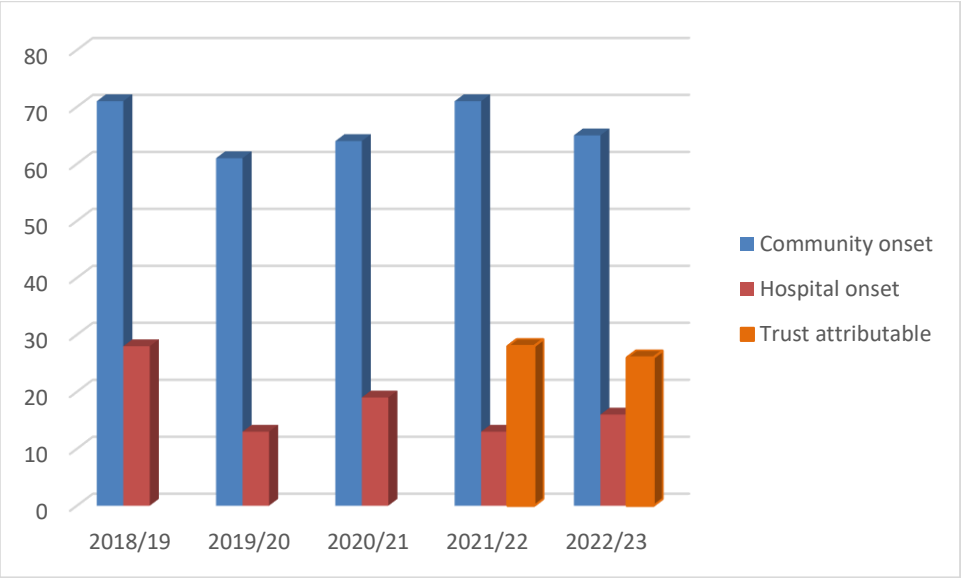
Previous actions taken to reduce the rate of *E. coli* bacteraemia have been continued in 2022/23 and is having an impact on healthcare acquired infections at MTW.

Further measures are outlined in the HCAI reduction plan for 2023/24.

1.6.3 *Klebsiella* species bacteraemia

Klebsiella species are gram negative rod-shaped bacteria which are ubiquitous in the environment and are found in the human gut. Three main species cause the majority of human infection; *K. pneumoniae, K. oxytoca* and *K. aerogenes.* Common presentations include ventilator-associated pneumonia (VAP), wound infections and urinary and biliary tract infections.

Figure 11: *Klebsiella* bacteraemia cases 2018-22



1.6.4 *Pseudomonas aeruginosa* bacteraemia

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

In a healthcare setting pseudomonas can contaminate devices that remain moist such as respiratory equipment and catheters but also ice-making machines and equipment with a water reservoir. It can also cause outbreaks where there are contaminated water systems. Cases remain low with 42 cases seen in total, with 16 hospital onset cases and a total of 30 Trust attributable cases.

1.7 Glycopeptide resistant Enterococci (GRE)

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

A screening programme amongst haematology patients was put in place in March 2014 with all haematology patients screened on admission and discharge. 29 carriers of GRE

were newly identified in this group from April 2022 – March 2023. Identification of carriers enables antibiotic regimens to be tailored to individual patients depending on their carrier status, improving patient safety. Knowledge of the carriage rate is alo helpful in recognising any increase of concern and planning action to prevent the organism becoming endemic in our hospitals.

Although the incidence of GRE infection has always been very low at MTW, with just four healthcare associated blood stream infections recorded in 2022/23, it is known that other Trusts in the region have endemic GRE and patients can acquire long-term carriage of this organism.

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

ESBL organisms have the capability to produce enzymes which break down some of the more commonly used antibiotics. The numbers of patients developing infections with these organisms has been rising steadily over the last few years. A number of these organisms also have other mechanisms of resistance which can in some cases severely restrict the choice of antibiotic and may lead to admission to hospital for intravenous antibiotics because there are no options for oral treatment.

Surveillance has been ongoing in the Trust since 2007. Earlier retrospective data shows that these organisms were seen at the Tunbridge Wells end of the Trust earlier than at Maidstone although the numbers seen at each hospital and the new acquisitions for inpatients are staying steady. Most patients affected will carry the organism in their gut and as a result, urinary tract infections are the most commonly seen and account for around 90% of cases.

Figure 12: New ESBL cases 2013 - 2023

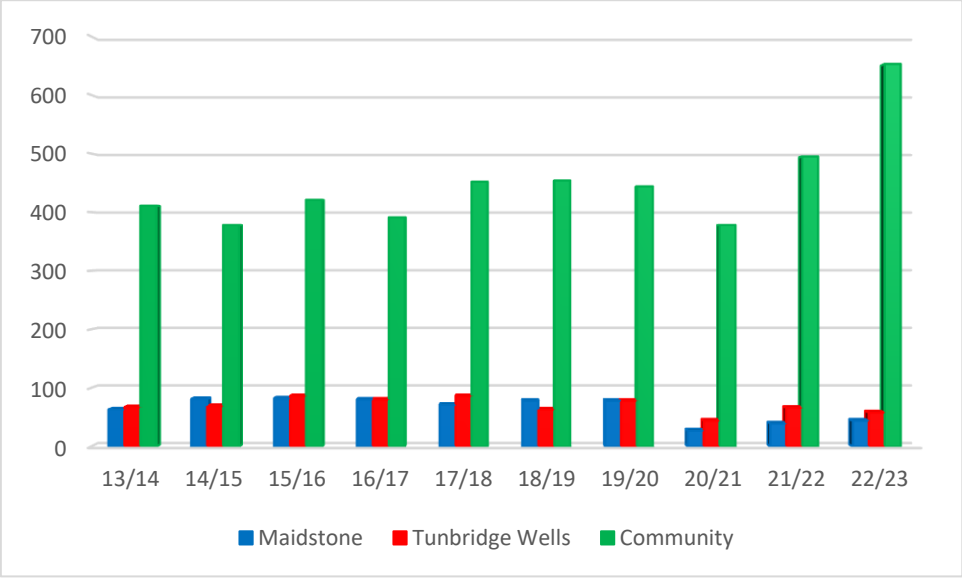
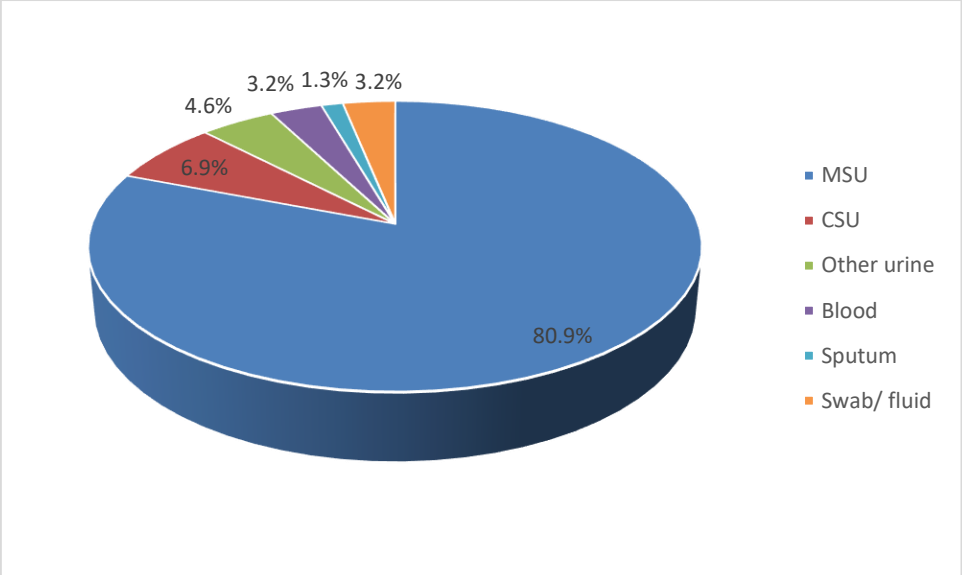


Figure 13: New ESBL isolates by specimen type 2022-23



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

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

All Trusts have been required to have a screening programme for Carbapenem resistant organisms in place following a Patient Safety Alert in 2014. In 2022/23, 1212 CRE/CPE screening swabs were processed, slightly fewer than the previous year.

Updated guidance has been implemented which reduced the number of screens for an individual patient from three to a single swab, so the overall number of screening swabs remains lower than pre-pandemic numbers.

Three adult patients and one child were identified as carriers on admission screening, all had recently been inpatients in London hospitals. All necessary precautions were implemented according to the policy and there were no episodes of cross infection.

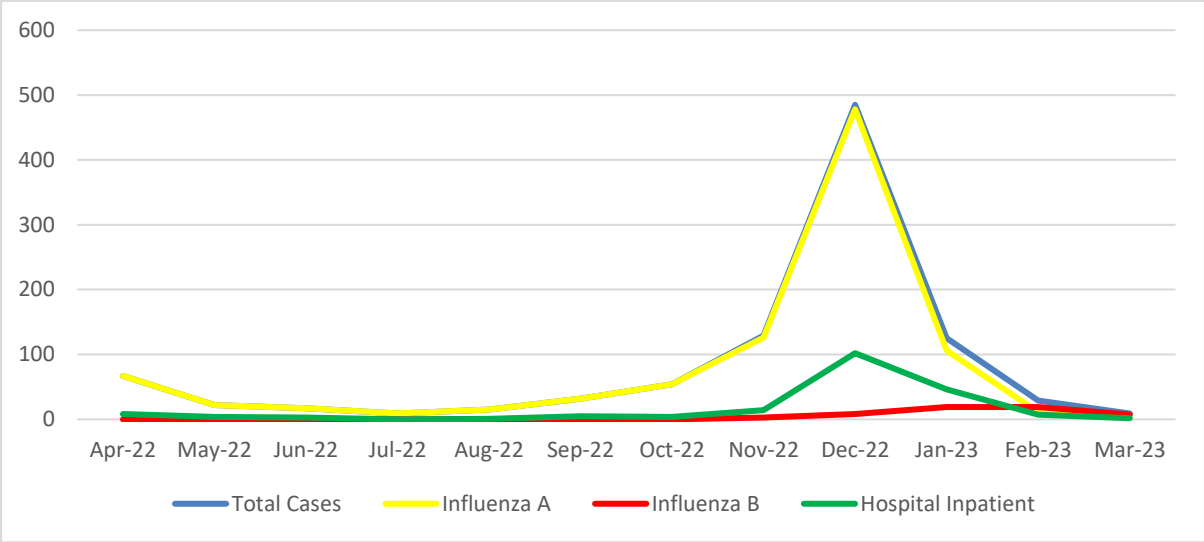
1.10 Influenza

The year was predicted to have high incidence of Influenza and the season started relatively early in October reaching a peak of admissions during the second half of December when 407 A&E patients tested positive for Influenza, resulting in 96 admissions.

Influenza A dominated with only a few Influenza B cases seen late in the season.

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

Figure 14: Influenza diagnoses and admissions 2022-23



1.11 Norovirus

The number of norovirus infections seen in hospital have been low for the third year in succession. No cases were seen until December 2022 and there were a total of 17 inpatient cases to the end of March. All except one case (a child) were seen at Maidstone Hospital

1.12 SARS-CoV-2 (COVID-19)

COVID-19 continued to dominate the work of the IPCT during 2022-23, despite most inpatients not having COVID as their primary diagnosis.

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

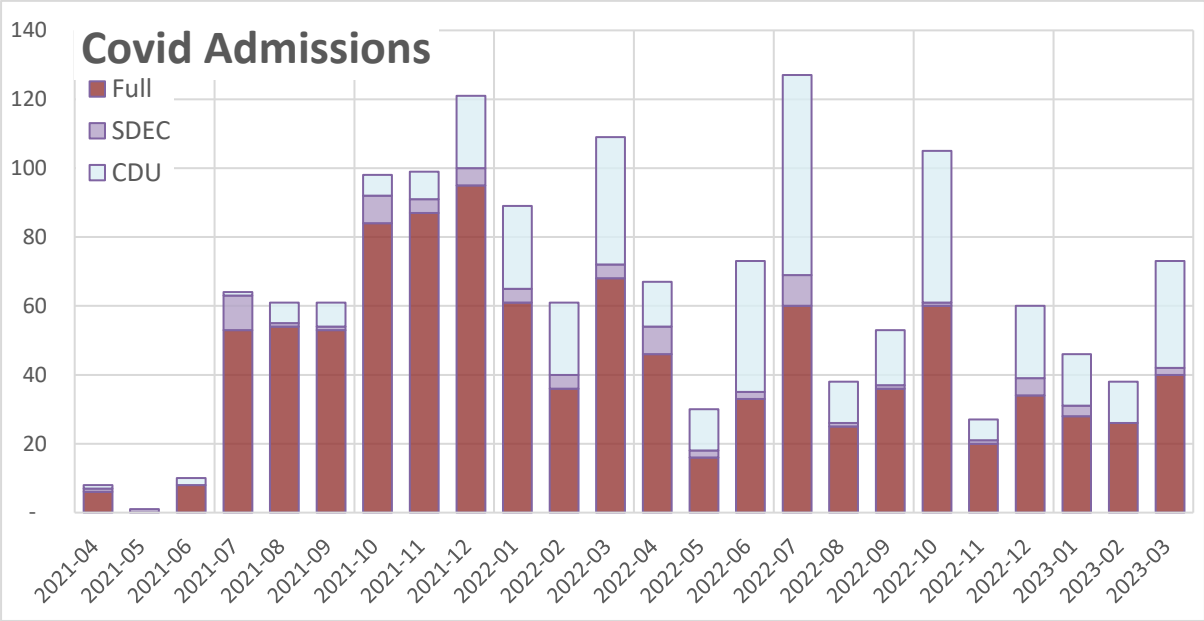
In May 22 MTW ceased compulsory mask wearing in most clinical areas and returned to pre-pandemic physical distancing.

On 31 August, as a result of changes to national guidance, asymptomatic testing of inpatients ceased apart from admission testing, outbreak investigation and discharge testing for those going into care settings.

Following a dip in patient numbers to a low of 6 inpatients on 6 September, numbers rose again and by 7 October there were 80 COVID positive inpatients in our hospitals, with increasing numbers of cases in the community and increasing numbers of outbreaks involving both patients and staff in both hospitals. This was in the context of an autumn booster campaign for staff and high occupancy and acuity within the hospitals.

Many COVID positive patients seen and diagnosed in A&E were managed through SDEC and avoided admission

Figure 15: COVID positive admissions by week April 2021 – March 2023



As a result of the increase in patient numbers in October, universal mask wearing was reintroduced in public areas and clinical areas and placement of COVID and influenza patients in both hospitals was clearly defined. Non-elective pathways were developed for respiratory and non-respiratory patients to ensure separation.

Mandatory mask wearing for staff and visitors (apart from for those caring for immunosuppressed patients and patients on the respiratory pathway) was stepped down on 1 March 2023. Masks continue to be provided for those who wish to wear them.

Untoward Incidents and Outbreaks

1.13.1 SARS-CoV-2 (COVID-19)

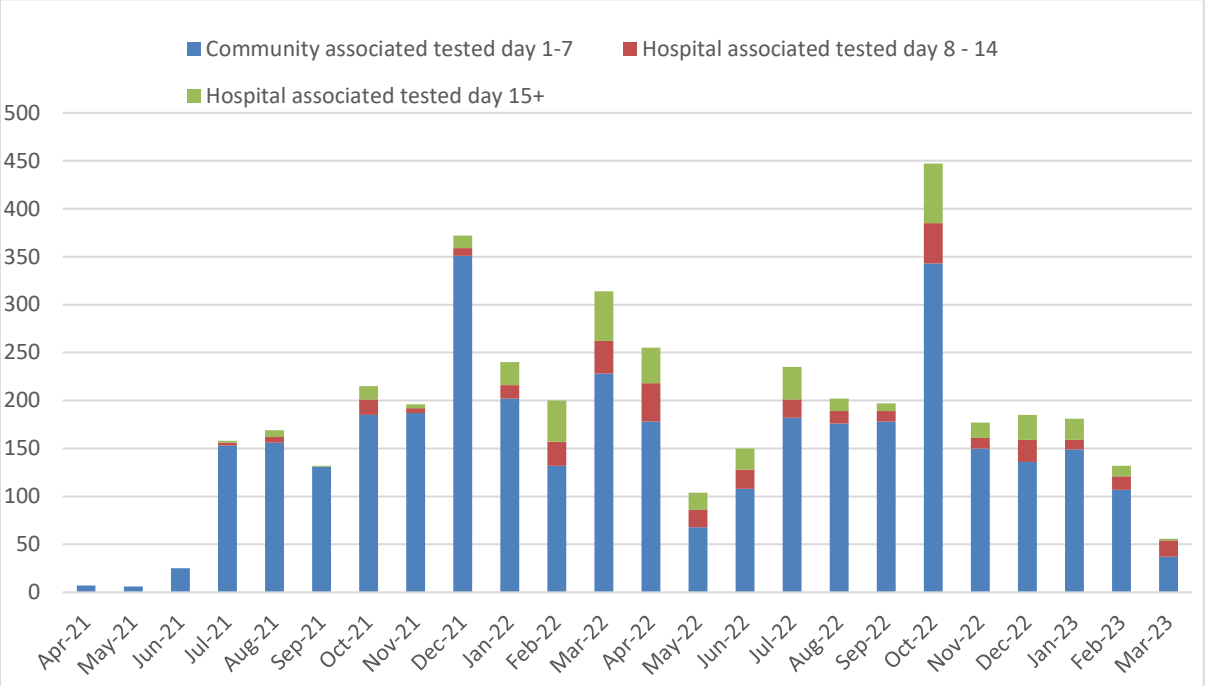
Outbreaks of COVID are difficult to prevent because of the highly transmissible nature of the virus. Infection prevention measures have been in place throughout the pandemic to minimise the risk of nosocomial (hospital acquired) COVID infection. These have included patient pathways to stream COVID and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

As new variants of COVID have emerged which more commonly cause asymptomatic infection, the control of infection in hospital, especially where patients are cared for in bays, has become more difficult. Exposed patients are ‘quarantined’ and are tested if they become symptomatic.

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

Sixty ward-based outbreaks of COVID were identified from April 2022 to March 2023.

Figure 16: COVID positive inpatients April 21-March 23



1.13.2 *C. difficile*

A Trust-wide increase in *C. difficile* cases was seen in 2022 with cases peaking in August 2022. In response, Trust-wide incident meetings were held to develop a recovery plan called 'Back to Basics'.

Actions included additional training, engagement with staff to take ownership of IPC standards, improving cleaning and ensuring effective reporting to wards, directorates and divisions.

All outbreak management procedures were followed and additional infection control support and training was been given to the ward staff.

1.13.3 Group A Streptococcus (GAS)

In December 2022, reports of Group A streptococcus infection, including tonsillitis and scarlet fever, rapidly increasing were issued. Parental concerns led to a large increase in attendances to our Emergency Departments and new guidance was issued by UKHSA for management of any cases presenting during this period. Nationally, 10000 cases of scarlet fever were reported in one week in the second week of December. (Fig 15)

A new point of care test was introduced to facilitate the demand management. Positive swabs were confirmed by laboratory testing (see Figure 16).

Figure 17: Scarlet fever notifications in England 2017-2023

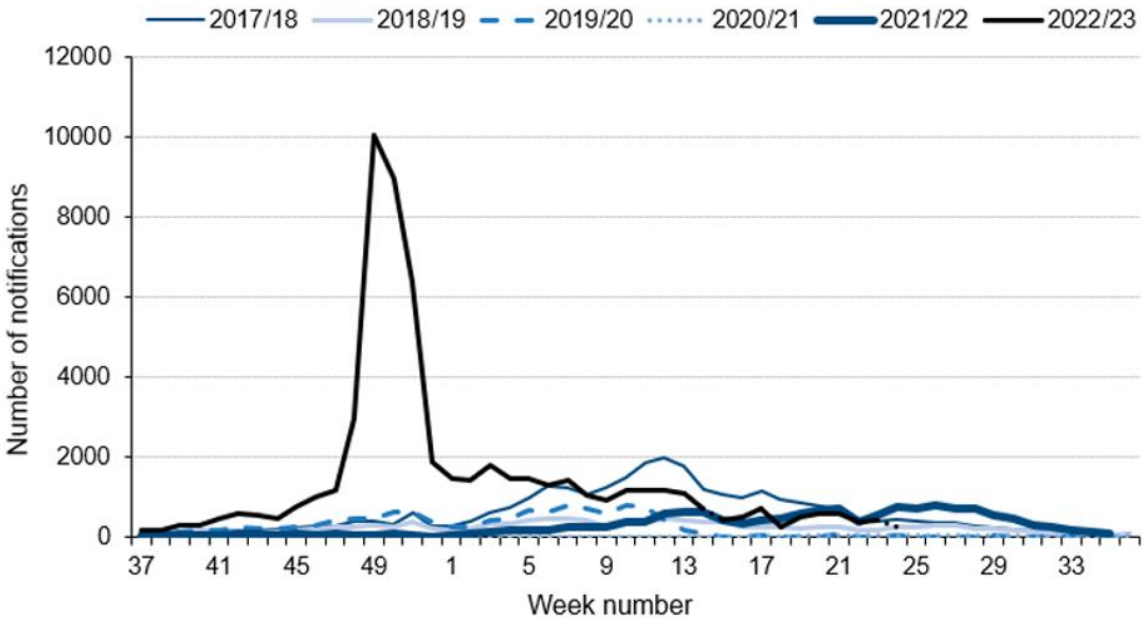
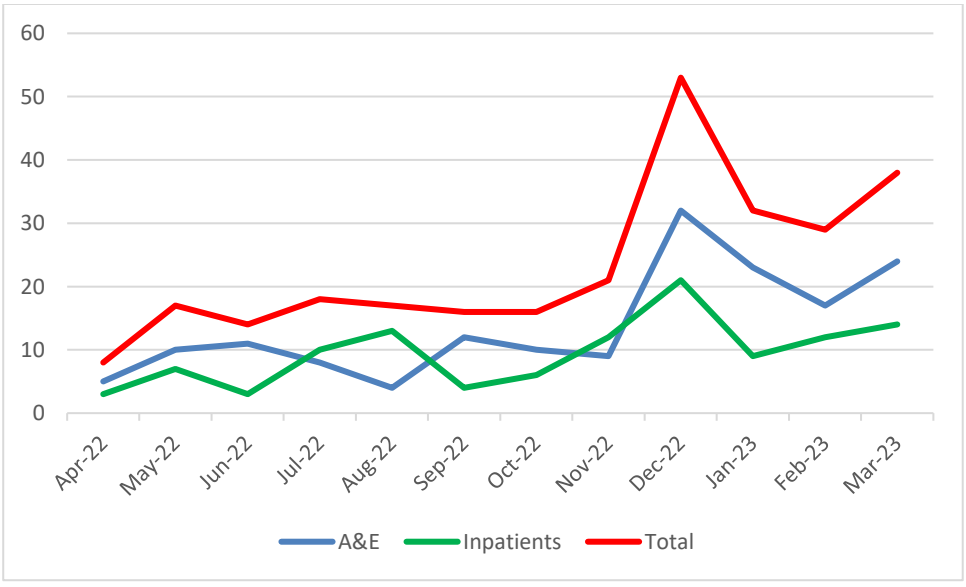


Figure 18: Group A streptococcus laboratory isolations



1.13.4 Influenza

Influenza patients who are identified on admission are isolated or cohorted to prevent contact with other patients. Where contact inadvertently occurs, prophylactic anti-viral medication is given to patients to prevent or modify infection.

There were four outbreaks of influenza affecting a total of seven patients.

1.13.5 Norovirus

There were four small outbreaks of norovirus at Maidstone hospital in March 2023. The common risk factor for all was symptomatic visitors. A total of 13 patients and two staff were affected.

Mandatory Surveillance of Surgical Site Infections

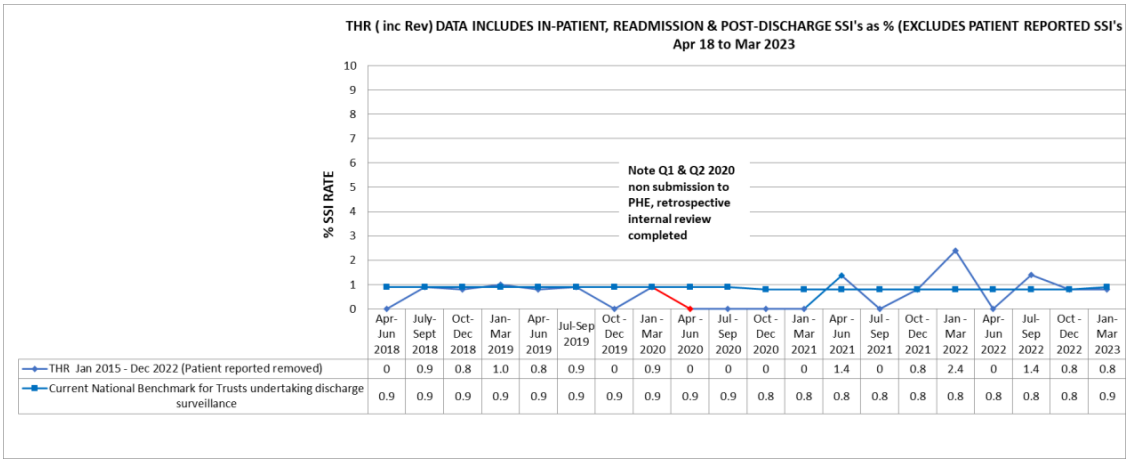
1.13 Orthopaedic surgery

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

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

Patients are monitored for the first 60 days and infection rates monitored for up to a year post operatively. Monitoring is completed on inpatients and also by post-discharge surveillance through hospital readmission, outpatient review and patient discharge questionnaires. MTW completes the mandatory surveillance of elective total hip and total knee surgery, fractured neck of femur continuously throughout each year. Patient-reported SSIs are not included in the SSI performance data as no infection has been proven. However, these infections are monitored and captured as part of the ongoing surveillance reports.

Fig 19: Results for elective hips

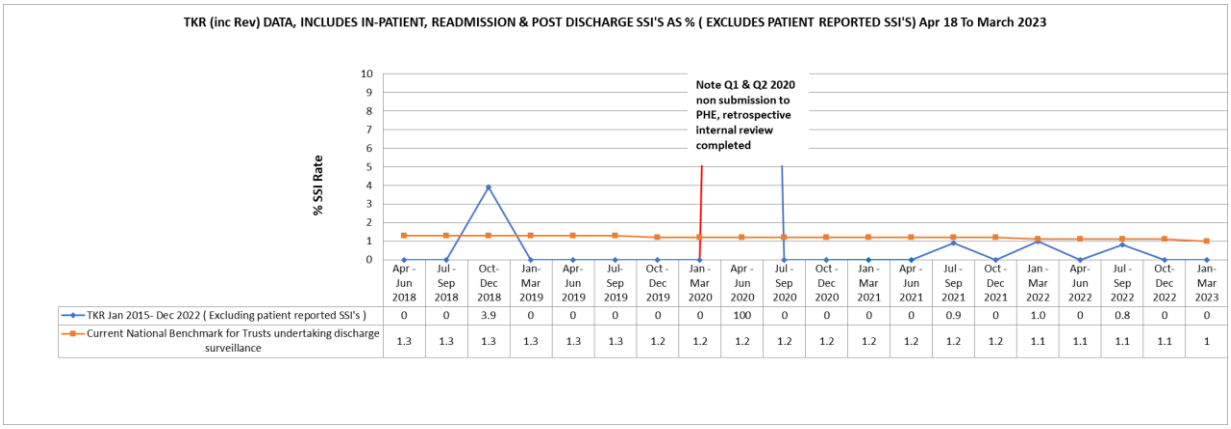


	Apr-Jun 2018	July-Sept 2018	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	Oct-Dec 2020	Jan-Mar 2021	Apr-Jun 2021	Jul-Sep 2021	Oct-Dec 2021	Jan-Mar 2022	Apr-Jun 2022	Jul-Sep 2022	Oct-Dec 2022	Jan-Mar 2023
THR Jan 2015 - Dec 2022 (Patient reported removed)	0	0.9	0.8	1.0	0.8	0.9	0	0.9	0	0	0	0	1.4	0	0.8	2.4	0	1.4	0.8	0.8
Current National Benchmark for Trusts undertaking discharge surveillance	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.9

Three infections have been reported in year, two in Q2 and one each in Q3 and Q4 from a total of 538 procedures, an overall rate of 0.7%.

All surgical site infections are subject to case review at the orthopaedic clinical governance meeting to identify learning and actions.

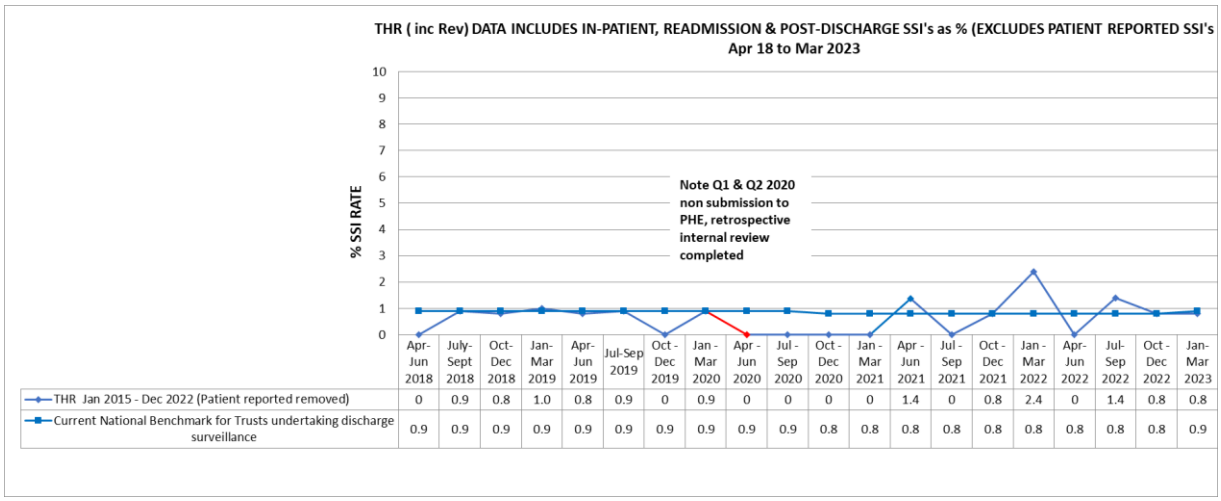
Fig 20: Results for elective knees



The overall infection rate for 2022/23 is 0.26% with 1 infection out of 389 total knee replacements.

The national average SSI rate in this group is 1.1%.

Figure 21: Results for repair of fractured neck of femur



The overall infection rate for 2022/23 is 1.8% with 9 confirmed infections from 500 repairs of fractured neck of femur.

Work to address the higher than average rate of infections continues and all cases are reviewed by a consultant surgeon and a multi-disciplinary team.

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

Refurbishment and New Builds

2.1 Estates

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

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

Projects with which the IPCT have been involved include the plans for the CDC development, the new cardiology build, Acute Stroke Unit, the Kent and Medway Orthopaedic centre and various ventilation issues.

Work is ongoing to enhance the sign off process for large estates projects including IPC sign off of water and ventilation data.

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

Decontamination

2.2 Decontamination

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

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

Decontamination and high-level disinfection of flexible endoscopes is carried out in the endoscopy departments on both sites. The departments have maintained all requirements for both HTM 01-06 and the Joint Advisory Group (JAG).

The Trust laundry unit located off site at Parkwood continued to provide linen service to both of the Trust's hospital sites until 28 February 2023. The contract has now been awarded to a third-party provider. Monitoring processes are in place and the IPCC receives a report bi-annually.

Cleaning arrangements

2.3.1 Monitoring

The National Standards of Healthcare Cleanliness 2021 were introduced from April 2021 to replace the *National Specifications for Cleanliness in the NHS 2007*. The revised mandatory standards seek to drive improvements towards high quality and safe cleaning services contributing to the overall patient experience and care. The categories of risk have been expanded, requiring an improved and more robust auditing process to be put in place to ensure the healthcare environment is kept clean to the levels required and expected.

MyAudit is a digital compliance system used to support cleanliness auditing, based on the functional risk of an area and covering the 50 elements guidance. The new standards will continue to see regular audits taking place, with public facing cleanliness star ratings now required to be displayed.

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

2.3.2 Cleaning levels

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

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

Table 2: Annual cleans for Maidstone and Tunbridge Wells Hospitals 2022-23

Tunbridge Wells

	Level 2 Discharge Cleans	Level 3 - Steams	Level 3 – UV's	Level 4 - FOGs
2021/22	43697	1434	3951	644
2022/23	39007	632	3182	581

Maidstone

	Level 2 Discharge Cleans	Level 3 - Steams	Level 3 – UV's	Level 4 - FOGs
2021/22	25719	713	1342	236
2022/23	28181	730	1289	273

At Maidstone there is a large increase in level 2 cleans which are routine for COVID discharge from a bay. There is also an increase in level 4 – FOGs likely due to the increased number of *C.difficile* cases

2.3.3 Deep Cleaning

The rolling deep cleaning programme continues to be interrupted by the very high bed occupancy on both sites as deep cleaning relies on having a decant ward to facilitate the process. Every UVC and HPV clean contributes towards the deep clean process and dirty utility and treatment rooms on both sites have been an area of focus this year.

Water Safety

2.4 Water Safety

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

Significant challenges with the water system at TWH, including the finding of legionella and pseudomonas on testing, have resulted in remedial works on the three main risers in order to re-balance the system and maintain the temperature of the hot water system at a safe level. This work involved switching off the water supply to wards and departments and has been carried out in a phased way to minimise the disruption to clinical services. The clinical operations team and the facilities team have worked collaboratively with Mitie to achieve the efficient management of this work. In order to protect patients from any contamination which may arise from the manipulation of the water system, point of use filters have been applied to all outlets in TWH together with enhanced surveillance of the system with testing of the water when filters are changed. Further work will be required during 2023/24 to complete the programme. If the water temperature cannot be maintained at the required 55°C, a secondary control measure such as chlorine dioxide dosing of the water system may be required. The IPCT continue to work closely with Mitie to ensure that any risks associated with the system are mitigated and patient safety maintained.

Legionella and pseudomonas water sampling is undertaken twice yearly at Maidstone Hospital as a minimum. Samples for both legionella and pseudomonas are taken from various outlets and supplies such as water tanks and calorifiers. The sampling points at

Maidstone Hospital have been reviewed and reconfigured so that every water system within the hospital is tested over a period of a year. Positive counts are recorded on the resampling action tracker, and recommendations undertaken in a timely manner. Prompt action to rectify issues identified enables all areas to return to operational use. Standard responses to high positive counts are established and where persistent high counts are found, despite remedial action, point of use filters are used whilst investigation into further remedial works proceeds.

The IPCT continues to be closely involved with issues related to water safety

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

Antimicrobial Stewardship

3. Antimicrobial Stewardship Group (ASG)

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

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

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

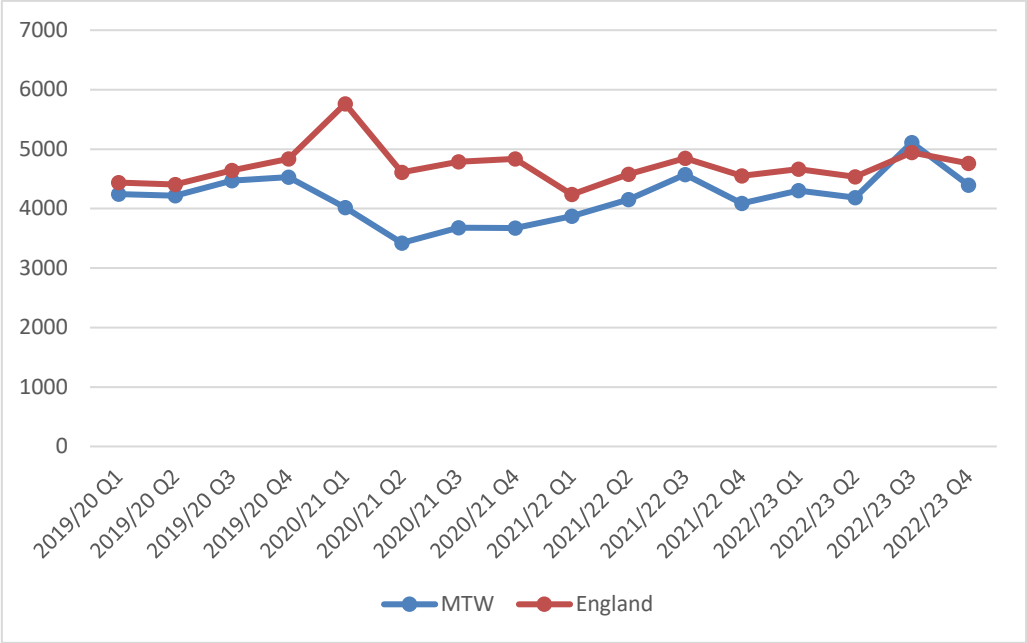
3.1 Antimicrobial Usage

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

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

Usage has not varied significantly despite the increase in bed occupancy and acuity seen during the year.

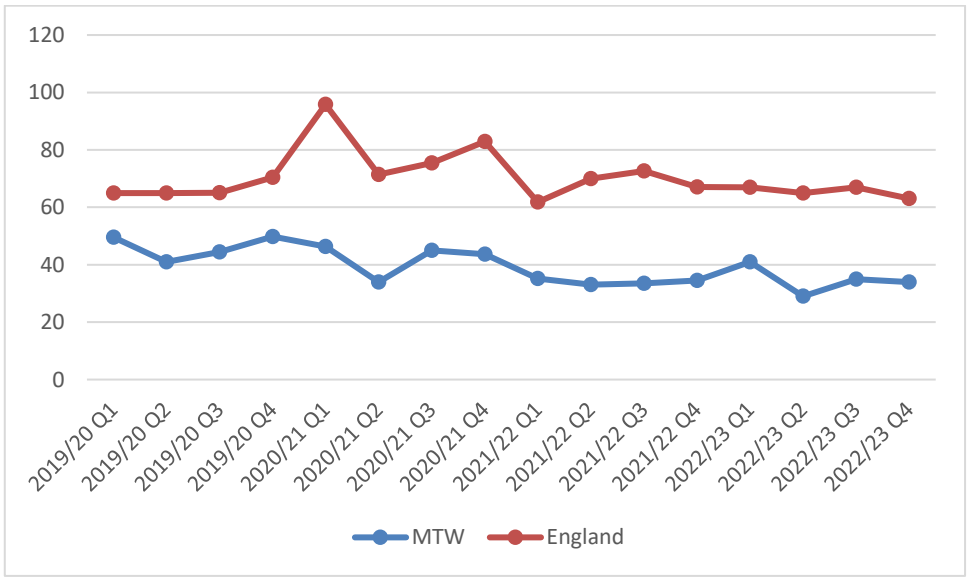
Fig 22: Total antibiotic prescribing DDDs per 1000 admissions by quarter



MTW remains below the national average for antimicrobial prescribing apart from Q3 which appears to be largely driven by prescribing of antibiotics for Group A streptococcal infection (Phenoxymethylpenicillin, amoxicillin and clarithromycin).

MTW prescribing of carbapenems is significantly below the England rate (Fig 23).

Fig 23: Carbapenem usage in DDDs/1000 admissions



3.2 Antimicrobial training and Education

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

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

3.3 Antimicrobial Audit

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

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

3.4 Antimicrobial CQUIN

The ASG had oversight for the 2022/23 antimicrobial CQUIN *Appropriate antibiotic prescribing for UTI in adults aged 16+.* The Trust achieved 83% compliance against an upper expected threshold of 60%.

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

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

During outbreaks or infection prevention incidents, duty of candour is completed for all patients affected either directly or indirectly.

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

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

Information is provided to external partners as appropriate including:

- Notifications of *C. difficile* cases and gram negative blood stream infections to the relevant CCG HCAI lead
- Electronic discharge notifications include MRSA status

- Inter-hospital transfer forms include information relevant to IPC
- Patients identified as *C. difficile* carriers or with *C. difficile* infection are issued with a 'green card' which advises other healthcare providers of their diagnosis and the importance of prudent antimicrobial prescribing
- IPC information is shared with GPs for information on a case by case basis
- COVID information is available for patients and visitors on the Trust internet site and advice is included within appointment and admission letters

The infection prevention team attend the site meeting at least daily to share information regarding IPC risks and concerns.

The daily executive strategic command call is attended by the DIPC and deputy DIPC or Lead IPC nurse to share relevant IP&C information in real time.

Compliance Criterion	What the registered provider will need to demonstrate
5	That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.

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

All urgent microbiology results are telephoned to clinicians to ensure prompt treatment and review.

Side rooms are actively managed by the Infection Prevention team and the Isolation Policy, including risk assessments for side room requirement and leaving doors open, is available on the Trust intranet.

The IPCT performs risk assessments for any potential infectious disease incident in the Trust. Contact tracing for both staff and patients is facilitated by the IPCT working with Occupational Health where necessary.

Policies are available for the management of patients with diarrhoea and a wide range of infectious diseases.

Patients are screened for MRSA, MSSA, GRE, CRE/CPE and COVID as appropriate (see Criterion 1).

An outbreak policy is in place and colleagues in UKHSA are available to assist with outbreak control if required.

Compliance Criterion	What the registered provider will need to demonstrate
6	Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

Staff Development and Training

The infection control team undertakes both formal and informal teaching as part of its training and education role. The formal face to face sessions were suspended during COVID and most formal training was transferred to e-learning with national packages used which cater for two different levels for staff working in clinical areas and those based in non-clinical areas. These national packages also include reference to COVID and PPE.

Some face to face training has been reinstated although clinical induction for non-medical staff remains virtual.

The frequency of training depends on individual's role; annual update for frontline clinical staff including domestics and porters, two yearly updates for clinical but non-patient facing staff and three yearly updates for non-clinical staff.

Compliance with training is above target for all groups: 86.8% for annual, 89.4% for two yearly and 93.3% for three yearly training.

The team also participates in the induction training for junior doctors with the DIPC leading the infection control training. The consultant microbiologists provide training in antibiotic prescribing during induction training. In addition, training on infectious diseases and the use of antibiotics is provided as part of the post graduate educational programme.

Other bespoke practical training sessions have been developed to provide targeted training to facilitate learning in staff who may not have English as a first language.

A resource pack has been developed for the wards containing a wide range of handbooks for various staff groups (temporary and substantive) and exemplars of how to complete IC documentation.

Virtual link nurse meetings are held monthly. Each meeting has an educational element followed by a round table session leading to discussion about issues raised. In addition, a link nurse study day is held annually with invited speakers and this is also open to MTW staff who are not link nurses and healthcare staff from other organisations. The annual study day was not held in 2022 due to staffing and COVID issues.

The DIPC teaches on the aspiring DIPC training course run by the Hospital Infection Society.

Within the IPCT members of the team are actively encouraged to pursue educational opportunities.

Over the last two years there has been increasing collaboration between Kent and Medway infection control teams from all providers. This has been facilitated by weekly teleconferences to share learning and experience initially through the COVID pandemic but now continued to provide ongoing links. An IPC Leadership forum for DIPCs and their deputies has also met monthly and is chaired by the MTW DIPC as SRO for IPC for the system. During 2022/23 the group collaboratively developed the system-wide 3-year IPC strategy which was approved by the ICB executive in April 2023.

Further educational opportunities are being developed across the system for both established and aspiring IPC professionals, with two educational days held during 2022/23.

What the Board needs to know in order to fulfil its responsibilities in respect of Infection Prevention and Control

6.1 History

Infection prevention and control has been an area of focus within MTW since 2006 when the Trust suffered one of the largest *C. difficile* outbreaks in the UK which was subsequently investigated by the Healthcare Commission and described in their report: *Investigation into outbreaks of Clostridium difficile at Maidstone and Tunbridge Wells NHS Trust*, October 2007. The report estimated that 90 deaths were directly due to C. difficile and a further 241 deaths had occurred where *C. difficile* had been a contributory factor.

Crucially the report identified that management systems had failed to provide patient safety and introduced the concept of board-to-ward accountability and responsibility.

The Trust's response to the report was positive and a year later the Healthcare Commission reported that there were encouraging signs of improvement. This improvement has continued and sixteen years on from the publication of the report, MTW is seen as a high performing Trust for Infection Prevention and Control.

The Trust Board has recognised and agreed collective responsibility for minimising the risk of infection and has delegated responsibility for the strategic and operational leadership to the Director of Infection Prevention and Control.

6.2 Key points

- All employees of the Trust have infection control responsibility detailed within their job description
- Infection prevention and patient safety remain key priorities for the Trust
- There is wide engagement with the infection prevention agenda throughout the Trust

- A challenge culture has been encouraged within the Trust to ensure that all staff comply with infection prevention policies and processes.
- A wide range of infection prevention policies and procedures have been developed and are regularly reviewed and updated
- Emphasis has been placed on the clinical environment and cleanliness. The infection prevention team works closely with the facilities management team. The Trust has been innovative in the introduction of cleaning methods such as Hydrogen Peroxide vapour (HPV) in 2007 and UV-C light in 2016. Cleaning standards are audited regularly and reported through the Trust including to the IPCC.
- *C. difficile* has been reduced to consistently low levels across the organisation although there are current challenges associated with the national rise in rates which resulted in MTW exceeding the national objective for 2022/23.

6.3 Hygiene Code compliance

The Health Act 2008, now superseded by the Health and Social Care Act 2012, contains a Code of Practice usually referred to as the Hygiene Code. The Code was most recently updated in December 2022. The 2008 Act requires acute Trusts to comply with the Code and outlines penalties for non-compliance.

The Trust declared compliance with the Hygiene Code in March 2009 and continues to remain compliant, maintaining evidence files and undertaking self-assessment of compliance on an annual basis, reporting the outcome to the IPCC. A hygiene code gap analysis was undertaken for 2022/23

There is a compliance statement on the Trust Website Hygiene-code-compliance-statement-2023.pdf (mtw.nhs.uk)

The compliance criteria and some examples (not comprehensive) of how we comply in addition to this report are shown in the table below;

Table 3: Hygiene code compliance criteria (2022)

Compliance criteria		**Examples of how we comply**
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 that their environment and other users may pose to them.	• Governance and reporting structure • DIPC in post - reports to CEO • Infection prevention team • PPE and fit testing team • IPCC ToR • Annual work programme and action plan • Mandatory training • Link nurse network • Annual IPC audit programme • IPC policies and procedures in place • Board level risk register • Outbreak policy

		• Surveillance systems • This report • COVID measures in place • Designated decontamination lead • Water safety group in place • Ventilation group established
2	The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	• Estates bi-annual reports to IPCC • Policies for decontamination, cleaning and laundry in place including record keeping processes • Cleaning processes agreed with Infection Prevention • Cleaning audits reported to IPCC • Deep clean programme in place • Hand hygiene facilities, signage and audit • JAG accreditation • Commode audits • Uniform policy • Changes in cleaning frequency to support COVID management • PLACE inspection programme • Water steering group and action plan
3	Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance	• Antimicrobial stewardship group meets monthly • Antimicrobial prescribing policy • Antimicrobial prescribing guidelines • Antimicrobial pharmacists in post • ASG reports to IPCC • 'Start smart then focus' in place • Antimicrobial training for doctors • Disposal of antibiotics poster
4	The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion	• Range of information leaflets for patients and relatives • Regular communication with ICB HCAI lead • EDN includes MRSA status • Switchboard messages on norovirus • IC messages on internet site for visitors and patients including numbers of infections • Information for patients on antimicrobials • IC information shared with GPs on case by case basis • ICT attendance at daily site meetings • Participation in COVID ICC meetings and strategic command calls
5	That there is a policy for ensuring that people who have or are at risk of developing an infection are identified	• Urgent microbiology results telephoned to clinicians • Isolation policy

	promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.	• Active side room management by ICT • Risk assessments carried out • Screening in place for MRSA, MSSA, GRE, CRE/CPE, COVID as appropriate • Diarrhoea policy • Reporting mechanism for notifiable disease to UKHSA in place • Temperature and symptom check at front doors (stepped down June 22). • Separation of flow into respiratory and non-respiratory pathways to ensure the streams do not mix • Introduction of rapid COVID testing in ED to identify cases early and prevent nosocomial spread of infection
6	Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	• Mandatory training for all staff and volunteers • Information provided to contractors • Handbooks and competency for temporary staff • Bespoke training for certain groups of staff, eg porters, domestics • Handbooks for various staff groups • Exemplars of documentation provided to wards • IC resource folders on all wards • Infection control responsibility included in all job descriptions • Facing to face ward-based training for new nurses • Additional training for international nurses • Induction training for junior doctors • Induction training for medical students
7	The provision or ability to secure adequate isolation facilities.	• Isolation policy • Negative pressure rooms available – A&E at TWH and John Day at Maidstone • TWH has >90% side rooms • Isolation rooms with positive pressure lobby on Lord North • Active management of side room provision • Clear isolation signage • COVID signage to designate wards • Negative pressure rooms created on Chronic Pain Unit and additional side rooms on Peale for COVID isolation

8	The ability to secure adequate access to laboratory support as appropriate	• Microbiology laboratory on Maidstone site • KPIs monitored • ISO 15189 accredited • All referral labs accredited • Telepath system interfaced with ICNET • COVID PCR and antibody testing available on site including rapid testing in both Emergency Departments. • Report authorisation SOP • Alert organism surveillance SOP
9	That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.	• Standard infection control policy • Waste policy • Ward closure policy • Policies for a range of individual infections • Outbreak policy • Other policies in place to meet the requirements of the Code • Audit programme in place to monitor compliance with policies • All policies available on Trust intranet site • COVID measures in place. • UKHSA guidance followed
10	That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.	• Immunisation of staff policy in place • All staff can access on site occupational health services • Influenza vaccination offered to all staff and volunteers with achievement of annual targets for frontline staff • Risk based screening for communicable diseases and assessment of immunity • OH arrangements in place in respect of blood borne viruses • COVID testing available for staff through rapid route if required. Advice provided on lateral flow tests • COVID spike antibody testing available as needed • COVID vaccination provided for staff within national guidelines

6.4 Governance and Assurance

The Board receives assurance through the governance reporting structure described at 1.2, and directly from the DIPC who attends Board meetings to provide updates on

infection control and new guidance relevant to the Trust. During the COVID pandemic the IPC Board Assurance Framework was discussed at Board meetings regularly.

C. difficile MRSA and gram-negative bacteraemia numbers and rates are on the Board level dashboard together with MRSA screening rates.

The IPCC reports to the Quality Committee which is a sub-committee of the Board.

6.5 National Priorities

There are two key national priorities related to Infection Prevention and Control

Antimicrobial resistance – The next phase UK 5-year antimicrobial resistance strategy was published in 2019. The plan has been designed to ensure progress towards the 20-year vision on AMR, in which resistance is effectively contained and controlled. It focusses on three key ways of tackling AMR:

- Reducing the need for, and unintentional exposure to, antimicrobials
- Optimising use of antimicrobials
- Investing in innovation, supply and access

To support these aims there are actions across 15 'content areas', ranging from reducing infection and strengthening stewardship to improving surveillance and boosting research. The plan also sets out four measures of success to ensure progress towards the 20-year vision. These include, among others, targets to:

- Halve healthcare associated gram-negative blood stream infections
- Reduce the number of specific drug-resistant infections in people by 10% by 2025
- Reduce UK antimicrobial use in humans by 15% by 2024
- Reduce UK antibiotic use in food-producing animals by 15-30% between 2020 and 2024 varying depending on animal type
- Be able to report on the percentage of prescriptions supported by a diagnostic test or decision support tool by 2024

COVID-19 and Seasonal Respiratory Viruses

The COVID-19 pandemic has had a major impact on the way healthcare is provided in the UK. In addition, there are concerns that an influenza epidemic may place the system under additional pressure during the winter period. Pathways have been redesigned to accommodate respiratory and non-respiratory patient flows with plans in place for placement of affected patients. Rapid testing for COVID, influenza A & B and RSV has been implemented in both Emergency Departments.

The infection prevention team is committed to continuing to support the Trust to ensure that the safety of our staff and patients is maintained throughout whilst delivering national requirements and adhering to national guidelines.

Compliance Criterion	What the registered provider will need to demonstrate
7	The provision or ability to secure adequate isolation facilities

Isolation Facilities

The Isolation policy is published on the Trust Intranet, together with the standard infection control policy which includes the use of personal protective equipment.

The Trust has a high proportion of single rooms although there is a disparity between the two sites with Tunbridge Wells Hospital having over 95% of beds in side rooms and Maidstone Hospital with 57 side room beds. Overall 54% of the beds in the Trust are in single rooms with 50.4% en-suite, compared with 29.9% single rooms in England, 17.9% en-suite.

The target time for isolating patients with unexplained and potentially infectious diarrhoea (Pathway 1) is two hours. A rapid risk assessment is in place for all patients with diarrhoea

Active management of side room provision continues. The Infection Prevention team monitors isolation rooms on a daily basis to support the bed managers and ensure the best use of the side rooms available at Maidstone Hospital and to alert staff of infection control issues at Tunbridge Wells Hospital. The team advises on which patients may be de-isolated if necessary and prioritises higher risk patients who would benefit from isolation and the level of cleaning required when the patient is moved out of isolation. The team also alerts site practitioners to community issues such as outbreaks of COVID and norovirus in local nursing homes and community hospitals and any wider outbreaks which may result in patients attending A&E.

All *C. difficile* patients are isolated on diagnosis, if not already in a side room, and remain in isolation throughout their admission. In addition, those identified as carriers are isolated whilst they are symptomatic and for at least 48 hours after they become asymptomatic.

Pathways have been developed and are in use in A&E to separate COVID and non-COVID patients and ensure that there is no contact between the streams. COVID patients are cared for in side rooms and cohorted when numbers outstrip the number of available single rooms. Strict conditions are in place to determine when the patients can be stepped down safely to general ward areas. Additional side rooms have been developed to aid the COVID response at Maidstone on Peale ward which is used for COVID positive and quarantine patients.

There are planned facilities in both Emergency Departments for isolating highly infectious individuals such as those suspected of having Ebola virus. The pathway for these patients is practised regularly to ensure that staff are aware of the enhanced precautions and how to don and doff the protective suits.

Compliance Criterion	What the registered provider will need to demonstrate
8	The ability to secure adequate access to laboratory support as appropriate

Laboratory Services

Microbiology laboratory services are based at Maidstone Hospital. The laboratory has ISO 15189 accreditation and is inspected on a regular basis by the UK Accreditation Service (UKAS).

The laboratory is open 7 days a week and provides a 24-hour service with on call facilities from 6pm to 8am.

Reference laboratory support is available at all times from both the UKHSA reference laboratories and other commercial laboratories which provide additional rapid diagnostics.

The laboratory, together with the other MTW pathology departments, is part of the Kent and Medway Pathology Network which enables laboratories to provide and receive mutual aid when required.

The microbiology laboratory also manages the Point of Care testing service in ED for COVID and other respiratory viruses.

In 2022/23 the point of care testing facility took over a large amount of the COVID testing required. Nevertheless, the laboratory processed 42,933 tests for COVID with a positivity rate of 4.6%.

Compliance Criterion	What the registered provider will need to demonstrate
9	That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections

The Trust has policies, guidelines and standard operating procedures in line with the *Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance*. The documents are reviewed on a rolling programme and published on the Trust Intranet site.

The documents are monitored using a variety of audit tools to measure staff compliance with guidance.

Audit Programme

The infection control team have worked closely with the audit department to develop a comprehensive rolling audit programme which monitors all aspects of infection control including compliance with infection control policies within the Trust. Audits are reported to the IPCC. Formal audits included:

- Commode audit
- Compliance with the Policy and Procedure for the Assessment of patients presenting with diarrhoea.
- Endoscopy re-audit on the manual cleaning of flexible endoscopes, prior to decontamination through an Automated Endoscope Reprocessor (AER).
- Re audit of compliance with screening for Carbapenemase producing enterobacteriaceae (CPE).
- Audit of non-elective MRSA screening
- The use of personal protective equipment (PPE)

In addition to these audits the IPT undertakes bi-monthly triangulation audits which are compared with the monthly ward audits and reported as a performance report to the IPCC by the directorate matrons.

The triangulation audits are conducted on:

- Bare below the elbows
- Hand hygiene including patient hand hygiene prior to meals
- Commode cleanliness
- MRSA decolonisation
- MRSA care pathway compliance
- MRSA non-elective screening
- Waste management
- PPE

As part of the PII process additional audits are completed on

- Ward laundry management
- Decontamination of reusable devices

Compliance Criterion	What the registered provider will need to demonstrate
10	That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control

Occupational Health

The Occupational Health service provides pre-employment health assessments and assessment of immunity and provides vaccinations for new staff.

10.1 COVID-19

Guidelines are available on the intranet for staff COVID sickness, isolation and return to work and are updated with publication of national guidance.

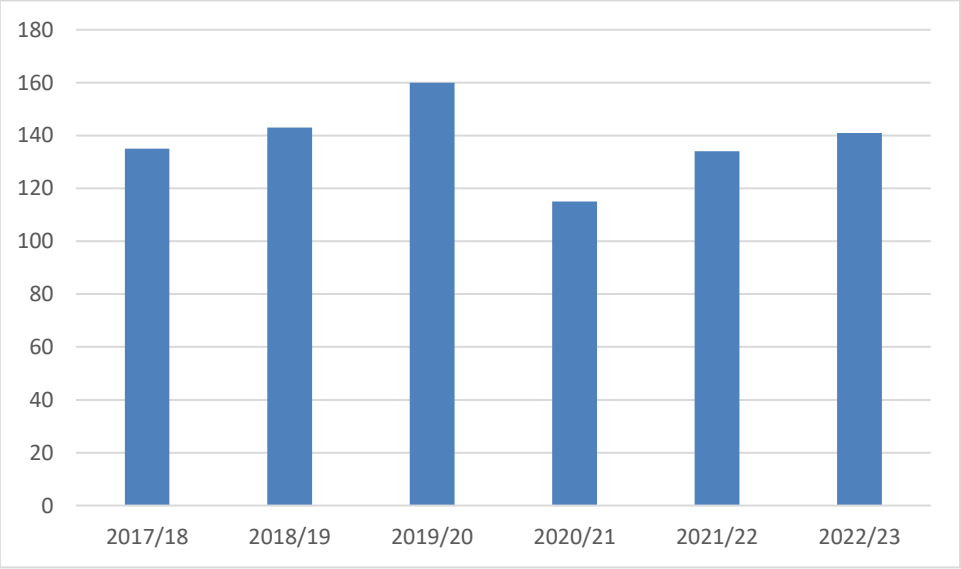
A number of staff are experiencing ongoing symptoms of fatigue and reduced resilience and OH are offering them ongoing support and referral to a dedicated Trust physiotherapist.

10.2 Sharps/Splash Injuries

The occupational health department continues to review sharps injuries and examine ways to reduce the incidence with the Health and Safety team and the Sharps Working group.

The split between types of injury has remained constant at around 75% sharps to 25% splash injuries

Fig 2: Sharps and Splash injuries 2017-2023



10.3 Vaccination

10.3.1 COVID-19 vaccination

Vaccination against COVID was been offered to all eligible staff for the autumn booster campaign in 2022. The campaign ended in January 2023 with 3194 staff having received the booster vaccine.

10.3.2 Influenza vaccination

The Occupational Health department leads the seasonal flu vaccination campaign. For 2022/23 there was very low uptake with the Trust achieving 35.44% coverage. Vaccine fatigue was thought to be a major factor in the low uptake.

The campaign was launched in October and used a peer vaccination programme to outreach into clinical areas as well as combining with the COVID vaccination autumn booster programme.

For 2023/24 the CQUIN minimum target for Influenza vaccination for staff is 70%.

Recommendations

The Trust Board is asked to note the progress in reducing healthcare associated infections, the COVID response and the Infection Prevention and Control Annual Work plan for 2023/24 (appendix 1)

INFECTION PREVENTION AND CONTROL WORK PLAN 23/24

RAG RATING DEFINITION	
R	ACTIONS APPEARS UNACHIEVABLE NEEDS RE-BASELING / REASSESSING
A	SUCESSFUL DELIVERY OF PROJECT TIME AND THERE ARE NO THREATS TO DELIVERY
G	COMPLETED AND CLOSED NO FURTHER ACTIONS REQUIRED

Action No	Date Identified	Source	Output (What are we trying to achieve)	Action (How are we going to do it)	By when	Work plan Quarter	Owner	Current Progress (How are we doing)
CULTURE AND ENGAGEMENT								
CE-001	Apr-23	APW	Improved attendance and engagement to the IPC Link workers programme and meetings	1) Monthly link worker meetings to be held via Microsoft teams and face to face 2) Link worker attendance to be monitored, fed back to divisions and monitored through IPCC 3) Summary report to be presented to IPCC with action plan to improve attendance and engagement such as, re-introduction of link of the year.	Mar-24	Q4	Clair Taylor (Infection Prevention Nurse)	Summary report to presented to IPCC in July 23
CE-002	Apr-23	APW	Monitor and improve compliance with IPC practice and procedures	1) IPC team working with wards where non-compliances are identified, providing additional training and support 2) PPE compliance is monitored by the PPE officers and presented at IPCC 3) Findings from PII investigations are fed back, followed up and monitored 4) Audit/ QI programme developed and available on the Q drive. Also refer to Audit and Surveillance section of this work plan	Mar-24	Q4	Lesley Smith (DDIPC)	IPC team undertaking focus of the week to promote core IPC practice on the wards

CE-003	Apr-23	APW / K&M IPC Strategy	All medical devices and equipment to meet IPC requirements for use	1) IPC team to work with procurement to provide IPC advice on new products being considered 2) Attend the Medical devices meeting 3) IPC approval of products via pre-purchase questionnaire (PPQ) 4) Consider joint procurement of equipment with other care providers within the ICB where feasible	Mar-24	Q4	Danny Moore (Infection Prevention Nurse)	
CE-004	Apr-23	APW / K&M IPC Strategy	Continue to raise the profile of Infection Prevention and control	1) IPC attendance at ward managers and Matrons meetings 2) IPC team to visit wards & department daily 3) Participate in national and local initiatives to promote IPC. (Global Hand hygiene day, glove awareness week, International Infection Prevention week) 4) Use of social Media to promote IPC team and deliver key messages 5) Monthly IPC newsletter 6) Participate in national campaigns to improve HCAI rates	Mar-24	Q4	Lesley Smith (DDIPC)	
CE-005	Apr-23	K&M IPC Strategy	Development and learning opportunities for all members of the IPC team	1) IPC team members to attend local, regional and national IPS conferences, meetings and webinars 2) Explore and support opportunities for IPC team to experience primary care / community care placements and vice versa 3) Support apprentice and student placements as appropriate	Mar-24	Q4	Lesley Smith (DDIPC)	New IPC nurse attended IPC conference in Birmingham in April - brought back learning and updates to the team

CE-006	Apr-23	K&M Local metrics	To meet the quality requirements of the K&M Acute schedule 4 local metrics 2023-24	1) Attend and participate at the K&M leadership forum 2) Send ratified IPC annual report to the ICB 3) Annual programme of work to be sent to the ICB when ratified by the board at the end of Q1 4) MRSA screening audit compliance to be presented to IPCC quarterly 5) Summary of Water Hygiene Group to be presented to the IPCC bi annually 6) IPC link worker summary report to be presented to IPCC 7) Facilities report which includes environmental audits to be presented to the IPCC quarterly 8) IPC training compliance to presented to the IPCC as part to the Directorate reports 9) Fit testing / PPE report to be presented to the IPCC quarterly 10) MRSA bacteraemia PIR / SIs to be presented to the IPCC 11) Outbreaks and PIIs to be reported to ICB 12) ICB IPC to be invited to outbreak meeting 13) HCAI weekly status to be presented to the IPCC 14) ICB to be invited to all RCA / PIR panels / table top reviews 15) Email pandemic policy and implementation plan to ICB 16) New cases of CPE to be reported to ICB	Mar-24	Q4	Lesley Smith (DDIPC)	
CE-007	Apr-23	APW	Deliver IPC study day / conference	1) Academic centre at Maidstone booked for Tuesday 17th October 2) Reps and speakers to be contacted to support event 3) Evaluation and short report to be presented to IPCC	Nov-23	Q3	Clair Taylor (lead Nurse IPC)	
SAFE AND CLEAN ENVIRONMENT								

SCE-001	Apr-23	APW	Safe water systems	1) IPC representation at the Water Safety Meeting 2) All water sampling results and mitigating action taken to be sent to the IPC team for information & follow up as necessary 3) *Pseudomonas* risk assessment reviewed and updated yearly 4) Water safety workstream to be supported by consultant microbiologist	Mar-24	Q4	Joanne Green (Lead Nurse IPC)	IPC Lead nurse attends water safety meetings
SCE-002	Apr-23	APW	Environment is designed and refurbishments are completed with infection prevention and control in mind	1) IPC representation at capital planning meetings 2) Process is developed to ensure IPC is considered at the planning stage of building or refurbishment projects	Mar-24	Q4	Joanne Green (Lead Nurse IPC)	IPC lead nurse involved in all new and existing projects
SCE-003	Apr-23	KLOEs (S1)	Revised isolation risk assessment to be implemented and imbedded in practice	1) Isolation risk assessment to be uploaded onto Sunrise 2) Information to be disseminated to Ward Manager via email and ward managers meeting 3) IPC team to monitor usage and compliance with completing the isolation risk assessment	Dec-24	Q3	Clair Taylor (Lead Nurse IPC)	May 23: Isolation risk assessment now available on Sunrise. Email sent to ward managers informing them, and process for completion
SCE-004	Apr-23	KLOE (S1) H&SCA	Systems in place to ensure that patient equipment is clean between use and assurance that standards are maintained (Criterion 2.1)	1) Where deficiencies are identified through PII and audit, the process for the cleaning of patient equipment within the wards and department will be reviewed 2) Devise a process to identify if cleaning of patient equipment is robust across the Trust	Mar-24	Q4	Danny Moore (Infection Prevention Control)	
SCE - 005	Apr-23	KLOE & BAF (S1)	Greater involvement in cleaning and environmental audits to provide assurance of standards being reported	1) Ward / Department staff to attend the cleaning audits that are undertaken by the domestic supervisor 2) IPC team to attend a number of cleaning audits for assurance purposes 3) IPC to participate in PLACE assessments 4) IPC to participate in mock CQC walkabouts	Mar-24	Q4	Joanne Green (Lead Nurse IPC)	

SCE-006	Apr-23	H&SCA	Criterion 2: Complete outstanding planned maintenance work at Maidstone hospital	Ward improvement tasks and finish group National Standards of Cleanliness working group to be convened to monitor progress against the audit programme	Mar-24	Q4	Joanne Green (Lead Nurse IPC)	
SURVEILLANCE & AUDIT								
SA-001	Apr-23	APW	Programme of audit / QIP to be developed and completed for 23/24 & Support the introduction of the electronic audit programme (InPhase)	1) Audit / QI programme to be developed and agreed at IPCC 2) Support the completion of IPC audits on InPhase 3) Ward /Dept environmental audits 4) PII audits of MRSA and CDI 5) IPC team to attend and participate in InPhase implementation meetings	Mar-24	Q4	Jo Green (Lead Nurse IPC)	
SA-002	Apr-23	KLOE (S2)	Improved compliance with the documentation of MRSA decolonisation	1) MRSA checklist to be uploaded onto sunrise - (MRSA care bundle removed from policy. 2) Decolonisation regime added to EPMA 2) Revised process to be implemented and evaluated	Dec-24	Q4	Clair Taylor (Lead Nurse IPC)	MRSA checklist now available on sunrise - ward managers, link workers and matrons informed - further work needs to be done to ensure that it is thoroughly implemented
SA-003	Apr-23	APW & K&M IPC Strategy	Mandatory reporting of surgical site surveillance	1) SSIS to be reported 6-monthly to IPCC 2) Quarterly reports to UKHSA 3) Feedback of findings to orthopaedic directorate 4) Increase scope for SSIS to include breast and laparotomy 5) support the implementation of the SSIS on ICNet 6) Surgical site surveillance report to presented to the IPCC	Mar-24	Q4	Linda Baker (surgical site surveillance Nurse) & Clair Taylor (Lead Nurse IPC)	Breast surveillance to be started in July 2023

SA-004	Apr-23	APW / K&M IPC Strategy / K&M local metrics	No avoidable > 48 hour MSSA / MRSA bacteraemia (9 avoidable in 22/23)* * Subject to change as outcomes pending on outstanding RCAs	1) All pre and post 48 hours MSSA / MRSA bacteraemia to be reported on the DCS 2) RCAs to be completed on all > 48 hour MSSA/MRSA bacteraemia within 5 days and presented to the monthly panel for sign off 3) Trends and lessons learnt to be shared within the Trust wide 4) Panel outcomes to be shared with IPCC 5) monitor and review action plans to reduce MSSA & MRSA 6) Community acquired MRSA bacteraemia to be reported to the ICB within 2 working days of positive result 7) ICB IPC to be invited to MRSA PIR 8) Develop and implement VAD QIP to improve compliance with management and documentation of VADs 9) Implementation of DRIPP vascular access resources https://dripp.org.uk/Resources/	Mar-24	Q4	Lesley Smith (DDIPC)	
SA-005	Apr-23	APW	Reduce rates of MSSA by 5% Rates for 22/23 = 24 Rates for 21/22 = 27 Rates for 20/21 = 24	1) Continue to promote good IPC practice 2) Act on lessons learnt from RCAs and disseminate for shared learning - focus on cannula care and central lines 3) Complete actions identified above (SA-004) to prevent avoidable infections	Mar-24	Q4	Lesley Smith (DDIPC)	

SA-006	Apr-22	APW & K&M IPC Strategy	Support the NHS's long term plan for a 50% reduction in gram negative blood stream infections by 2024/25 5% reduction on 22/23 data. Data in ( ) below indicate limits for 23/24 based on a 5% reduction E. coli 76 (72) P.aeruginosa 20 (19) Klebsiella spp 25 (24)	1) Patient indwelling catheter cards to be provided to patients going home with indwelling catheters (E1.5) 2) Preventing CAUTI cards which promote Houdini (E1.5) 3) Laminated 'tea cup posters to be provided to ward to promote the hydration of patients (E1.5) 4) Continue to promote catheter passport 5) Report all > 48hr & <48 hr E.coli, Klebsiella and Pseudomonas aeruginosa bacteraemia on the National Data Capture System 6) RCAs to be completed on all gram negative bacteraemia which are considered avoidable and / or identify areas for learning 7) Volunteers to support additional drinks rounds to assist in promoting hydration. 8) Monitor trends against the national UKHSA fingertip data 9) Gram negative reduction meetings to be held 10) utilisation of GNBSI reduction plan tools and plan available at: https://improvement.nhs.uk/resources/gram-negative-bloodstream-infection-reduction-plan-and-tools/ 11) Monitor and review action plans to reduce gram negative blood stream infections 12) Re-introduce hydration project 13) All community acquired gram negatives to be reported to the ICB within 2 days	Mar-24	Q4	Clair Taylor (Lead Nurse IPC)	
SA-007	Apr-23	APW / K&M IPC Strategy / K&M local metrics	*Clostridium difficile* Trust attributable infections to be within the Trust Limit of 61 20/21, 50 cases against a limit of 55 YTD 21/22, 68 against a limit of 55 YTD 22/23 79 cases against	1) Monitor trends from the RCA & PIIs and act on findings 2) All RCAs are to be completed in 5 working days and presented to the monthly panel for agreement and sign off. 3) All samples to be sent for Ribotyping 4) Monitor for any evidence of transmission of infection 5) Monitor and review action plans to reduce CDI 6) COCA, COIA to be reported to the ICB within 2 working days	Mar-24	Q4	Lesley Smith (DDIPC)	

			a limit of 62 (31% per 100,000 bed days)					
SA-008	Apr-23	BAF	Board assurance framework is reviewed on a regular basis and presented to Trust Board when there is significant changes	1) Significant changes to board assurance frame work to be presented to the Trust Board	Mar-24	Q4	Sara Mumford (DIPC)	
SA-009	Apr-23	KLOE (S1)	Bed and Trolley mattresses to be clean and systems in place to ensure that checked, condemned and replaced if needed	1) Participation with annual bed and trolley mattress & pillow audits out and reports presented to IPCC 2) Review of trolley mattress to ensure they are cost effective and met the correct specification 3) Work with PMO to develop QIPs to address areas that require improvement 4) Triangulation mattress audits completed by the IPT and fed back to divisions and wards	Mar-24	Q4	Danny Moore (IPC Nurse)	IPC attend the bed and mattress meeting, current focus on improving the process for carrying out and documenting integrity checks.
TRAINING & EDUCATION								
TE-001	Apr-23	APW	All training to be updated to reflect the IPC education framework and best practice guidance	1) Liaise with learning and development to review the IPC education framework and its implementation Review all IPC training to ensure that it is up to date and meets the requirement of the framework including *Online training package *Face to Face training *Hand hygiene practical sessions *Doctors training	Mar-24	Q4	Clair Taylor (Lead Nurse IPC)	
TE-002	Jan-23	H&SCA	Criterion 3.5: New Doctors to be provided with ongoing antimicrobial training updates	Mandatory e-learning antimicrobial training to be developed and introduced	Mar-24	Q4	Grace Sluga (Consultant Microbiologist)	
NATIONAL & LOCAL STANDARDS								

NLS-001	Apr-23	APW	Delivery of the local Antimicrobial Resistance Strategy	1) ASG to report to the IPCC 6 monthly 2) AMR CQUIN Appropriate antibiotic prescribing for UTI in adults aged 16+ 3) IPC representation to the ASG meetings	Mar-24	Q4	Helen Burns (Deputy Chief Pharmacist) & Grace Sluga (Consultant Microbiologist)	
NLS-002	Apr-23	APW / KLOE / K&M IPC Strategy	Demonstrate Shared learning from lesson learned from RCAs and incidents	1) Lessons learnt from RCAs to be identified and shared 2) Trends to be monitored and reported for wider shared learning 3) Closing the loops of RCAs - Actions from RCAs to be monitored through the IPCC to ensure that all actions have been completed (W4) 4) Lessons learnt to be included in the monthly IPC newsletter 5) Take opportunities to share learning across the K&M system 6) outcome and lessons learned from RCA investigation to be included in HCAI weekly status report	Mar-24	Q4	Lesley Smith (DDIPC)	Lessons learnt from IPC incidents included in Monthly IPC newsletter
NLS-003	Apr-23	APW / K&M IPC Strategy	Support the Implementation of the Annual Flu plan	1) Plan for vaccinators to support the 90% of frontline staff vaccination to be agreed 2) Fit testing of front-line staff 3) Support flu Campaign 5) Surveillance of flu cases 6) Timely raising awareness emails to be sent regarding signs and symptoms of flu and differential diagnosis	Mar-24	Q4	Clair Taylor (Lead Nurse IPC)	
NLS-004	Apr-23	APW & H&SCA / K&M IPC Strategy	Develop a Policy review programme to spread across the next 3 years to avoid Policies expiring at the same time Ensure Policies are reviewed in accordance with new national recommendations	1) *Candida auris* (New) (In progress) SM 2) Notification of Infection (New) (In progress) SM 3) Surveillance and data collection (New) 4) Immunisation of patients (New) Due 23/24 5) Laundry- July 2023 6) Isolation - Dec 2023 7) GAS policy and flow charts April 2023 8) Scabies policy - Sept 2023 9) Diarrhoea Policy Sept 2023 10) ANTT July 2023 11) VHF Sept 2023	Mar-24	Q4	Jo Green (Lead Nurse IPC) IPT	Policies that expire at the same time have been given a new review date to spread the reviews over time. A number of Policies are under review and have been allocated to the team to complete. First draft of the IPC Manual has been made and is in progress

			Review format of policies to consider similar format to the HR's people's policy Implement the National IPC manual alongside local policy updates Criterion 4.1: Patient impact of care including PPE to be incorporated into IPC policies	24/25 12) Decontamination of Mattresses - February 2024 (New review date July 2023) 13) Control of resistant organisms Oct 2024 14) Blood borne viruses - June 2024 (New review Feb 2024) 15) Infection Prevention and Control policies and procedures June 2024 (Standards precautions policy to be updated to reflect the impact of PPE / IPC on patients) 16) Norovirus - Oct 2024 17) TB - Oct 2024 (For review now as National changes) 18) Hand hygiene - Oct 2024 (New review July 2024) 19) safe handling of blood and body fluids - Oct 2024 (New review Sept 2024) 20) Single use medical devices - August 2024 (New review Oct 2023) 21) Ward closure - Oct 2024 22) VZV - Oct 2024 (new review May 2024) 23) Environmental disinfection -October 2024 (New review) 24) TSE policy- November 2024 25) Outbreak of communicable disease - October 2024 (New review June 2024) 26) CPE - February 2025 (under review now) 26/27 27) Hepatitis A - February 2026 28) MRSA June 2026 29) Animal visitor policy Sept 2026 30) Clostridium difficile December 2026 31) Meningococcal disease Feb 2026 29) IPC Policy Nov 2024 Policies to be formatted into similar format as Trusts people's policy				
NLS-005	Apr-23	APW / K&M IPC Strategy	Determine compliance with the code of practice the prevention and control of HCAIs	1) Self-assessment tool for prevention and control of HCAIs to be completed and reviewed quarterly 2) Declare compliance on the Trust Website 3) Compliance to be reported to IPCC	Mar-24	Q4	Lesley Smith (Consultant Nurse IPC)	Full review undertaken at the end of 22/23

NLS-006	Apr-23	APW & H&SCA	Revise all IPC leaflets due for update during 23/24 Criterion 9.3d: Isolation leaflet / information to be available for patients or the public Criterion 4.1: Provide information for patient and carers regarding IPC, antimicrobial awareness and preventing infections	All leaflets that require updating for 23/24 to be reviewed 1) Hand hygiene information for staff - October 2024 2) CPE / CRE leaflets merged awaiting approval 3) MRSA - large print needs uploading - (April 21) 4) COVID-19 leaflet to be developed (including easy read version) 5) Develop and publish isolation leaflet / information 6) MSSA small and large print (June 22) 7) ESBL awaiting approval (May 22) 8) Antimicrobial leaflet for patients and visitors (New) 9) isolation / IPC leaflet for patients and visitors(New) 10) GAS leaflet (New) 11) GAS contacts leaflet (New)	Mar-24	Qu4	Jo Green (Lead Nurse IPC)	
NLS-007	Apr-23	APW	Seek opportunities to publicise and promote the work undertaken by the IPC team both locally and nationally	1) Utilise social media to promote the IPC service and team 2) Consider areas for innovation 3) Undertake QI projects and present findings	Mar-24	Qu 4	Lesley Smith (DDIPC)	
NLS-008	Apr-23	H&SCA	Criterion 3.5: Antimicrobial resistant data to be effectively communicated back to prescribers in primary & secondary care	Policy for the investigation of HCAIs and alert organism surveillance to include annual antimicrobial susceptibility data feedback to primary and secondary care on commonly used antimicrobials	Mar-24	Q4	Grace Sluga (Consultant Microbiologist)	
NLS-009	Apr-23	H&SCA	Criterion 4.1: Provide assurance that specific vulnerabilities and protected characteristics have been considered in information and training	seek further evidence that specific vulnerabilities and protected characteristics have been considered in training and information for staff and service users	Mar-24	Q4	Jo Green (Lead Nurse IPC)	
NLS - 010	Apr-23	H&SCA	Criterion 9.3p: required to ascertain who is responsible to controlling polluting emissions to the air	Make enquiries to identify responsible person and if systems are in place to control air emissions	Mar-24	Q4	Lesley Smith (DDIPC)	

NLS-011	Apr-23	H&SCA	Criterion 10.2: ensure that systems are in place for the review and follow up of staff immunisation	Further assurance needed that systems are in place for the following up on staff immunisation status	Mar-24	Q4	Lesley Smith (DDIPC)	
NLS - 012	Apr-23	APW & K&M IPC strategy	Introduce PSIRF methodology and after-action review to identify real time learning from incidents and HCAIs	1) Review current RCA / PIR process to incorporate AAR and PSIRF 2) Work with K&M network to standardise approach	Mar-24	Q4	Lesley Smith (DDIPC)	
NLS-013	Apr-23	K&M IPC Strategy	Ensure that preparedness plans are in place for future IPC adverse events (including pandemics and emerging threats)	1) Work with EPRR team to ensure that pandemic and outbreak plans are in place and up to date 2) Support the preparedness training of relevant staff - such as VHF PPE training for ED staff 3) support the vaccination of staff (see NLS-003)	Mar-24	Q4	Lesley Smith (DDIPC)	
NLS - 014	Apr-23	K&M Local metrics	Produce Annual IPC report	1) Annual report to be presented to IPCC, Trust Board 2) Ratified report to be sent to ICB	Mar-24	Q4	Sara Mumford (DIPC)	
		Key						
		APW	Annual Programme of Work					
		KLOE	Key Lines of Enquiry					
		BAF	Board assurance Framework					
		EPOC	Exceptional people outstanding care					
		H&SCA	Health and Social Care Act					

NHS Maidstone and Tunbridge Wells NHS Trust

Findings of the national inpatient survey 2022 **Chief Nurse**

The enclosed report provides a benchmark report, headline results and scores for the Trust on the findings of the national inpatient survey 2022 results.

The report includes the following:

- The Trust's demographics in comparison to other Trusts.
- Scores for each evaluative question and banding for how the Trust's scores compare with all other Trusts.
- A summary of the Trust's highest and lowest scores for the survey year compared to the previous survey.
- Analysis of the five lowest evaluative questions for the Trust.
- Trust-wide and divisional recommendations and action plan.

The Trust Board is asked to note that the patient experience strategy is undergoing revision and will consider the themes from survey.

Which Committees have reviewed the information prior to Trust Board submission?

- Patient Experience Committee, 07/09/23
- Nursing, Midwifery, Allied Health Professionals and Pharmacy Board, 27/09/23.

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

Assurance, discussion and information.

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

Patient Experience Committee.

NHS
Maidstone and Tunbridge Wells NHS Trust

Adult Inpatient Survey 2022 results update.

Reason/s for submission to the NMAHP&P

Decision	
Discussion	✓
Information	✓
Other (state)	

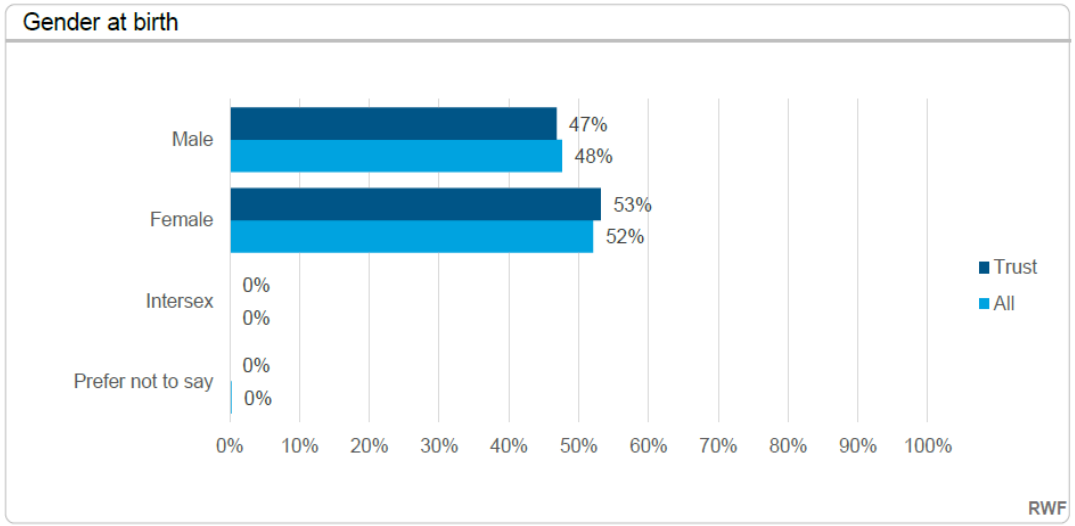
Link to corporate breakthrough objective/s (delete the tick for any that do not apply):

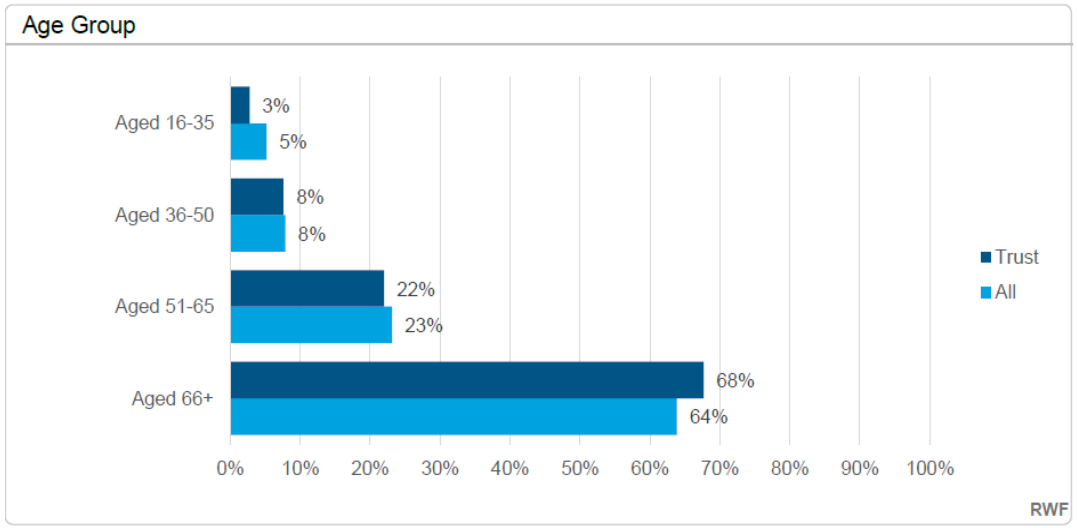
Reduce complaints re poor communication	✓	Increase discharges by 12pm	
Reduce patient falls to 6.5 per 1000 OBD		Reduce premium workforce expenditure	
Achieve planned levels of new outpatient activity		Reduce staff turnover to 12%	

Executive Summary

- The Adult Inpatient Survey was undertaken by IQVIA for Maidstone and Tunbridge Wells NHS Trust (MTW) between January 2023 and April 2023.
- A sample of 1,250 consecutively discharged inpatients, working back from the last day of November 2022, who had a stay of at least one night in hospital. There were a number of categories of patients excluded from the survey e.g. psychiatric patients and maternity patients.
- 489 completed questionnaires were returned from the sample of 1250 for MTW (41% final response rate for the Trust).
- 29 Trusts took part in the survey with IQVIA. However, raw data is not available to compare results with other local Trusts.
- This is a yearly survey.
- Key themes identified of areas to improve are patient feedback, information, food and sleep at night.
- Positive responses were cleanliness, privacy and dignity.
- The patient experience strategy is undergoing revision and will consider the themes from survey.
- Improvement plans/actions will be monitored at directorate/ divisional level with assurance provided at the quality improvement committee and the Patient Experience Committee. Due dates for completion of actions to be discussed with the divisional teams.

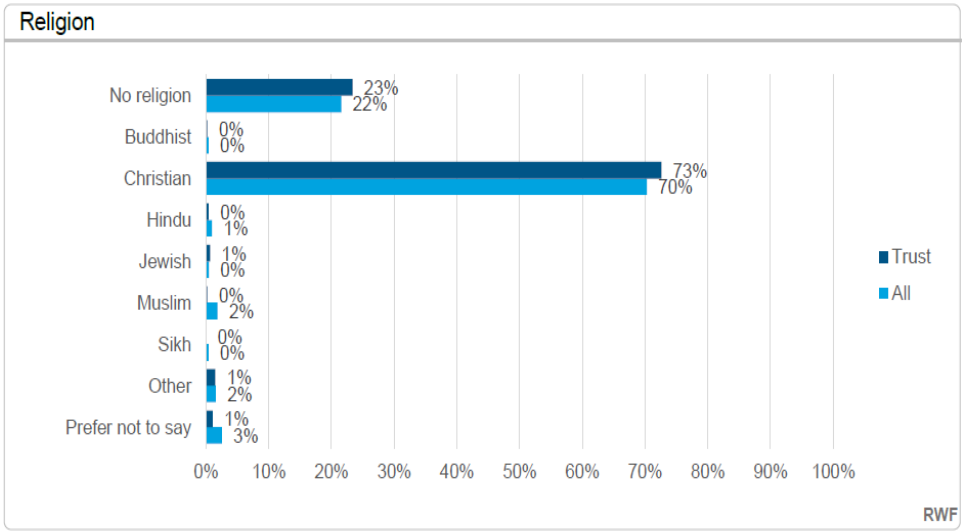
MTW Demographics in comparison to other Trusts

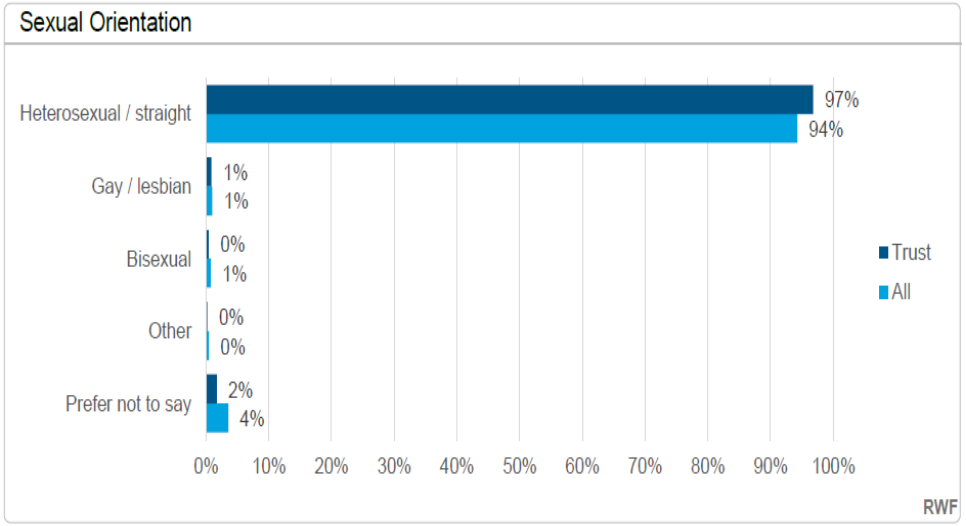




These demographics show that the higher responses were from female patients and from the 66+ age range.

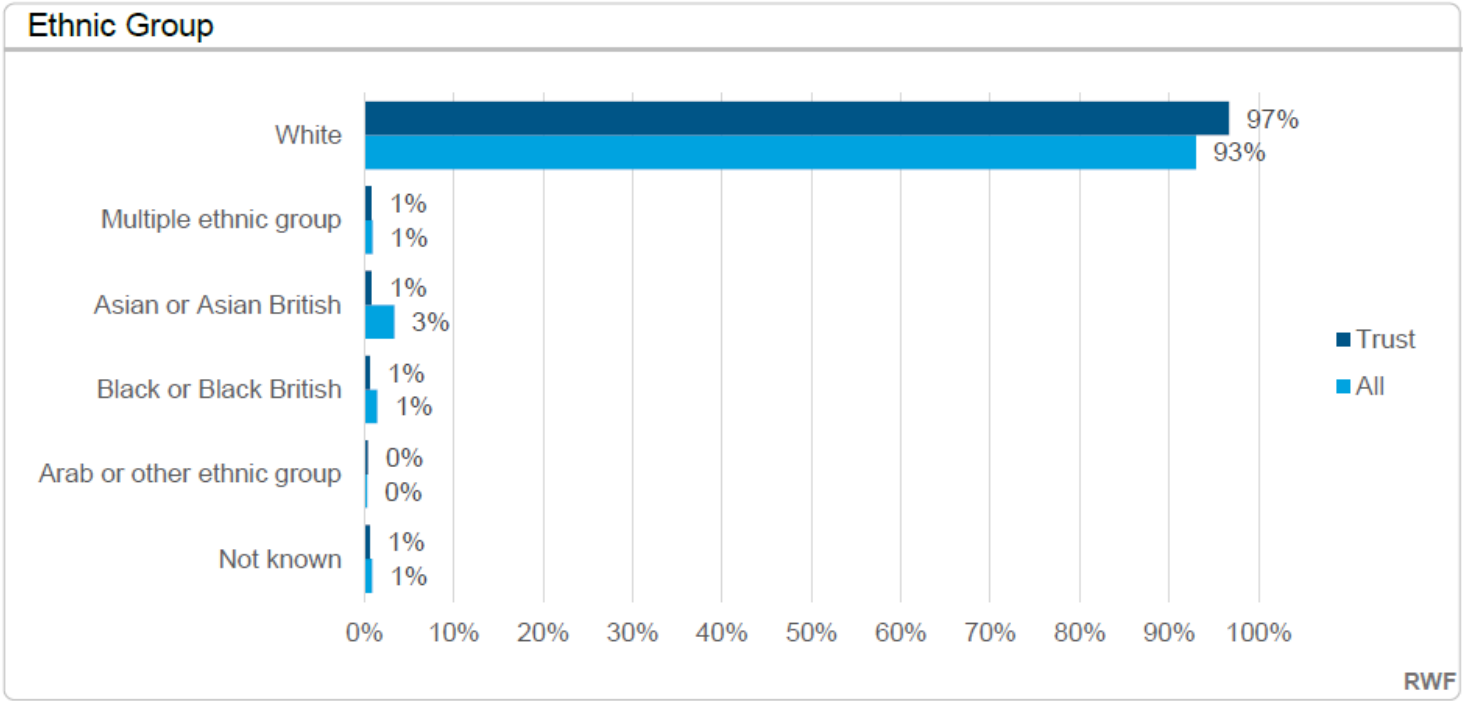
MTW Demographics in comparison to other Trusts





These demographics show that the higher responses were from Christian patients and the sexual orientation was heterosexual / straight.

MTW Demographics in comparison to other Trusts



The demographic is representative of the MTW catchment area

Responses received by CQC from patients at MTW.

	Patient Response	Compared with other trusts
Admission to hospital	7.4 / 10	About the same
The hospital and ward	7.8 / 10	About the same
Doctors	8.7 / 10	About the same
Nurses	8.5 / 10	About the same
Care and treatment	8.2 / 10	About the same
Operations and procedures	8.4 / 10	About the same

Responses received by CQC from patients at MTW.

	Patient Response	Compared with other trusts
Leaving hospital	6.9 / 10	About the same
Feedback on care	1.4 / 10	About the same
Respect and dignity	9.2 / 10	About the same
Overall experience	8.1 / 10	About the same
Long term condition	6.8 / 10	About the same

This section of the report summarises MTW's highest and lowest scoring results for the current year across the entire survey

Top 5 Questions	Score
Q15. During your time in hospital, did you get enough to drink?	95.7%
Q27. Were you given enough privacy when being examined or treated?	94.7%
Q8. How clean was the hospital room or ward that you were in?	91.4%
Q45. Overall, did you feel you were treated with respect and dignity while you were in the hospital?	91.4%
Q17. Did you have confidence and trust in the doctors treating you?	90.8%

This section of the report summarises MTW's highest and lowest scoring results for the current year across the entire survey

Bottom 5 Questions	Score
Q47. During your hospital stay, were you ever asked to give your views on the quality of your care?	13.4%
Q39. Thinking about any medicine you were to take at home, were you given any information?	43.9%
Q5f. Were you ever prevented from sleeping at night by any of the following?	47.9%
Q34. To what extent did hospital staff involve your family or carers in discussions about you leaving hospital?	51.1%
Q14. Were you able to get hospital food outside of set meal times?	54.0%

Comparison of the Best and the Worst Performance Scores

Best

2021		2022	
Question	Score/10	Question	%
Q5. Were you ever prevented from sleeping at night by noise from other patients?	7.0	Q15. During your time in hospital, did you get enough to drink?	95.7%
Q27. Were you able to discuss your condition or treatment with hospital staff without being overheard?	7.2	Q27. Were you given enough privacy when be examined or treated?	94.7%
Q37. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?	8.8	Q8. How clean was the hospital room or ward that you were in?	91.4%
Q5. Were you ever prevented from sleeping at night by noise from staff?	8.6	Q45. Overall, did you feel you were treated with respect and dignity while you were in the hospital?	91.4%
Q7. Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?	7.1	Q17. Did you have confidence and trust in the doctors treating you?	90.8%

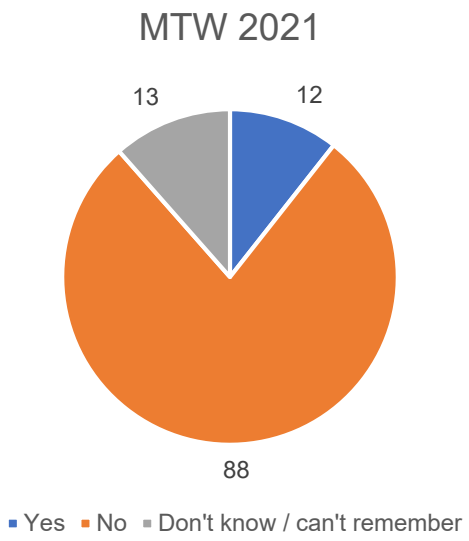
Worst

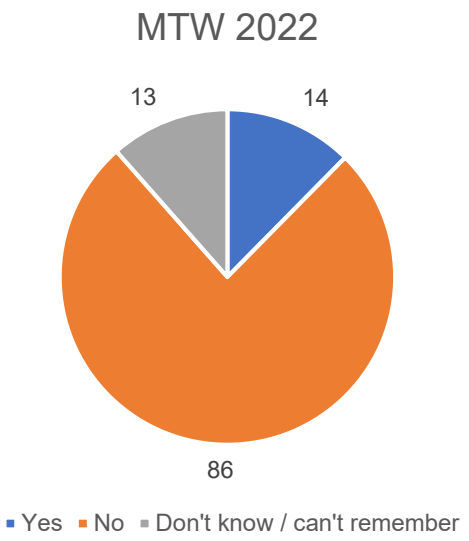
2021		2022	
Question	Score	Question	%
Q14. Were you able to get hospital food outside of set meal times?	5.1	Q47. During your hospital stay, were you ever asked to give your views on the quality of your care?	13.4%
Q12. How would you rate the hospital food?	6.5	Q39. Thinking about any medicine you were to take at home, were you given any information?	43.9%
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	7.3	Q5f. Were you ever prevented from sleeping at night by any of the following? None of these.	47.9%
Q13. Did you get enough help from staff to eat your meals?	7.3	Q34. To what extent did hospital staff involve your family or carers in discussions about you leaving hospital?	51.1%
Q35. To what extent did staff involve you in decisions about you leaving hospital?	6.8	Q14. Were you able to get hospital food outside of set meal times?	54.0%

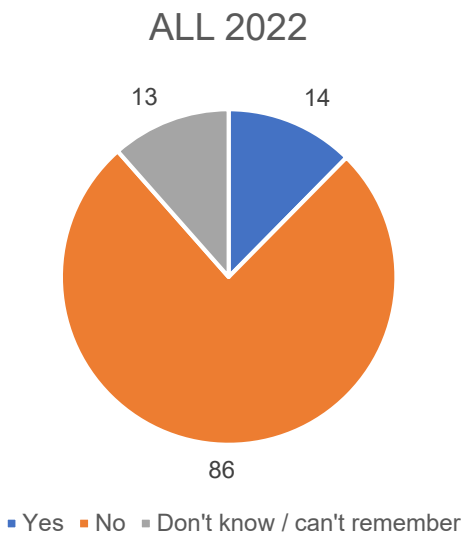
Comparison between MTW 2021/2022 and other Trusts to bottom questions

Q47. During your hospital stay, were you ever asked to give your views on the quality of your care?

	MTW 2021	%	MTW 2022	%	ALL 2022	%
Yes	51	12	56	14	1676	14
No	386	88	357	86	9940	86
Don't know / can't remember	64	13	60	13	1691	13

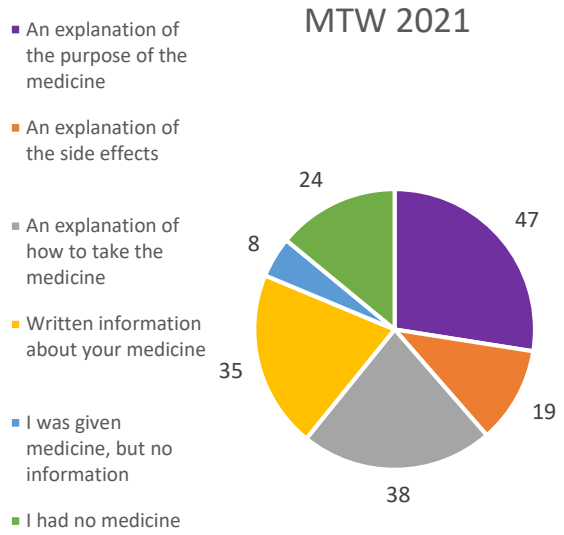


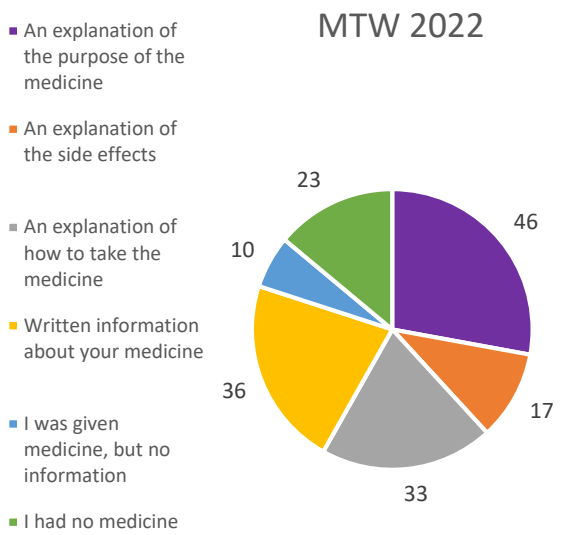


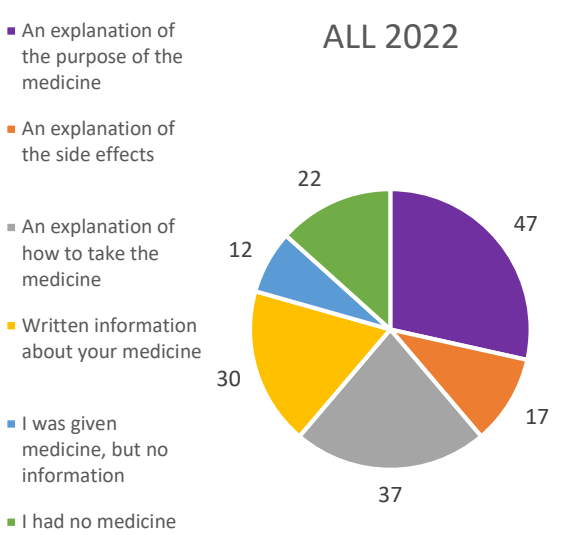


Q39. Thinking about any medicine you were to take at home, where you given any of the following

	MTW 2021	%	MTW 2022	%	ALL 2022	%
An explanation of the purpose of the medicine	236	47	218	46	6179	47
An explanation of the side effects	94	19	81	17	2227	17
An explanation of how to take the medicine	187	38	155	33	4816	37
Written information about your medicine	172	35	170	36	3988	30
I was given medicine, but no information	42	8	46	10	1530	12
I had no medicine	118	24	109	23	2858	22

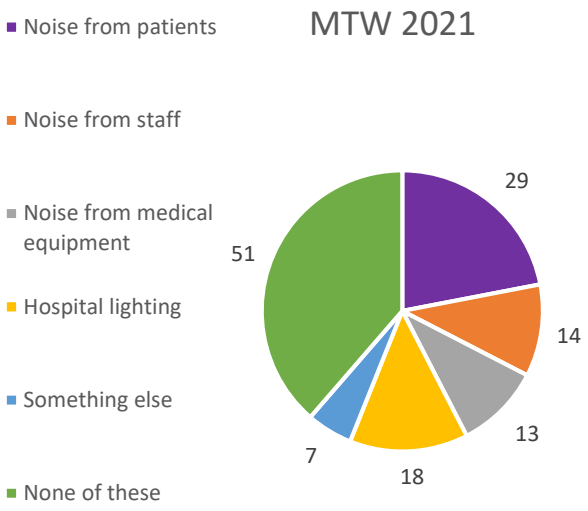


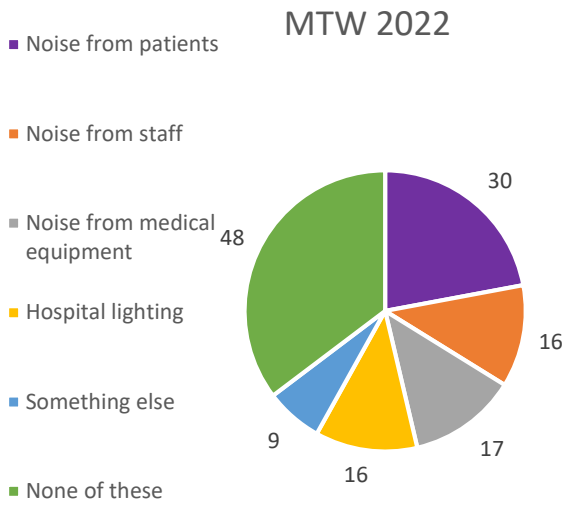


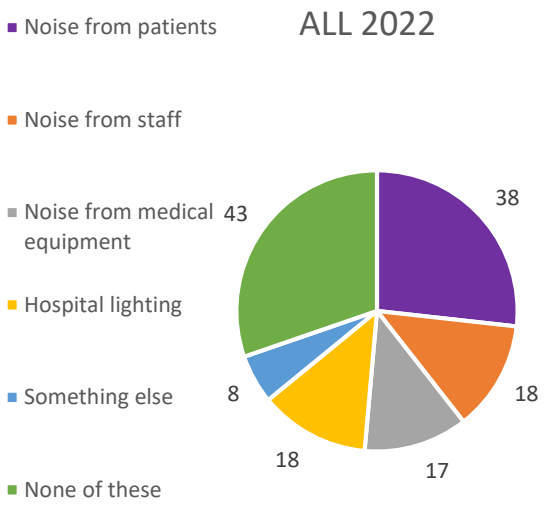


Q5. Were you prevented from sleeping at night by any of the following?

	MTW 2021	%	MTW 2022	%	ALL 2022	%
Noise from patients	145	29	145	30	5074	38
Noise from staff	69	14	76	16	2373	18
Noise from medical equipment	65	13	79	17	2339	17
Hospital lighting	92	18	75	16	2349	18
Something else	36	7	41	9	1131	8
None of these	254	51	227	48	5752	43

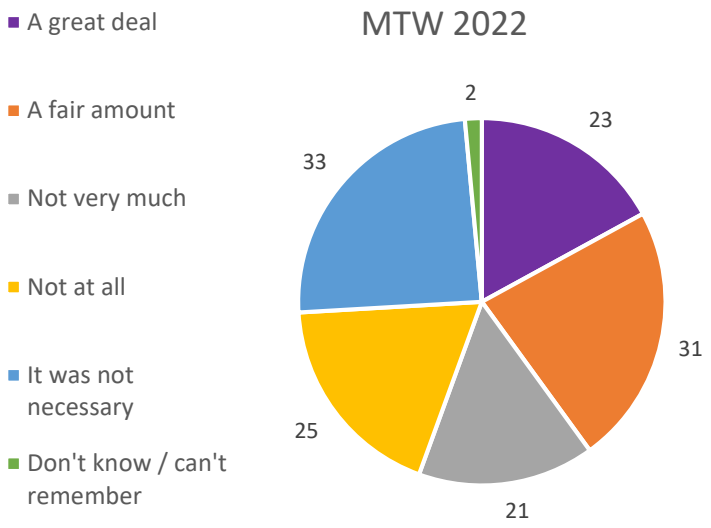


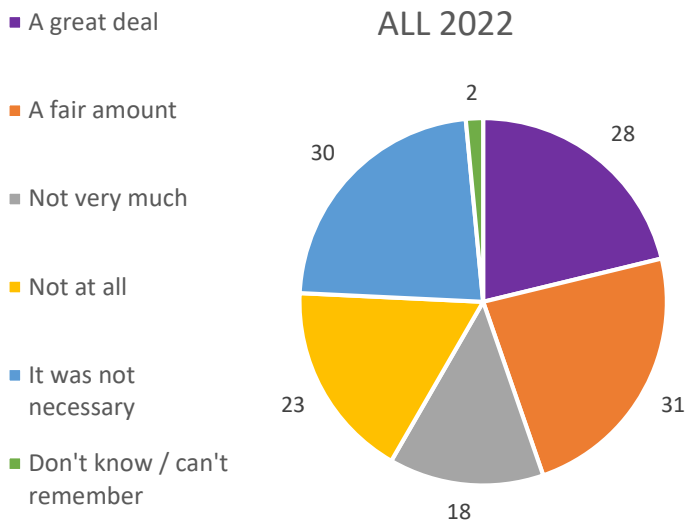




Q34. To what extent did hospital staff involve your family or carers in discussions about you leaving hospital?

	MTW 2022	%	ALL 2022	%
A great deal	73	23	2523	28
A fair amount	97	31	2795	31
Not very much	65	21	1678	18
Not at all	78	25	2119	23
It was not necessary	158	33	4078	30
Don't know / can't remember	12	2	235	2





Theme	Next Steps: Recommendation	Divisional/ Trust wide actions.	Timeframe
Environment	Investigate, understand and address the issues that are preventing patients from sleeping at night.	Look at the lighting on wards and surrounding areas at night. Monitor noise levels through patient feedback, complaints and matron's quality rounds.	Ongoing to March 2024
Food and Drink	Look at why some patients do not feel that the food on drink on offer is sufficient.	Ensure that there is a choice of food to meet varying dietary requirements and that patients have access to drinks at all times. Incorporating the National standards for healthcare food and drink- Benchmarking against national matrix commenced July 2023. Trust wide PLACE lite, PLACE annual Audit and mealtime assessments scheduled for November 2023	Ongoing July 2023-March 2024. November 2023
Privacy and Dignity	For doctors and nurses to look at ways of improving privacy for patients when they are being examined or treated	To be monitored through the matron's quality checks/ back to the floor, patient feedback through complaints and PALS	Ongoing
Communication	To be addressed as part of the break through objectives/ corporate project on complaints where communication is the main theme. This is monitored as part of the strategy Deployment Review (SDR) process: • For doctors and nurses to ensure that patients are acknowledged and included in all conversations which are around them and regarding their care. • Take steps to encourage staff to clearly communicate how an operation/procedure has gone to the patient shortly afterwards. • Ensure hospital staff involve family and/ or carers in discussions about discharge of patients. • Ensure all patients are given verbal and written information about who to contact if they are worried about their condition, or treatment, after leaving hospital.	Look at reasons why some patients think this is not the case. Audit on shared decision-making started October 2023 (Trust wide CQUIN Programme). Look at information that is shared by staff to patients (paper and electronic) and how Patient Knows Best portal can be used. Monitor progress through patient feedback, complaints and matron's quality rounds.	August 2023-January 2024 October 2023-Feb 2024. November 2023. Ongoing

NHS Maidstone and Tunbridge Wells NHS Trust

To approve the Medical Workforce Strategy 2024 – 2026 Medical Director

The Trust Board is requested to review and, if appropriate, approve the Medical Workforce Strategy for 2024 to 2026.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 18/04/23 (early draft)
- People and Organisational Development Committee, 23/06/23
- Executive Team Meeting, 18/07/23 and 17/10/23

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

To approve the To approve the Medical Workforce Strategy 2024 – 2026

[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
Exceptional people, outstanding care

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NHS Trust

Medical Workforce Strategy 2024 - 2026

Foreword

Maidstone and Tunbridge Wells NHS Trust provides acute hospital services (both general hospital services and specialist complex care) to around 760,000 patients.

This can only be achieved through the dedication and commitment of our outstanding people, many of whom are also patients and users of our services, and take great pride in what they do.

We employ a team of around 7,000 full and part time staff across our sites and have significantly invested in the workforce numbers over the last two years.

As in many NHS organisations, medical staffing is one of our greatest workforce challenges. This strategy aligns with the people and culture strategy and outlines our commitment over the next two years to deliver our strategic vision: to reduce our vacancies and increase the number of permanent staff in post.






Contents

Our people and culture vision

Creating an inclusive, compassionate and high-performing culture where our people can thrive and be their best self at work.

We will instil fairness and equality, and promote diversity, giving us access to a pool of talent with wide-ranging experience.

To achieve this for our medical workforce we have identified five strategic priorities:

1

We will strive
to be the healthcare employer of choice in Kent and Medway, creating an environment where exceptional people can deliver outstanding care

2

We will endeavour
to ensure our offering to existing and potential staff is best-in-class in terms of pay, training, flexibility and support

3

We will lead
in developing a non-medical workforce

4

We will embrace
new technologies as a fast follower to change how we work and reduce our future requirements for medical staff

5

We will constantly review
our processes, ensure that our staff are working at the top of their competencies and focus on tasks that add value to patient care

Preparing for success

We are working in new ways across organisational boundaries and in collaboration with system partners.

We support the NHS People Promise as a Trust and this will be delivered by our people strategies.

Our system People Plan highlights the following priorities:

In 2018 we moved to a clinically-led structure to put our expert clinicians at the heart of everything we do. Our teams have faced tough challenges in responding to the pandemic and have done so magnificently.

We know there are ongoing and widespread challenges in recruiting a fully-established medical workforce. Our teams tell us we are already doing great things but this isn't a consistent experience for everyone.

To achieve our vision of reducing vacancies and increasing the number of permanent staff in post we need to improve the consistency of experience, tackle areas of poor experience, learn from good practice and be innovative.

This strategy will contribute to the Trust vision of 'Exceptional people, outstanding care', our clinical strategy and our people and culture strategy.

Challenges and themes for continuous improvement

We employ around 1000 medical staff of which 370 are consultants. Our consultant vacancy rate remains at 10% which is too high for consistent and sustainable high quality care.

We will focus our efforts on the following themes to bring this down.

Equality, diversity and inclusion

We will create an environment where people feel valued for their contribution and thrive in an environment free from discrimination or harassment.

In line with the Trust's Equality, Diversity and Inclusion (EDI) Strategy, we will deliver a positive approach to diversity by running inclusive and de-biased recruitment processes to ensure we have the most adaptable and effective teams who better represent the patients we treat.

In common with other NHS organisations, our Medical Workforce Race and Equality Standards data highlights BME under-representation in senior medical roles.

We must ensure that in the future our recruitment is both inclusive and transparent.

We have already aligned with the NHS Kent and Medway medical workforce inclusion charter, with a commitment to:

- Improve representation at senior medical levels
- Eliminate bullying and harassment of all staff
- Support a fairer process for General Medical Council (GMC) referrals
- Support career progression for all doctors

Our plan 2024 - 2026:

2024

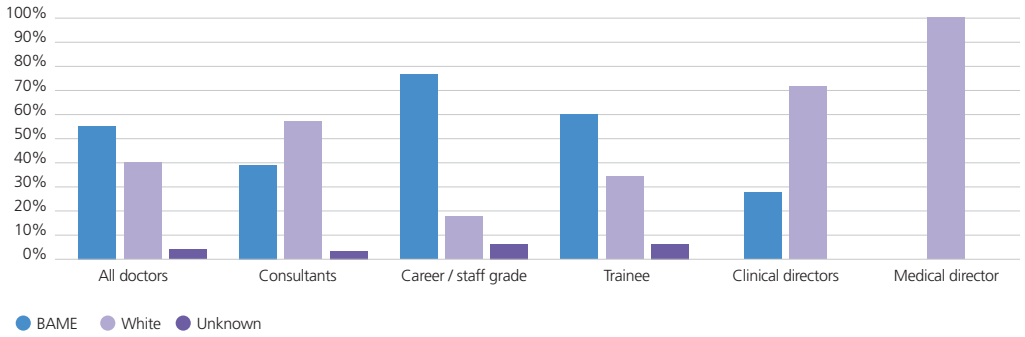
- Specific anti-bias training for panel members and shortlisters
- Trained EDI representatives on interview panels
- Introduce stakeholder panels for Consultant interviews to ensure diverse staff groups are involved in the selection process
- Working with the EDI team and our many network groups including:
  - Cultural and Ethnic Minorities
  - LGBT+
  - Senior Women Leaders
  - Carers
  - Disability

2025

- Greater flexibility on job-planning around pregnancy or return to work after parental leave
- MWRES data to be collated locally and reviewed regularly at a Divisional level to ensure every part of the organisation understands their profile and is consciously focused on diversity and inclusion

2026

Support career progression for all doctors



Recruitment

Our clinical strategy sets out a clear ambition for service development and new roles.

Through medical workforce planning and clear career pathways we will create a sustainable, productive workforce. Innovative pathways of care will require a transformation in the workforce including increased use of technology, a different skill mix and new roles.

For a good candidate, securing and remaining in a role at MTW should be the path of least resistance and a trusted process.

We recognise that our recruitment process can take too long and may not always be responsive. We will work to remove barriers and delays with the aim to onboard UK-based clinicians in 6 weeks and for this process to take 10 weeks for those requiring a visa.

The Kent and Medway Medical School offers us the opportunity to develop home-grown talent with doctors and non-medical staff drawn from our own community.

Our plan 2024 - 2026:

2024

- Divisions to have a rolling programme of advertising vacancies
- Extend the provision of high quality pre-application information to ensure MTW attracts the best candidates
- Develop an easy to access work-experience programme for schools including our active involvement in careers activities
- Work with our medical students to ensure a rewarding and positive experience
- Work with KSS Deanery to provide a best-in-class training experience
- Consider dedicated consultant leads for recruitment with SPA time scheduled for shortlisting and interviews, especially in the most challenged areas

2025

- Consider international recruitment if a vacancy is not attracting local candidates on the second round of advertising
- Commence 'settling in' conversations at the three month point to ensure our people are thriving
- Consider over-recruiting in areas of high turnover
- Use job planning as a tool to discuss future career intentions to ensure better support and identification of development opportunities
- Conduct exit interviews for all medical staff

2026

Securing and remaining in a role at MTW should be the path of least resistance and a trusted process

Business planning and intelligence

MTW holds huge amounts of information in our various corporate systems, including finance and HR, but we do not share this information productively in the Trust. We need to develop tools to give clinical leaders greater awareness of their vacancies projected forward over time.

We recognise that this needs further development both within and across the divisions and that we need to share and leverage the data we currently hold. We need to triangulate to ensure accuracy, and develop dashboards and tools that help mangers and senior clinicians to have visibility of their current and future staffing issues.

Our recruitment success or failure must be measured via a dashboard which ensures one version of the truth and allows for deep dive areas to be identified. This aligns with the people and culture strategy.

Our plan 2024 - 2026:

2024

- Ensure we can provide services and divisions with current information on:
  - Vacancy levels and trends
  - Agency and bank use
  - Fill rates
  - Pipeline
  - Turnover
  - Number of leavers

2025

- Close vacancy gaps and ensure they are recognised as part of business planning
- Project future workforce demand forward a minimum of three years using local and national intelligence

2026

We need to develop tools that help managers and senior clinicians have visibility of current and future staffing issues

Improving our offering

We need to ensure MTW offers the most attractive package in our region for substantive staff.

By improving our offering we can increase resilience, reduce sickness absence, and improve staff experience. All of these factors impact positively on our ability to recruit and retain staff.

We employ four different types of doctor, as well as a developing non-medical workforce:

- Consultants on the specialist register
- Senior speciality doctors (previously associate specialists)
- Junior speciality doctors (previously junior or senior clinical fellows)
- Doctors in training, both foundation and higher specialist trainees

While a number of offerings are applicable to all and should be consistent, individual groups require bespoke offerings to ensure we are an employer of choice, delivering effective and productive services for patients and their families while ensuring the wellbeing and work-life balance of our people.

By improving our offering we can increase resilience, reduce sickness absence, and improve staff experience

Our medical workforce

Consultants are at the peak of their profession; they work independently, drive change and improvement and make a significant contribution toward delivering our strategic vision and objectives.

Currently our work requires around 370 consultants and around 10% of these posts are vacant or filled with temporary staff. This puts an enormous strain on current staff, junior teams and patients. It then becomes self-perpetuating, making recruitment more challenging.

In some specialties vacancies at consultant level are particularly pronounced:

Cancer
- 6 Oncology

Medicine
- 4 Acute and Geriatrics
- 6 General

Surgery
- 7 Anaesthetics
- 3 Trauma and Orthopaedics
- 3 Ophthalmology

Core Services
- 5 Pathology

As at September 2023

Planned service developments such as the Kent and Medway Orthopaedic Centre will place a significant additional demand on all staff groups including our consultants.

Vacancies can also be seen in the other medical and non-medical workforce cohorts.

Doctors in training from F1 to ST6 tend to be high quality, motivated and dedicated workers. They are recruited and managed by the Deanery – removing some administrative burden from us – and come with some funding, which reduces our costs.

They have training needs that must be supported but bring a number of benefits that greatly outweigh the costs and each trainee is a potential consultant of the future.

Currently we require around 370 consultants and around 10% of these posts are vacant or filled with temporary staff

Our plan 2024 - 2026:

2024 | 2025 | 2026

Consultants

- Embrace the coaching culture and encourage our clinical leaders to undertake the Exceptional Leaders programme
- Work with consultants on flexibility regarding the number of PAs, support for research and medical education, annualised rotas, and options for home working in line with our flexible working policy, taking into account service needs
- Embrace remote working where possible, for example radiology and digital outpatients
- Encourage specialist interests that benefit our Trust and/or the wider system
- Sign up to the BMA Consultant Charter and the SAS Charter and abide by their recommendations
- SPA time above the core 1.5 PA necessary for revalidation should be directed to priorities such as quality improvement, education, mortality review, appraisal and governance activity
- Consultant development and engagement should be prioritised through:
  - The consultant development course
  - Exceptional Leaders
  - Regular Medical Director engagement events
- Work to offer 'best in class' appraisal and revalidation processes, providing easy access to data on CPD, workload, incidents, complaints and outcomes to facilitate compliance with revalidation requirements

Senior SAS

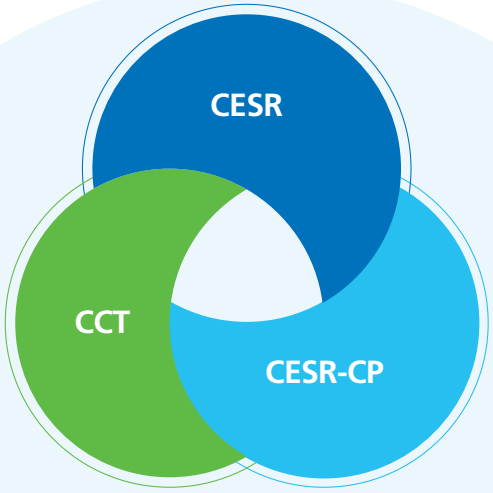
- Develop and introduce the 'Specialist' role allowing independent practice in defined areas including on-call working and operating lists. This empowers our most experienced staff and acts to improve consultant working conditions with lower on-call frequency
- Commit to equivalence of educational opportunity between training and non-training grades
- SAS tutor and SAS advocate roles will act as a bridge between the executive team and SAS cohort. Working together these roles should champion the SAS body, improving their visibility within the Trust and growing their qualifications and skill
  - The SAS advocate acts to improve the wellbeing of SAS doctors and their work experience
  - The SAS tutor acts to promote educational opportunity for the SAS cohort
- Promote the development of a CESR route to specialist registration for our most senior SAS doctors. Depending on the specialty this will involve:
  - Educational supervision
  - Exams
  - Training
  - Secondments within MTW
  - Portfolio development

Junior SAS

- Support our doctors to undertake PGCert or Master's-level qualifications where appropriate
- Continue to grow our clinical fellows programme including simulation, trauma, informatics, management and safety

Trainees

- Look to grow our training numbers in all specialties, focusing initially on those with persistent vacancies
- Ensure our trainees have increased opportunities to develop themselves with us ahead of securing their first consultant post, i.e. through acting up



Our non-medical workforce

We recognise the huge contribution that our non-medical workforce makes to the delivery of patient care and the development of strong teams.

Advanced Clinical Practitioners (ACPs) and Physicians Associates (PAs) provide a stable, highly skilled workforce across our Trust. Depending on seniority and training they operate from F2 to HST level and deliver a wide range of activities that have traditionally been performed by doctors. We currently employ 50 ACPs and 14 PAs.

As the Trust delivers our clinical strategy it must develop increasingly innovative pathways of care and continue to invest in training and learning opportunities which support professional development. We know that there is inconsistent access to these opportunities across our services, with some specialties and departments offering extended roles and others at the start of that journey.

Our plan 2024 - 2026:

2024

- Develop a governance and training framework to support our non-medical staff to operate at the top of their competencies
- Expand opportunities to ensure we deliver positive career progression for nurses and allied health professionals as well as management and educational roles

2025

- Support divisions to consider filling medical vacancies with non-medical staff, creating these roles through existing medical workforce gaps
- Explore opportunities to develop clinical academic posts
- Explore opportunities to grow our workforce locally, for example the 'Medical Doctor Degree Apprenticeship' and other clinical apprenticeships

2026

Clinical practice

Knowledge, skills and behaviours needed to provide high quality healthcare that is safe, effective and person centred

Facilitating learning

Knowledge, skills and behaviours needed to enable effective learning in the workplace

Leadership

Knowledge, skills and behaviours needed to lead and to fulfil management responsibilities

Evidence, research and development

Knowledge, skills and behaviours needed to use evidence to inform practice and improve services

Increasing efficiency and embracing new technologies

Demand for our services is rising faster than ever before. Along with growing our medical workforce we must also become more efficient.

A greater organisational focus on technology and reviewing our processes has the potential to yield increased activity and ultimately reduce our requirement for medical staff.

Sunrise EPR presents an extraordinary opportunity to increase our productivity. The system automates many functions previously requiring paper entry and this will free up medical and non-medical time to deliver care.

Our plan 2024 - 2026:

2024 — 2025 — 2026

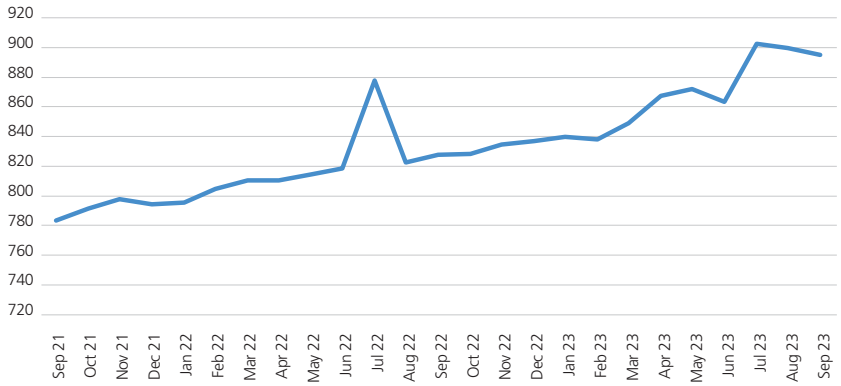
- Prioritise mobile access to Sunrise and mobile observations
- Embrace opportunities to reduce administrative burden in all system designs driven by clinical input focusing on:
  - Do I need to do this at all – is it adding value?
  - Can Sunrise or my system do this automatically?
  - Can administrative staff do this just as well?
- Continue to explore opportunities to automate and digitise common tasks:
  - EDN & TTO process on discharge.
  - Contacting other staff
  - Acute GP referrals
  - Handover
- We should engage with developing technologies such as artificial intelligence for image interpretation and pathology

Sunrise EPR presents an extraordinary opportunity to increase our productivity

Building our medical workforce

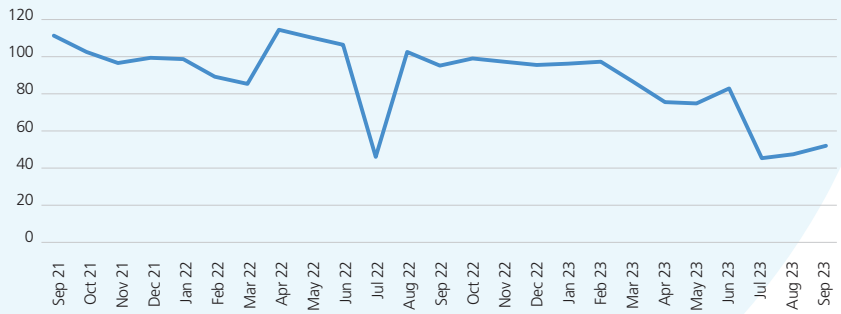
Funded medical posts have risen sharply in response to increased demand post-pandemic. We have made excellent progress recruiting to these plus pre-existing vacancies and have reduced the gap from 140 posts to around 60.

Medical staff in post



However almost all of that improvement has come in non-consultant grades, leaving approximately 40 consultant vacancies – around 10% – the same number we had two years ago. Our focus will therefore be on consultant attraction, recruitment and retention going forward.

Medical staff vacancies



Medicine and Emergency Care

The Division has made great progress in junior doctor recruitment, having successfully brought in 45 new doctors in the past two years. However, Consultant recruitment has been less successful with a persistent shortfall of 10 across the Division.

Surgery

The Division has over 30 vacancies with 15 at Consultant level, almost all in anaesthetics. This reflects a national shortage of anaesthetists and an enormous increase in the demand for their services as the NHS refocuses on waiting list reduction.

Cancer

Although lower absolute numbers, the Division has five long-standing vacancies at Consultant level in Oncology despite being the tertiary referral centre for Kent and Medway.

Conclusion

Delivering the medical workforce strategy will improve the experience and working lives of our people and help us continue to improve the experience, care and outcomes of the communities we provide care for.

It will help us to achieve our aims of reducing vacancies and increasing the number of permanent staff in post.

It will ensure we are able to support and develop our medical and non-medical workforce to provide sustainable services and outstanding care by exceptional people.

We will become an employer of choice offering an attractive environment in which our people can thrive.

MTW
Exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells
NHS Trust

Maidstone Hospital
Hermitage Lane
Maidstone
Kent, ME16 9QQ

01622 729000

Tunbridge Wells Hospital
Tonbridge Road
Tunbridge Wells
Kent, TN2 4QJ

01892 823535

10.2022 – 524-V7

NHS
Maidstone and Tunbridge Wells NHS Trust

Update on the West Kent and Care Partnership (HCP) and NHS Kent and Medway Integrated Care Board (ICB)	**Director of Strategy, Planning and Partnerships**

The enclosed report provides information and updates on the establishment of the Kent & Medway Integrated Care Board (ICB) and the West Kent Health Care Partnership (WKHCP) and includes details of the progress with the key programmes and projects.

Which Committees have reviewed the information prior to Board submission?
- Executive Team Meeting, 24/10/23

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

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

ICB and West Kent HCP update

October 2023

ICB/ System news

- On Thursday 19th October the ICB held a System Flow and Discharge Summit ahead of winter reviewing all aspects of health and social care provision.
- On Friday 20th October the ICB hosted their 2nd Symposium focussing on partnership working and the development of the Integrated Care Strategy refresh.
- Provider collaborative plans to go the ICB Board in early November for approval.
- The staff consultation with the HCP facing teams started on 19th October.

- QVH are engaging with stake holders ahead of developing their strategy. There is link for responding that has been sent out to chiefs

West Kent HCP

- Dr Vijay Koshal has commenced in his role as Primary Care Medical Director for WK and will be working primary care development, focussing on Integrated Neighbourhood teams and the ICB primary care strategy development.
- The ICB staff consultation with HCP facing staff has commenced. Sally and I will work with the team to support them and we are hopeful that previous work and utilising vacancies will minimise the impact on our team.
- There was an HCP away half day on 5th October which was well attended by all partners. The focus was on ICPs and the creation of an ICP Development Framework to describe the next 2 to 3 years and build consensus among partners.

West Kent Projects & Programmes	What we are doing now
Frailty & Adults Complex Needs	▪ Community falls prevention to reduce conveyances to ED ▪ Step down from hospital Virtual Wards ▪ Single point of access
Adults & Children's Mental Health	▪ Dementia diagnosis (exploration of DiADeM tool) ▪ Self-harm prevention ▪ Serious mental-illness ▪ LD Health Checks
Integrated Neighbourhood Teams	▪ Defining how the system works together on managing complex needs and embedding prevention ▪ A focus on wider health and wellbeing support ▪ Social prescribing and care navigation ▪ Addressing inequalities through shared data to inform local needs at a neighbourhood level ▪ Developing a representative Resident and Community Forum in each INT
Primary Care Demand and Capacity	▪ Establish a clear picture of the demand and capacity of each GP Practice in West Kent ▪ Build a comprehensive data system that can report at HCP level to better understand and manage demand and capacity
Maidstone Inequalities	▪ Targetting specific communities through wider determinants ▪ Tackling food insecurity
Discharge & Flow	▪ Developing better use of shared resources ▪ Establishing a single version of the truth through data to facilitate the patient journey towards discharge
Long Term Conditions	▪ Early identification (COPD, Cardiac and Pulmonary Rehabilitation) ▪ Proactive management of long-term conditions
Workforce	▪ Developing skills to enhance care support and deliver of key initiatives (i.e. social prescribing, support PHM and Prevention)
Digital & Data	▪ Embed better use of technology to provide community support ▪ Facilitate information sharing protocols to develop a reliable shared data set

Risks and challenges

- *Workforce* - All providers are identifying capacity issues with staffing core services and 2022/23 planning. Of particular note are ongoing shortages of domiciliary care staff in social care. primary care staffing capacity to meet increasing demands presenting at practices also raised as an issue and nursing capacity pressures in secondary care.
- *Demand pressures* - Pressures across WK system arising from range of sources including: planned care backlog; Covid/Post Covid related demand; new ways of working i.e. VCA/remote consultations, vaccination/booster programme and urgent care demand.

NHS Maidstone and Tunbridge Wells NHS Trust

To approve the plans for the development of the Kent and Medway Provider Collaboratives	Director of Strategy, Planning and Partnerships

The enclosed report provides information on the current position and next steps for developing provider collaboratives including proposed Terms of reference for the Provider Collaborative Board. Currently, there is no proposed delegated authority to the provider collaboratives beyond that of the attendees.

It is proposed the acute provider collaborative will focus on service reviews, commencing with ENT and dental cases requiring general anaesthetic.

The Trust Board should note that further amendments are likely to be made to the Terms of Reference for the Provider Collaborative Board, as some comments have been made on the submitted version.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting (ETM), 17/10/23

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

The support the establishment of the 3 new provider collaboratives

[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

Kent and Medway Provider Collaboratives

Supporting paper for:

Provider Chairs/CEOs

9th October 2023

Kent and Medway Integrated Care System

Attain

In this document you will find…

Context of provider collaborative development in Kent and Medway

- How provider collaboratives have been developed
- Role of provider collaboratives in the system
- Principles of provider collaboratives in Kent and Medway

Proposed **governance** (supported by Provider Collaborative Board Terms of Reference (separate Word document))

Areas of responsibility, authority, governance, membership and leadership of the proposed four at-scale provider collaboratives in Kent and Medway

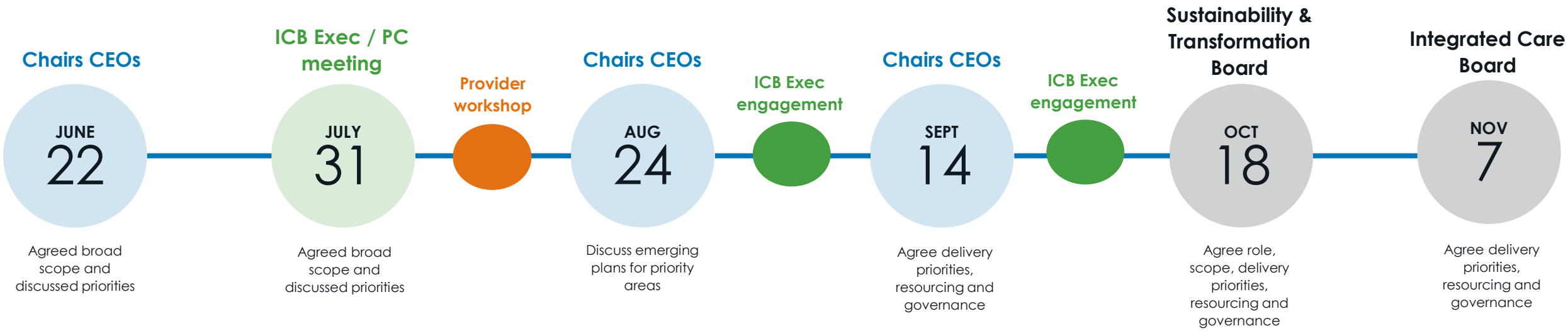
Resourcing

Early assessment and next steps of the at scale provider collaboratives' maturity against the NHS England **Provider Collaborative Maturity Matrix**

Milestone Plan

Attain

The design of Provider Collaboratives has been a partnership between the leaders of providers and the ICB



The provider collaborative development work has included:

- Support with early development work from the Kings Fund
- Leadership from provider Chairs and CEOs
- Wide engagement and contribution from provider executive teams
- Extensive engagement with the ICB Executive Team, including the ICB's Financial Recovery Programme and alignment to the ICB's pathway programmes

The principles of provider collaboration that were agreed in late 2022 have underpinned this development work

- any collaboration must be justified on the basis of its ability to demonstrate measurable improvements in patient and population outcomes, patient experience, efficiency/productivity, and the reduction of inequalities
- any collaboration needs to have decision making located at the appropriate level in the system and involve the appropriate individuals
- any collaboration should be based on the principles of subsidiarity and taking decisions as close to the patient and citizen as possible
- any collaboration must recognise that it may create 'winners and losers' and therefore encompass a commitment to manage the impact of any such problems
- any collaboration must be clear about the problems it is attempting to resolve and avoid creating additional tiers of bureaucracy
- any collaboration must demonstrate that it is added value over and above any existing approach
- any collaboration must be based on strong clinical and care professional engagement that has provided an evidence base for its work programme and a platform for its implementation
- any collaboration needs to be based recognise staffing and workforce issues as a driver to set priorities and as a conscious restriction on the pace and scope of its work programme
- any collaboration should recognise the time frames in which it may operate - delivering quick tactical benefits and longer term more strategic solutions
- any collaboration should operate by doing only what it can do best, and be coherent with work at HCP level and at the ICB level

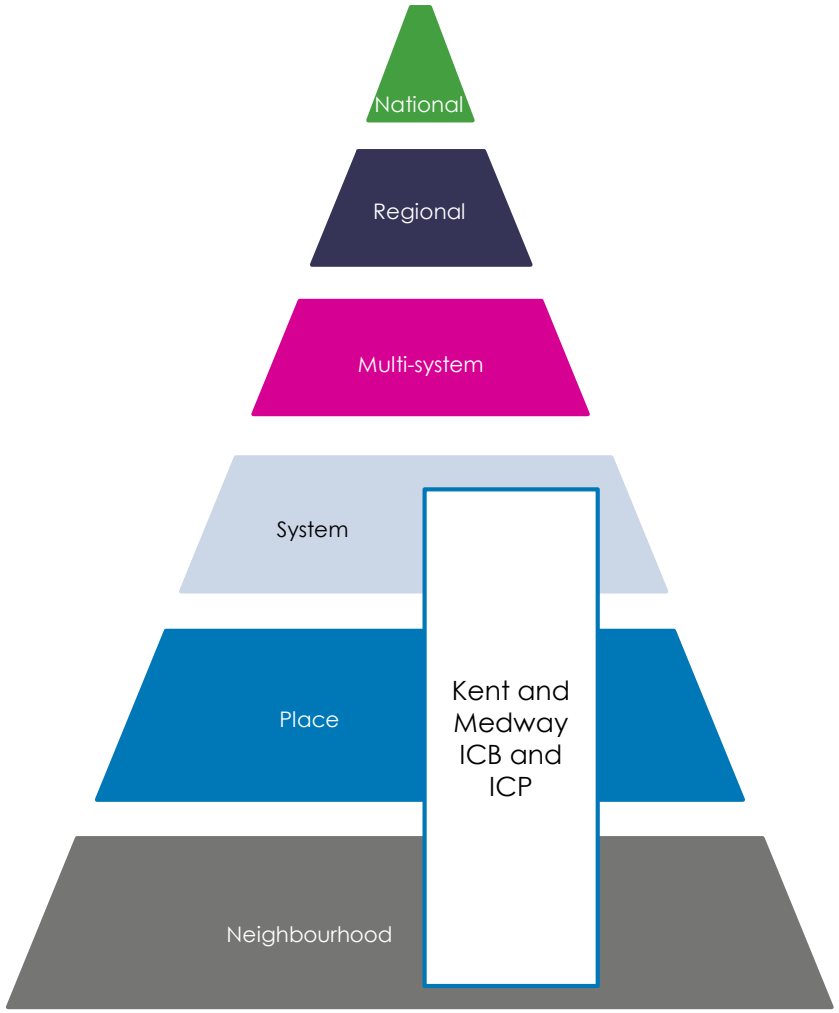
Recent engagement has added the following:

- any collaboration will only be to the depth required to have an impact
- any collaboration should start with the simple stuff, building complexity with our maturity – and keeping the list of priorities small
- any collaboration should be supported by the right resources and supporting governance – to enable us to deliver the ambition
- Any collaboration will support the Kent and Medway system to deliver its efficiency targets (Financial Recovery Programme)

The functions of the provider collaboratives in Kent and Medway

Scope of this paper, including how they relate to H&CPs and Neighbourhoods

System levels



Collaborative delivery of health services

Provider collaborative arrangements	Purpose of collaboration	Kent and Medway collaboratives	Partners	Example services
AHSNs, AHSCs, public-private partnerships	Collaborative arrangements to deliver specialised services across the region	E.g. Kent Surrey Sussex Academic Health Science Network	Specialist providers Research universities Industry	Highly specialist services Specialised services
Specialist clinical networks Provider collaboratives	Collaborative arrangements to deliver specialised services across **multiple systems**	E.g. Provider Collaborative Kent, Surrey and Sussex Kent and Sussex CAMHS Tier 4	Providers (including from outside Kent and Medway)	Highly specialised services Community and MH
Provider collaboratives	Collaboration between providers to work together **at scale** to benefit their populations	**Provider Collaborative Board** **MHLDA Collaborative** **Community Collaborative** **Acute Collaborative**	Providers, GPs, KCC and Medway Council, VCSE	Secondary care Community care (physical and mental)
H&CPs	Providers of health and care, collaborating to deliver **smaller 'place based' geographies**	Dartford & Gravesham H&CP East Kent H&CP West Kent H&CP Medway H&CP	Providers GPs KCC and Medway Council Voluntary sector	Community health Social care Urgent care
Neighbourhood Teams PCNs	Hyper local collaboration of **front-line teams** to delver integrated care to the population	Neighbourhood Teams PCNs	GPs Voluntary sector KCC and Medway Council Providers	Primary care Prevention, public health and wellbeing Community health Social care

What will be different? Provider collaboratives will supplement existing delivery mechanisms in the Kent and Medway ICS

*Provider collaboratives can take responsibility for delivering elements of the ICB's ambitions – including the ICB's **Financial Recovery Programme** and areas of system complexity that require providers to work together to tackle difficult problems*

ICB

Provider Boards

*Provider collaboratives will support their constituent provider organisations to **tackle areas where collaboration with other local providers will support them to address challenges** and provide improved services, more efficiently*

Existing provider collaboratives and networks

*A more strategic approach to provider collaboratives will provide a **mechanism for existing provider collaborative activity to be consolidated** (e.g., Diagnostics and Pathology Network)*

Kent and Medway at-scale health service provider collaboratives

*Provider collaboratives will be responsible for supporting **local delivery at an H&CP and neighbourhood level** by creating mechanisms for the sharing of resources (e.g., holding Section 75s with local authorities)*

H&CPs

Neighbourhoods

Where we can tackle complex problems better together **at scale, as providers of health services** we will collaborate to deliver (or enable the delivery of) improved outcomes, transformation and efficiencies for the population and system of Kent and Medway.

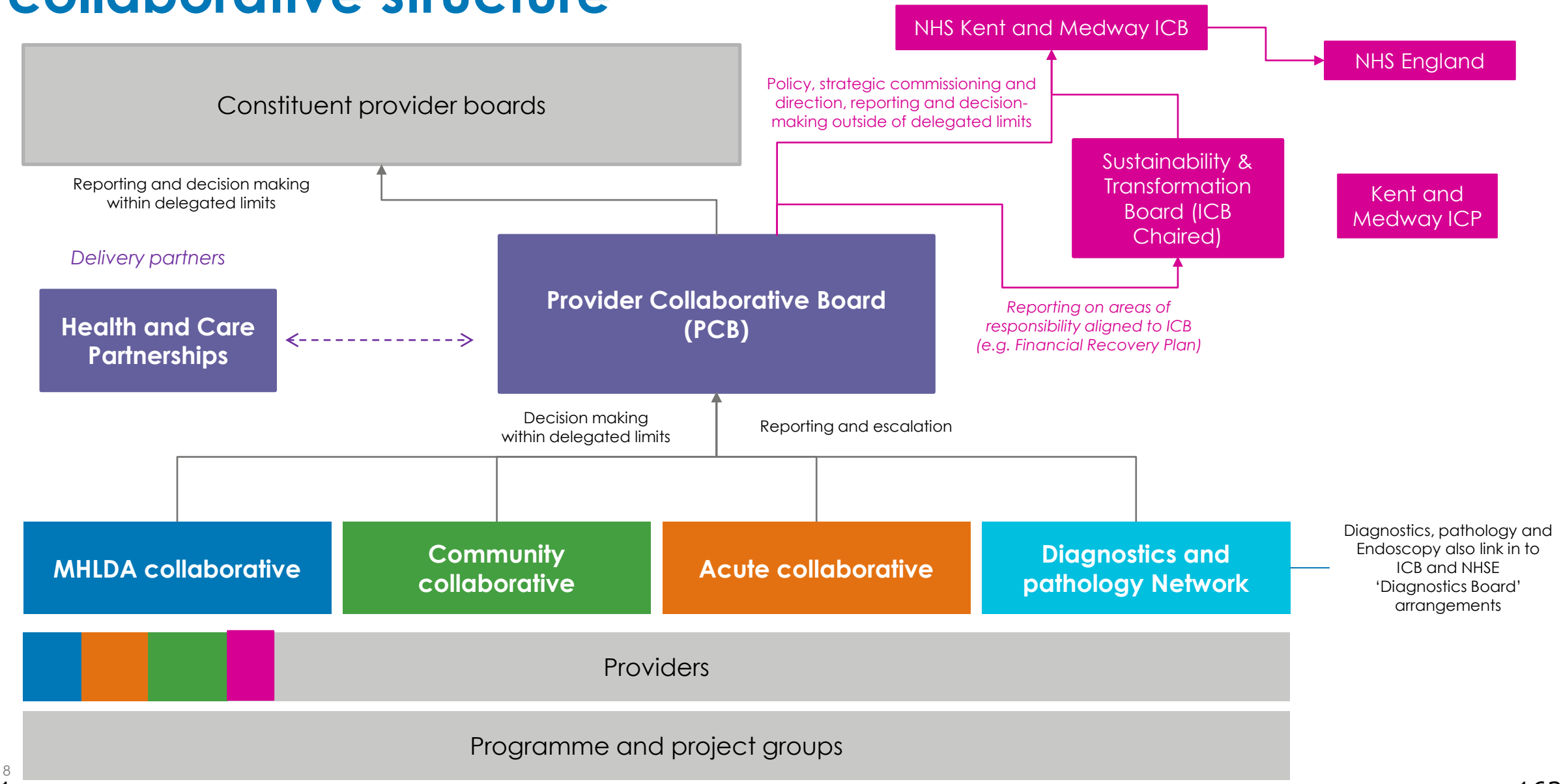
Four at scale collaboratives of health providers will provide a design, delivery and enabling function to supplement the existing delivery infrastructure in the system. These four provider collaboratives will be:

1. **[All] Provider Collaborative Board**
2. **MHLDA Provider Collaborative**
3. **Community Collaborative**
4. **Acute Collaborative**

Kent and Medway are proposing the development of four at scale provider collaboratives

Provider Collaborative Board	MHLDA	Community	Acute
To drive the delivery of collaborative programmes of work across all providers in Kent and Medway To provide leadership and assurance of and support to the work and development of the three provider collaboratives and the Diagnostics & Pathology Network	Building on the current collaborative and it's work programme, together tackle complex MHLDA services where a joined-up approach will drive improved outcomes for the population and system	To drive a collaborative approach to the delivery of complex community and primary care services at scale, including with our local authority partners	To drive transformation of secondary care services where collaboration will deliver improved outcomes for the population and the system
All providers • KMPT • Medway Community • HCRG • EKHUFT • KCHFT • MTW • DG • Medway • SECAM	**MHLDA partners** • KMPT • KCC • Medway Council • VCSE • KCHFT • Medway Community • ICB • Primary care • NELFT	**Community partners** • KCHFT • Medway CT • HCRG • VCSE • KCC • Medway Council • ICB • Primary care	**Acute partners** • EKHUFT • MTW • DG • Medway • ICB

Proposed governance of the at scale provider collaborative structure



Provider Collaborative Board

Responsibility for the delivery of…

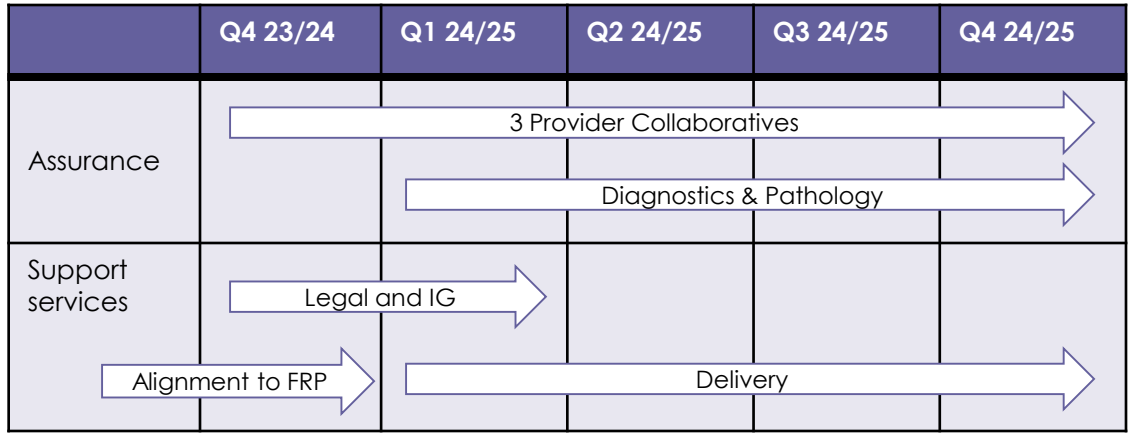
Assurance of work of other collaboratives and their development (through the maturity matrix)

Support Services Programme to drive efficiencies of a share approach to these organsiational functions (**aligned to the ICB's Financial Recovery Programme**), including:

1. Legal and IG
2. One Public Estate (inc. LAs)
3. Procurement

Assurance of the work of the Diagnostics and Pathology Network

Plan for 2024/25



Authority and governance

- The Board has the decision-making authority of the individuals on the Board and the powers delegated to them by the positions they hold (Chairs and CEOs). **It does not have delegated authority from the ICB or from the Trust Boards.**
- For decisions outside the scope of these individuals (e.g., material in scope / significant financial impact / requiring public consultation (e.g., would not secure HOSC approval)), the Board will make recommendations to the provider boards and / or the Sustainability & Transformation Board.
- Any actions or recommendations made by the Board will be through consensus. Where consensus cannot be achieved, agreement of 75% of those present will be sufficient, subject to the meeting being quorate, for a matter to be determined.
- Any decisions endorsed will be shared with the provider executive teams, Sustainability & Transformation Board, and four H&CPs to support local planning.
- The Board will have no commissioning responsibilities
- Priorities will be reviewed annually. Governance may evolve in time, by mutual agreement of the providers and ICB, as required to deliver priorities.

Partners and membership

Chairs and CEOs from all eight providers – KMPT, Medway Community, HCRG, KCHFT, EKHUFT, SECAMB, MTW, DG and Medway

Leadership

Chair: David Highton

Exec Lead: Sheila Stenson

Exec Lead Support Services: Chris Wright

MHLDA Provider Collaborative

Responsibility for the delivery of…

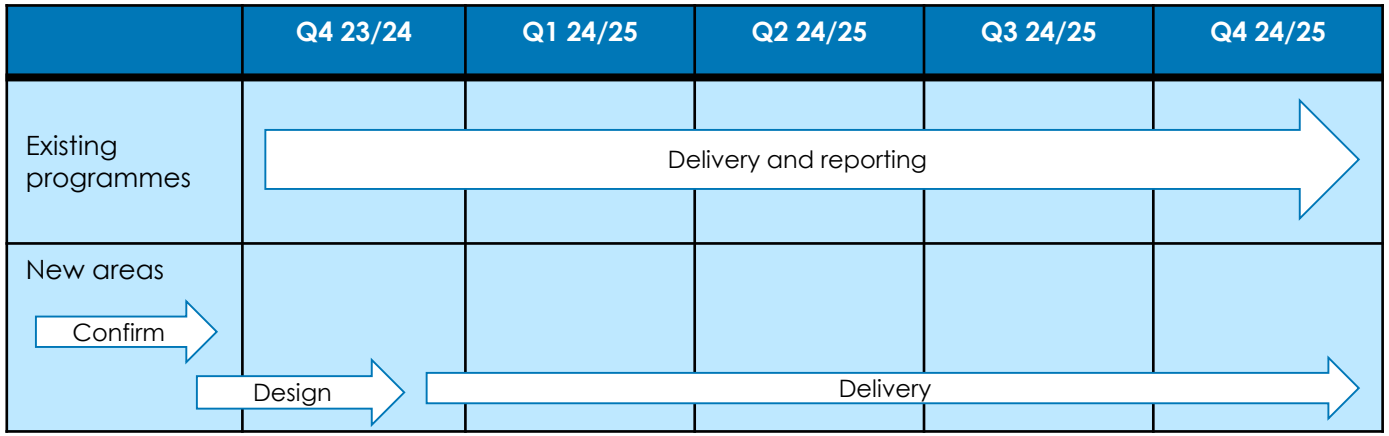
Continued delivery of programme areas that have historically sat with the MHDLA Provider Collaborative Board, including:

1. Community Mental Health Transformation Programme
2. LDA out of area placements Project
3. CYP transitions and out of area placements Project
4. Suicide Prevention Project
5. Mental health urgent and emergency care

Other areas in scope that may be delivered over a longer period, and require further development include:

1. Mental health frequent attenders project
2. Delivery of the Mental Health Digital Strategy
3. Neurodiversity project

Plan for 2024/25



Authority and governance

- The Board has the decision-making authority of the individuals on the Board and the powers delegated to them by the positions they hold. It does not have delegated authority from the Provider Collaborative Board, ICB or from provider boards
- For decisions outside the scope of these individuals, recommendations will be made to the Provider Collaborative Board for approval or escalation
- Any actions or recommendations made by the Board will be through consensus. Where consensus cannot be achieved, agreement of 75% of those present will be sufficient, subject to the meeting being quorate, for a matter to be determined
- Any decisions endorsed will be shared with the provider executive teams, Sustainability & Transformation Board, and four H&CPs to support local planning
- Priorities will be reviewed annually. Governance may evolve in time, by mutual agreement of the providers and ICB, as required to deliver priorities
- Includes ICB membership

Partners and membership

KMPT, KCC, Medway Council, VCSE, KCHFT, Medway Community, ICB, Primary care, NELFT

Leadership

Chair: Sheila Stenson

Exec Lead: TBC

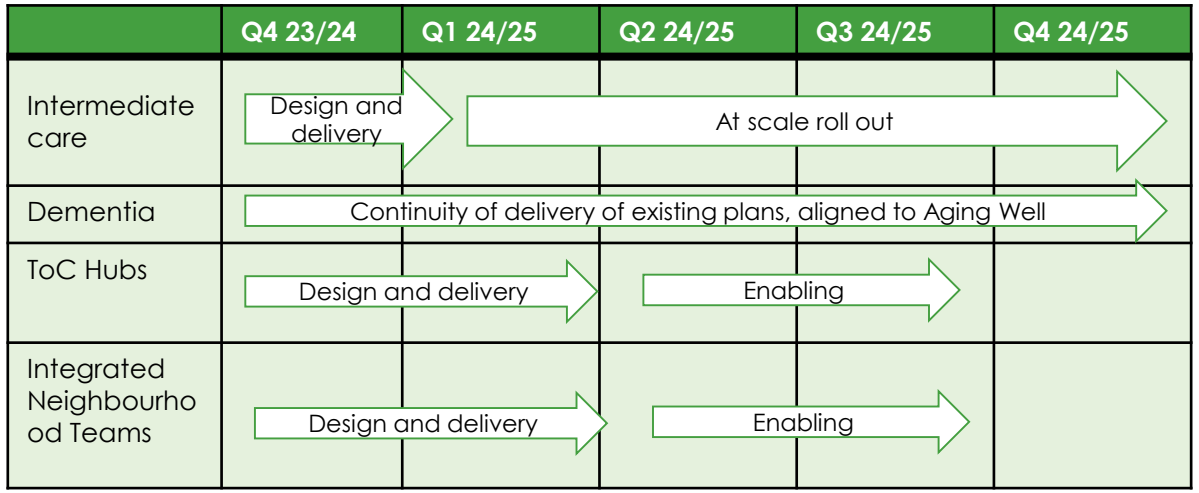
Community Provider Collaborative

Responsibility for the delivery of…

At-scale delivery of:

- Intermediate care model – building on the East Kent pilot of a winter integrated bed model to improve provision of short-term services (and reduce spot purchasing of beds) (**aligned to FRP's Better Use of Beds**)
- Transfer of care hubs
- Dementia improvement project (final collaborative 'home' TBC through discussion with clinical colleagues – may be MHLDA provider collaborative)
- Enabling deployment of resources to the Integrated Neighbourhood Teams (with LA partners through Section 75s)

Plan for 2024



- In time, the delivery of the community transformation will be delivered through this forum

Authority and governance

- The Board has the decision-making authority of the individuals on the Board and the powers delegated to them by the positions they hold. It does not have delegated authority from the Provider Collaborative Board, ICB or from provider boards
- For decisions outside the scope of these individuals, recommendations will be made to the Provider Collaborative Board for approval or escalation
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- Any decisions endorsed will be shared with the provider executive teams, Sustainability & Transformation Board, and four H&CPs to support local planning
- Priorities will be reviewed annually. Governance may evolve in time, by mutual agreement of the providers and ICB, as required to deliver priorities
- Includes ICB membership

Partners and membership

KCHFT, Medway CT, HCRG, VCSE, KCC, Medway Council, ICB, primary care providers (PCNs/Confeds)

Leadership

Chair: Mairead McCormick

Exec Lead: TBC

Acute Provider Collaborative

Responsibility for the delivery of…

Service review (**aligned to the ICB's Financial Recovery Programme**)of all acute services (including, where significant, the interface with community, mental health and independent sector services) and specialised commissioning to establish the sustainability of services and opportunity for improvement of this position. Delivery of recommendations from review could be through individual providers, PCs, HCPs or ICB. Recommendations may include service improvement, service redesign and/or service reconfiguration

Service Review - factors of sustainability

Early focus on ENT and Dental GA to drive improvements in the service

Support to deliver the system's endoscopy work programme (including bids for estates)

Plan for 2024/25

	Q4 23/24	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25
Service Review	Service Review	Service Review: Detailed design and delivery Quick win delivery			
ENT	Discovery and design	Delivery of impact			
Endoscopy	Review and sign-off proposals				

Authority and governance

- The Board has the decision-making authority of the individuals on the Board and the powers delegated to them by the positions they hold (Trust Executive Team members). It does not have delegated authority from the Provider Collaborative Board, ICB or from the Trust Boards
- For decisions outside the scope of these individuals' recommendations will be made to the Provider Collaborative Board for approval or escalation
- Any actions or recommendations made by the Board will be through consensus. Where consensus cannot be achieved, agreement of 75% of those present will be sufficient, subject to the meeting being quorate, for a matter to be determined
- Any decisions endorsed will be shared with the provider executive teams, Sustainability & Transformation Board, and four H&CPs to support local planning
- Priorities will be reviewed annually. Governance may evolve in time, by mutual agreement of the providers and ICB, as required to deliver priorities
- Includes ICB membership

Partners and membership

Executive Team members from each of the four acute trusts and the Director of Delivery of the ICB

Leadership

Chair: Jayne Black

Exec Lead: TBC

The resourcing of the at scale provider collaboratives

ICB

Provider Collaborative Board	MHLDA	Community	Acute
Chair: David Highton Executive Lead: Sheila Stenson Executive Leadership of Support Services Programme: Chris Wright	Chair / Executive Lead: Sheila Stenson	Chair / Executive Lead: Mairead McCormick	Chair / Executive Lead: Jayne Black

Provider Collaborative MD – JD drafted for a substantive, went to advert in September
Interim support is being provided by Attain

Additional provider resources to be determined as more detailed workplan emerges

External support provided to deliver elements of the Service Review

TBC (after restructure) | TBC (after restructure) | TBC (after restructure)

Population health

Information governance

Kent and Medway Provider Collaborative maturity – measured against the NHS England Provider Collaborative Maturity Matrix

Domain	Objective	Provider Collaborative Board	MHLDA Provider Collaborative	Community Collaborative	Acute Collaborative
Outcomes and benefits	Reduce unwarranted variation and inequalities in patient outcomes, access and experience Improve resilience Enhance productivity and value for money	**Emerging** Identifying areas for improvement with shared data sets and committing to addressing the challenges together – including sharing resources and mutual aid	**Developing** Co-designing collaborative transformation plans and programmes to address challenges	**Emerging/Developing** In some areas, co-designing collaborative transformation plans and programmes to address challenges	**Emerging** Identifying areas for improvement with shared data sets and committing to addressing the challenges together – including sharing resources and mutual aid
Governance and Leadership	Implement shared vision and governance Build a culture of mutual support and accountability Embed multi-professional clinical and care leadership	**Emerging/Developing** Developing and implementing shared governance, committing to an open culture, identifying shared approach to managing risks and collaborative resources	**Developing** Shared vision, implementing shared governance, identifying programmes for shared risk (CMHT), transformation designed with strong clinical leadership	**Emerging/Developing** Developing and implementing shared governance, committing to an open culture, identifying shared approach to managing risks and collaborative resources, strong clinical leadership	**Emerging** Agreeing governance, agreeing to share risk, committing to an open culture and data sharing, agreeing shared approach to continuous improvement, establishing links with clinical groups
System working	Support ICSs to deliver priorities Build strong relationships with partners Engage and co-design with people and communities	**Developing** Establishing regular communication between partners and ICB, developing aligned plans, building relationships between partners	**Developing** Establishing regular communication between partners and ICB, developing aligned plans, building relationships between partners	**Developing** Establishing regular communication between partners and ICB, developing aligned plans, building relationships between partners	**Emerging/developing** Establishing regular communication between partners and ICB, developing aligned plans, building relationships between partners

There are existing areas of provider collaboration (e.g., Diagnostics and Pathology Network) where there is greater maturity. This maturity matrix is focusing on the new Provider Collaborative Boards, but is actively seeking to learn the lessons from historic provider collaboration.

Attain

The Provider Collaborative Board will lead and support the collaboratives to develop

Domain	Objective	Provider Collaborative Board	MHLDA Provider Collaborative Board	Community Collaborative Board	Acute Collaborative Board
Outcomes and benefits	Reduce unwarranted variation and inequalities in patient outcomes, access and experience Improve resilience Enhance productivity and value for money	Working towards: • Delivering programmes to reduce inequalities, address fragile services and deliver efficiencies • Co-design of transformation plans • systematic approach to mutual aid and sharing resources • delivery of joint corporate functions			
Governance and Leadership	Implement shared vision and governance Build a culture of mutual support and accountability Embed multi-professional clinical and care leadership	Working towards: • Shared vision that drives all transformation programme • financial risk sharing • ensuring the fullest range of clinical and care leadership • delegation/decisions that are in the system interest and independent of all sovereign interests • Embedded common QI methodologies and embedding of best practice • Ensure member Boards are routinely abreast of outcomes			
System working	Support ICSs to deliver priorities Build strong relationships with partners Engage and co-design with people and communities	Working towards: • Defined and maturing interfaces and relationships with HCPs and local authorities • Integration of programmes with population health disciplines • Work with partners outside Kent and Medway • Routine evaluation and population engagement			

The development journey of provider collaboratives will be informed by the learning and experiences of the arrangements as they rollout, deliver and evolve.

There are already areas to be explored in the coming months, and then further into 24/25.

These will form part of a Provider Collaborative Operating Model and Development Plan to be developed in Q4 23/24.

Attain

Milestone Plan

Sustainability & Transformation Board

OCT 18

Agree role, scope, delivery priorities, resourcing and governance

Integrated Care Board

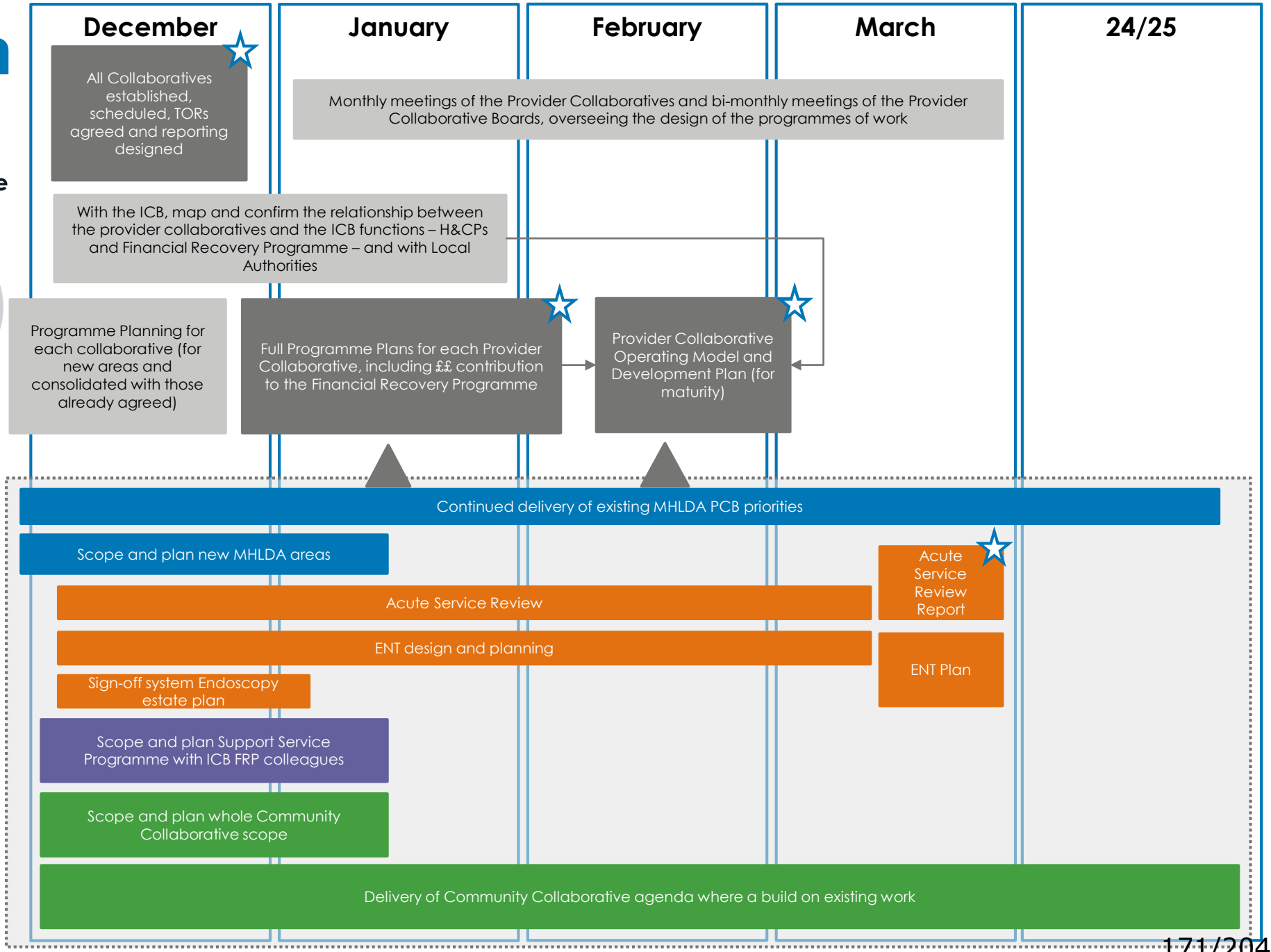
NOV 7

Agree delivery priorities, resourcing and governance

Concurrent provider board approvals

Milestones

- All Collaboratives established, scheduled, TORs agreed and reporting designed
- Full Programme Plans for each Provider Collaborative, including ££ contribution to the Financial Recovery Programme
- Provider Collaborative Operating Model, to include a development plan (for maturity)
- Acute Service Review Report
- ENT development Plan
- Sign-off system Endoscopy estate plan



For further information please contact:

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KENT & MEDWAY – PROVIDER COLLABORATIVE BOARD

DRAFT Terms of Reference

September 2023

Document History

Version	Date	Author	Comments
V0.1	06/09/23	Helen Pyecroft	Initial Draft
V0.2	07/09/23	Helen Pyecroft	With comments from David Highton, Provider Collaborative Chair
V0.3	08/09/23	Helen Pyecroft	With comments from Mike Gilbert, governance lead for K&M ICB
V0.4	12/09/23	Helen Pyecroft	With comments from Sheila Stenson, Provider Collaborative SRO
V0.5	18/09/23	Helen Pyecroft	With comments from the Chairs/CEO meeting on the 14th September

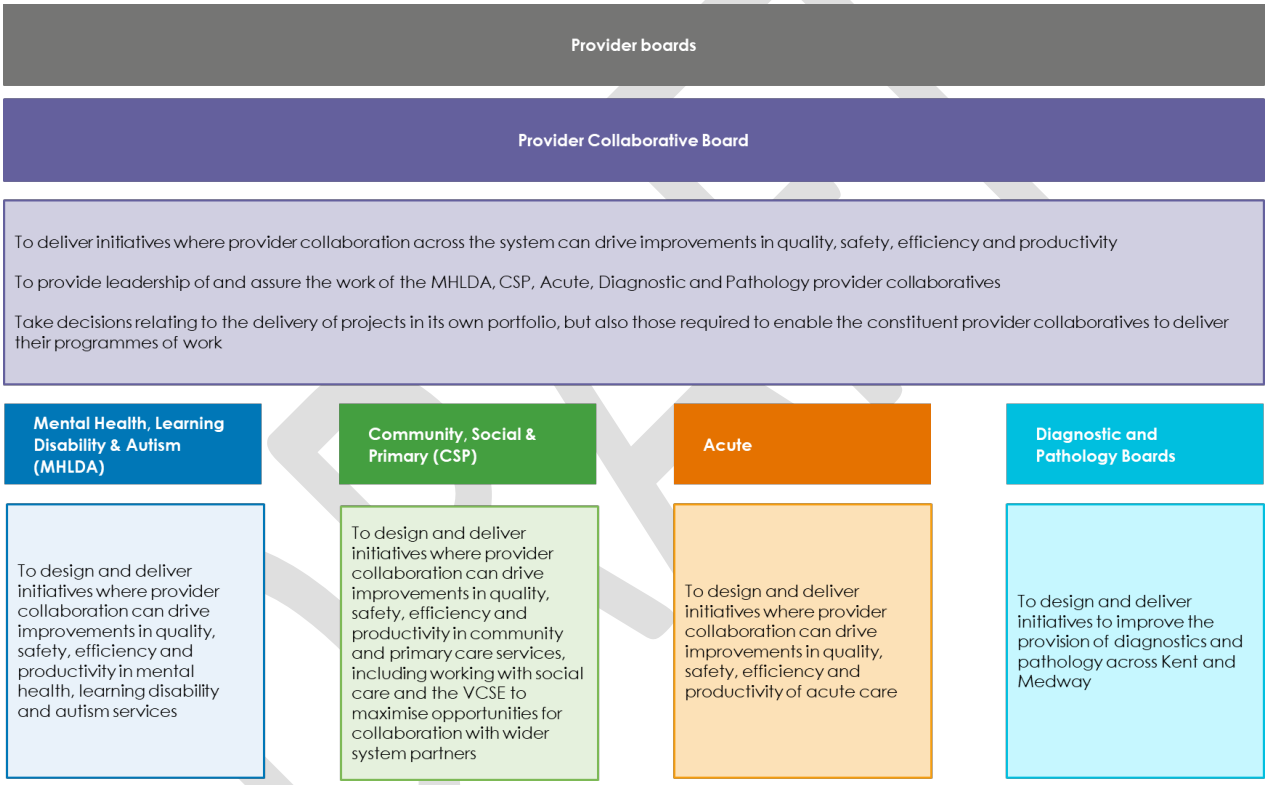
CONTENTS

INTRODUCTION AND CONTEXT

Collaboration between health and care providers already exists across Kent and Medway in various formats. Building on this to design structures for formal provider collaboration is in line with the national context set out in the Health and Care Bill 2021 and furthers the goals set out in the creation of Integrated Care Systems (ICS).

In early 2023 Kent and Medway ICS partners agreed to create a provider collaborative structure that will bring together partner organisations to collaborate on the design and delivery of care where collaboration supports delivering greater impact for the population and health and care system.

The provider collaborative structure in Kent and Medway



The scope of these Terms of Reference are for the Provider Collaborative Board.

In developing these Terms of Reference, and designing the scope and workplans for the provider collaboratives, it has been important to ensure that they are aligned to:

- Individual provider priorities and strategies
- NHS England published its Provider Collaborative Maturity Matrix
- ICS operating model – including the development of the scope of Health & Care Partnerships (H&CPs)
- The ICB Financial Recovery Programme (FRP)
- ICS Strategy
- ICB Pathway Programmes

1.PURPOSE

1.1. The Board exists to formally bring together providers across Kent and Medway to collaborate effectively and drive improvements in the delivery of services. Strategic in nature, the Board will seek to continually improve the function and delivery of care in Kent and Medway, ensuring that it's work aligns with existing programmes without overlap or duplication. The Board will:

- To provide leadership of and assure the work of the MHLDA, Community, Social and Primary Care, Acute, Diagnostic and Pathology provider collaboratives
- Design and deliver initiatives where provider collaboration across the system can drive improvements in quality, safety, efficiency and productivity
- Take decisions relating to the delivery of projects in its own portfolio, but also those required to enable the constituent provider collaboratives to deliver their programmes of work

1.2. Specifically, the Board will:

- provide leadership, oversight, and enable partnership working to improve care outcomes of the population of Kent & Medway
- ensure a strategic focus, acknowledging wider development of the Kent and Medway system and the collaboration required to deliver our Long-Term Plan ambitions
- support strategic thinking about the ongoing development of provider collaboratives in Kent and Medway
- delivery of financial efficiencies
- maintain effective working relationships with other ICB and ICS groups, including the H&CPs and ICB, recognising interdependencies and other priorities across Kent and Medway
- identify risks and issues to delivery and agree to mitigations to effectively resolve these
- empower providers to deliver shared solutions that meet the needs of Kent and Medway collectively by providing a framework within which to operate where appropriate
- ensure that programmes of work are being delivered effectively, reviewing any specific reporting by exception

More detailed responsibilities are set out at 3.0 below.

2.PRINCIPLES

2.1. In October 2022, the Kent and Medway providers and ICB came together to develop a set of working principles for the establishment of provider collaboratives. The principles agreed were:

- any collaboration must be justified on the basis of its ability to demonstrate measurable improvements in patient and population outcomes, patient experience, efficiency/productivity, and the reduction of inequalities
- any collaboration needs to have decision making located at the appropriate level in the system and involve the appropriate individuals
- any collaboration should be based on the principles of subsidiarity and taking decisions as close to the patient and citizen as possible

- any collaboration must recognise that it may create 'winners and losers' and therefore encompass a commitment to manage the impact of any such problems
- any collaboration must be clear about the problems it is attempting to resolve and avoid creating additional tiers of bureaucracy
- any collaboration must demonstrate that it is added value over and above any existing approach
- any collaboration must be based on strong clinical and care professional engagement that has provided an evidence base for its work programme and a platform for its implementation
- any collaboration needs to be based recognise staffing and workforce issues as a driver to set priorities and as a conscious restriction on the pace and scope of its work programme
- any collaboration should recognise the time frames in which it may operate - delivering quick tactical benefits and longer term more strategic solutions
- any collaboration should operate by doing only what it can do best, and be coherent with work at HCP level and at the ICB level.

2.2. These principles will guide the work of the Provider Collaborative Board.

3.SCOPE AND RESPONSIBILITIES

3.1. In designing the scope of the priorities for the provider colalboratives, including the Provider Collborative Board, the following principles were applied:

- We collaborate where we can do better together (and can demonstrate so, including what will be better than current arrangements) – and only to a depth required to have an impact
- We are clear about the nature of the collaboration – e.g., agreeing shared standards, colalborating to deliver discreet projects and/or delegating authority for the delivery of services
- We collaborate where the evidence supports the decision to do so
- We collaborate on the simple stuff to start with
- We collaborate where the right resources and supporting governance can and will follow

Scope and responsibilities for 2023-2024

Scope	Description	Responsibilities
Coordinate and assure the work of the Kent and Medway provider collaboratives, signing off and taking decisions on	The Provider Collaborative Board will oversee the work of the MHLDA, Community, Social and Primary Care, Acute, Diagnostic and Pathology provider collaboratives	• Hold the provider collaboratives to account for the delivery of their workplans • Make decisions on behalf of our trust's Boards where we have the relevant authority - to enable and support delivery of those workplans • Escalate decisions to Provider Boards and the Sustainability and

Scope	Description	Responsibilities
matters required to ensure they deliver their programmes of work		Transformation Board (and ICB) where required • Support the allocation of resources and management of risk to enable the delivery of the workplans • Continue to identify and develop evidence-based priorities for the Board and constituent provider collaboratives, with ICB colleagues
Support the design and delivery of the FRP Support Services programme and wider initiatives to improve the efficiency, productivity and quality of support services	The Board will design and deliver a series of initiatives, including: • Legal • One Public Estate (inc. LAs) • Procurement • Digital Some areas will overlap with the ICB's FRP programme and will, therefore need to be aligned.	• Agree scope and targets with the ICB before delivery • Agree detailed workplans for each area, with appropriate parties • Deliver workplans • Make decisions on behalf of our trust's Boards where we have the relevant authority - to enable and support delivery of those workplans • Escalate decisions to Provider Boards and the Sustainability and Transformation Board (and ICB) where required • Support the allocation of resources and management of risk to enable the delivery of the workplans

3.2. Further priorities for the Board will be identified through analysis of an evidence-base and in agreement with Provider boards and the ICB.

4. MEMBERSHIP

4.1. The Board will be chaired by David Highton, Chair of Maidstone & Tunbridge Wells NHS Provider.

4.2. It is recognised that a number of individuals undertake dual roles across Kent and Medway representing both their own organisations and system roles. For the purposes of the Board, broad representation of views is required, and as such some members will be expected to represent the partnership(s) they represent (e.g. local Health and Care Partnership (H&CP)) as opposed to their employing organisation.

4.3. To ensure clarity, the organisation each member is expected to represent is indicated in the membership list below:

Name	Role Title	Employing Organisation	Representing at Board
David Highton (Chair)	Chair	Maidstone & Tunbridge Well NHS Provider	Maidstone & Tunbridge Well NHS Trust
Niall Dickson	Chair	East Kent Hospitals University NHS Foundation Trust	East Kent Hospitals University NHS Foundation Trust
Joanne Palmer	Chair	Medway NHS Foundation Trust	Medway NHS Foundation Trust
Jackie Craissati	Chair	Kent & Medway NHS and Social Care Partnership Trust Dartford & Gravesham NHS Trust	Kent & Medway NHS and Social Care Partnership Trust Dartford & Gravesham NHS Trust
John Goulston	Chair	Kent Community Health NHS Foundation Trust	Kent Community Health NHS Foundation Trust
Bruce Potter	Chair	Medway Community Healthcare	Medway Community Healthcare
David Astley	Chair	South East Coast Ambulance Service	South East Coast Ambulance Service
Simon Weldon	Chief Executive	South East Coast Ambulance Service	South East Coast Ambulance Service
Sheila Stenson	Chief Executive of KMPT and SRO of Provider Collaboratives	Kent & Medway NHS and Social Care Partnership Trust	Kent & Medway NHS and Social Care Partnership Trust
Miles Scott	Chief Executive	Maidstone & Tunbridge Well NHS Trust	Maidstone & Tunbridge Well NHS Trust
Jayne Black	Chief Executive	Medway NHS Foundation Trust	Medway NHS Foundation Trust
Mairead McCormick	Chief Executive	Kent Community Health NHS Foundation Trust	Kent Community Health NHS Foundation Trust
Martin Riley	Chief Executive	Medway Community Healthcare	Medway Community Healthcare
Jon Wade	Chief Executive	Dartford & Gravesham NHS Trust	Dartford & Gravesham NHS Trust
Tracey Fletcher	Chief Executive	East Kent Hospitals University NHS Foundation Trust	East Kent Hospitals University NHS Foundation Trust

Debbie Lindon Taylor	Head of HCRG Care Groups North Kent	Health Care Resourcing Group	Health Care Resourcing Group
In Attendance – Non-Voting Members			
Provider Collaborative Programme Director	TBA		

4.4. Deputies may be accepted with prior agreement of the Chair.

4.5. The Board may call additional individuals to attend adhoc meetings or to attend on a regular basis. Attendees may present at Board meetings and contribute to discussions, but are not allowed to participate in any decision making.

4.6. The Board may invite or allow people to attend meetings as observers. Observers may not present or contribute to any Board discussion unless invited by the Chair and may not participate in any decision making.

5. QUORUM

5.1. There is a requirement for a minimum number of members to be present to enable the business of the Board to be effectively undertaken. For the purposes of these Terms of Reference this shall be known as the quorum and shall be noted as such in meeting agendas and minutes.

5.2. For the meeting to be considered quorate at least one representative from each member organisation needs to be in attendance, one of whom will be the Chair or Vice Chair of the Board.

5.3. Deputies may be appointed in the absence of a member, subject to the agreement of the Chair, but may not be another member of the Board or represent more than one member.

5.4. Members who are not physically present at a meeting but are present through the means of teleconference or other acceptable digital media shall be deemed to be present.

5.5. If any representative is conflicted on a particular item of business they may not participate in the discussion and may be asked to leave the meeting at the discretion of the Chair. These individuals shall not count towards the quorum for any decision/recommendation made. If this renders a meeting or part of a meeting non-quorate, subject to the discretion of the Chair:

- a non-conflicted person may be temporarily appointed or co-opted to satisfy the quorum requirements; or
- the requirement for that category of member to be present may be relaxed.
- Members have a collective responsibility for the operation of the Board. They will participate in discussion, review evidence, and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

6. MEETING FREQUENCY

6.1. Meetings shall be held bi-monthly – with every other meeting being in person.

6.2. The Board Chair may request additional meetings if they consider it necessary, including facilitating the function of assurance to the ICB and partner organisations.

7. AGENDA AND PARTICIPATION

7.1. The agenda and associated papers will be issued five working days in advance of each meeting.

7.2. Requests for agenda items should be sent a minimum of two weeks in advance of the meeting. The Chair will decide if items can be added, depending on previous commitments and time constraints.

7.3. To ensure that meetings run smoothly and effectively, members will be expected to:

- Read circulated papers and other materials in advance of meetings
- Follow planned agendas
- Show respect by listening to others and not interrupting
- Operate on a consensus and aim to seek general agreements
- Identify actions that result from discussions and commit to following through those actions
- Address items through the Chair of the meeting.

8. DECISION MAKING

8.1. The Board has the decision making authority of the individuals on the Board and the powers delegated to them by the positions they hold (Chairs and CEOs).

8.2. For decisions outside the scope of these individuals (e.g. material in scope / significant financial impact / requiring public consultation (e.g. would not secure HOSC approval)), the Board will make recommendations to the provider boards and / or the Sustainability & Transformation Board.

8.3. Any actions or recommendations made by the Board will be through consensus. Where consensus cannot be achieved, agreement of 75% of those present will be sufficient, subject to the meeting being quorate, for a matter to be determined.

8.4. Any decisions endorsed will be shared with the provider executive teams, Sustainability & Transformation Board, and four H&CPs to support local planning.

8.5. The Board will have no commissioning responsibilities.

9. DISPUTE RESOLUTION

9.1. Where a dispute or concern arises regarding the operation or management of the Provider Collaborative, this should be brought to the attention of the Chair in the first instance. The Chair will consider what appropriate action to take and whether the matter should be discussed with other partners, including Provider Boards and/or the ICB. Where a dispute or concern arises relating to the actions of the Chair, where possible the matter should be discussed with the Chair or Vice Chair and progressed as above.

9.2. For clarity, any decision made by the Board, including decisions not to support a proposal, cannot be challenged where the proposal has been put to a vote in accordance with these terms of reference, i.e. a concern cannot be formally escalated by a member simply because they do not like the outcome.

10. REPORTING PROCEDURE AND MINUTES

10.1. Actions and key decisions will be note at each meeting by the Provider Collaborative Managing Director and distributed to Board members no later than a week after each meeting.

10.2. The Board will provide quarterly progress reports to Provider Boards and the Kent and Medway Sustainability & Transformation Board. Routine highlight reports will be shared with local Health and Care Partnership across Kent & Medway to ensure at scale improvement and transformations are aligned with local place-based priorities.

11. POLICY AND BEST PRACTICE

11.1. The Board may instruct professional advisors and request the attendance of individuals and authorities with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its responsibilities.

11.2. The Board is authorised to establish such sub- groups as it deems appropriate in order to assist in discharging its responsibilities.

11.3. Unless stated otherwise in these terms of reference, the Board will be conducted in accordance with the Chair's organisations Standing Orders and Standards of Business Conduct and Managing Conflicts of Interest Policy. Specifically:

- There must be transparency and clear accountability
- The Group will hold a Register of Interests in accordance with good governance practice
- Members must declare any interests and /or conflicts of interest at the start of the meeting. Where matters on conflicts of interest arise, the Chair will determine what action to take in discussion with the lead executive officer as appropriate. This may include requesting that individuals withdraw from any discussion/voting until the matter is concluded.
- The Board shall undertake a self-assessment of its effectiveness bi-annually at the face to face board development meetings.
- Members of the Board should aim to attend all scheduled meetings, but must attend at least 75% of scheduled meetings in any financial year.
- Members, attendees and/or invited observers must maintain the highest standards of personal conduct and in this regard must comply with:
    - The laws of England and Wales
    - The spirit and requirements of the NHS Constitution
    - The Nolan Principles
    - The standards of behavior set out in their employing organisation's policies, as they would be reasonably expected to know

12. CONFIDENTIALITY

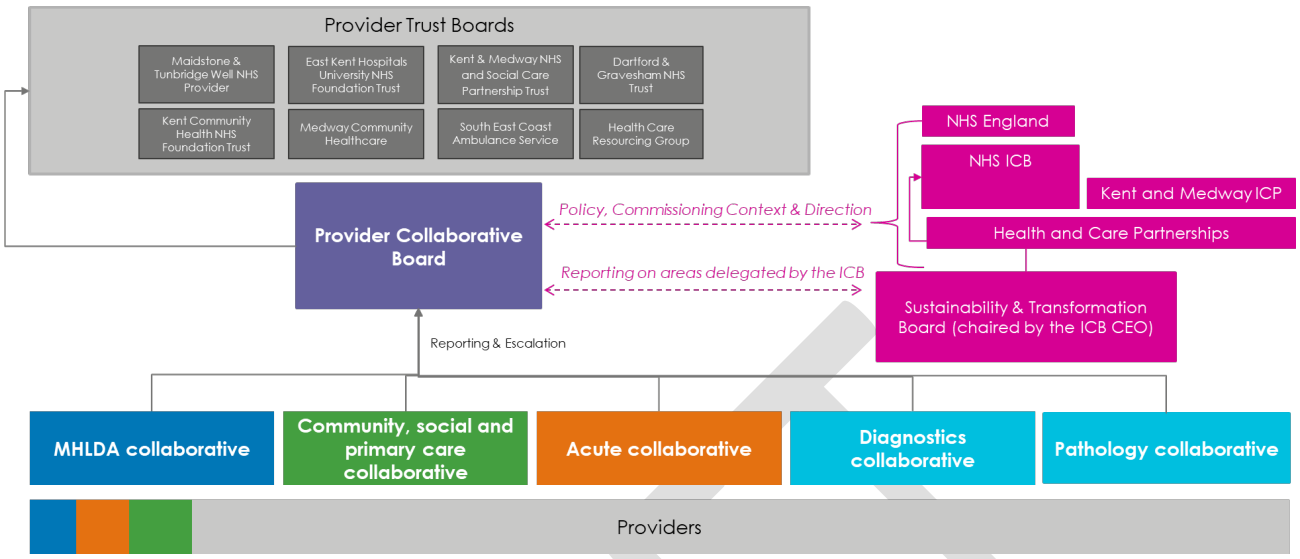
12.1. Members of the Board shall respect the confidentiality requirements set out in relevant corporate policies and these Terms of Reference, unless separate confidentiality requirements are set out for the Board, in which event these shall be observed.

12.2. Recommendations and actions of the Board will be detailed in the minutes of the meeting, and these shall be disclosable under the Freedom of Information Act, except where matters under consideration or when decisions made are of a confidential nature, in which case they will be excluded from any public record and shall not be publishable.

13. REVIEW

13.1. The Terms of Reference of the Board shall be reviewed at regular intervals to reflect the priorities of the Board and the environment within which it is operating as part of the Kent and Medway ICS.

Apendix One – Kent and Medway MHLDA Governance Structure



NHS Maidstone and Tunbridge Wells NHS Trust

Review of the draft winter plan for 2023/24 **Chief Operating Officer**

The draft winter plan for 2023/24 is enclosed.

Which Committees have reviewed the information prior to Trust Board submission?
- Executive Team Meeting (ETM), 17/10/23 and 24/10/23
- Finance and Performance Committee, 24/10/23

Reason for submission to the Trust 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

Maidstone and Tunbridge Wells NHS Trust

Winter Plan 2023/24

MTW

NHS
Maidstone and Tunbridge Wells
NHS Trust

Contents

Executive Summary

Purpose

- The purpose of the Winter Plan is to identify activities across the Trust which relate to planning for winter 2023/24, to ensure that all associated actions are being progressed to deliver safe and effective care for our patients whilst delivering performance and finances as planned and supporting the workforce.

Development of the Winter Plan

- The Plan is a live document that will be continuously updated, especially in light of demand and capacity modelling and is led by the Chief Operating Officer
- The Plan identifies the actions that will maintain patient safety and clinical quality over the period of expected surge in demand during winter
- NHS England has set out core objectives and key actions for operational resilience for winter in the 27 July letter outlining high impact interventions.

Data driven management:

- The Care Coordination Centre (CCC) will ensure centralised flow, optimizing resources supported by clear communication
- The principles of national Operational Pressures Escalation Levels (OPEL) framework will be employed to ensure a consistent approach
- Bed modelling from MTW B.I. and system wide data analysis from Lightfoot predicts a shortfall of acute beds. Schemes are developed or being developed to mitigate this to provide robust flow and patient safety

Finance:

- Schemes to support robust flow and offer increased capacity may require additional resource. This is being calculated and prioritised against realisation of benefits.

Emergency Department activity

Activity prediction

MTW B.I. have predicted lower ED attendances in 23/24 than last year. This is particularly noticeable in December, with a slight increase in January. It is thought that Nov and Dec 22 were outliers in activity due to the strep throat epidemic.

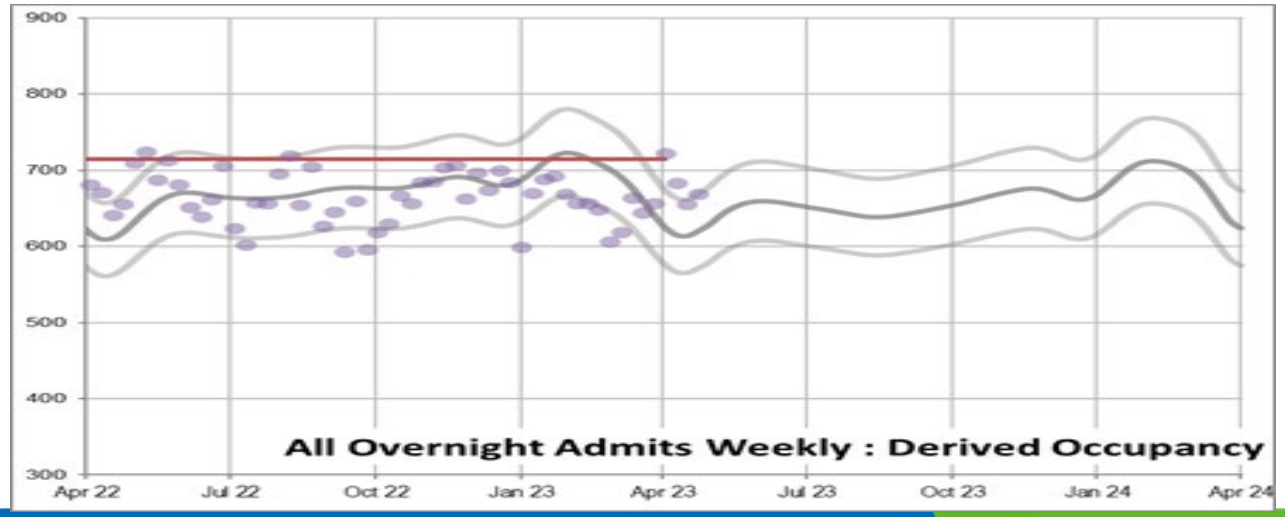
There is an underlying inflation of 1.5% to 2.0% per annum in demand for emergency care. Around half of this is driven by simple numerical population growth, and half from an ageing of our local population.

Month	2022/23 Actual	2023/24 Planning
Oct	17,835	17,792
Nov	17,625	17,238
Dec	19,440	17,793
Jan	16,163	16,983
Feb	15,554	16,310
Mar	18,313	18,120

Bed Modelling – MTW projections: peak 710 beds

Projections 23/24 (source: MTW B.I.) The peak for beds is estimated at 710 beds using medium projection – leaving a worse case scenario of a shortfall of 114 beds This figure will be updated later in the year.

- Bed occupancy projections this coming winter are similar to last winter, coming out as ***roughly the same or slightly less than last year***, based **entirely** on patterns of activity observed over the past 10 years. The assumption is that next winter will be 'average', i.e. without abnormal weather, epidemics or economic collapse. There are fairly broad confidence levels and do not take mitigation into account.
- Admissions are on track to be ***around the same or slightly higher*** but it is noted that LoS appears to be on a downward trajectory. The past 12 weeks has averaged 7.5 days against 8.4 for a similar period last year. This would lead to a reduction in bed occupancy.
- Non-elective length of stay (LoS) averaged 8.0 days in 2022/23. If schemes in place delivered a reduction of 0.5 days (continuing the trend), this would release around 45 beds
- These figures are likely to be offset by a 5% shifting of non-elective activity from overnight admissions to SDEC.



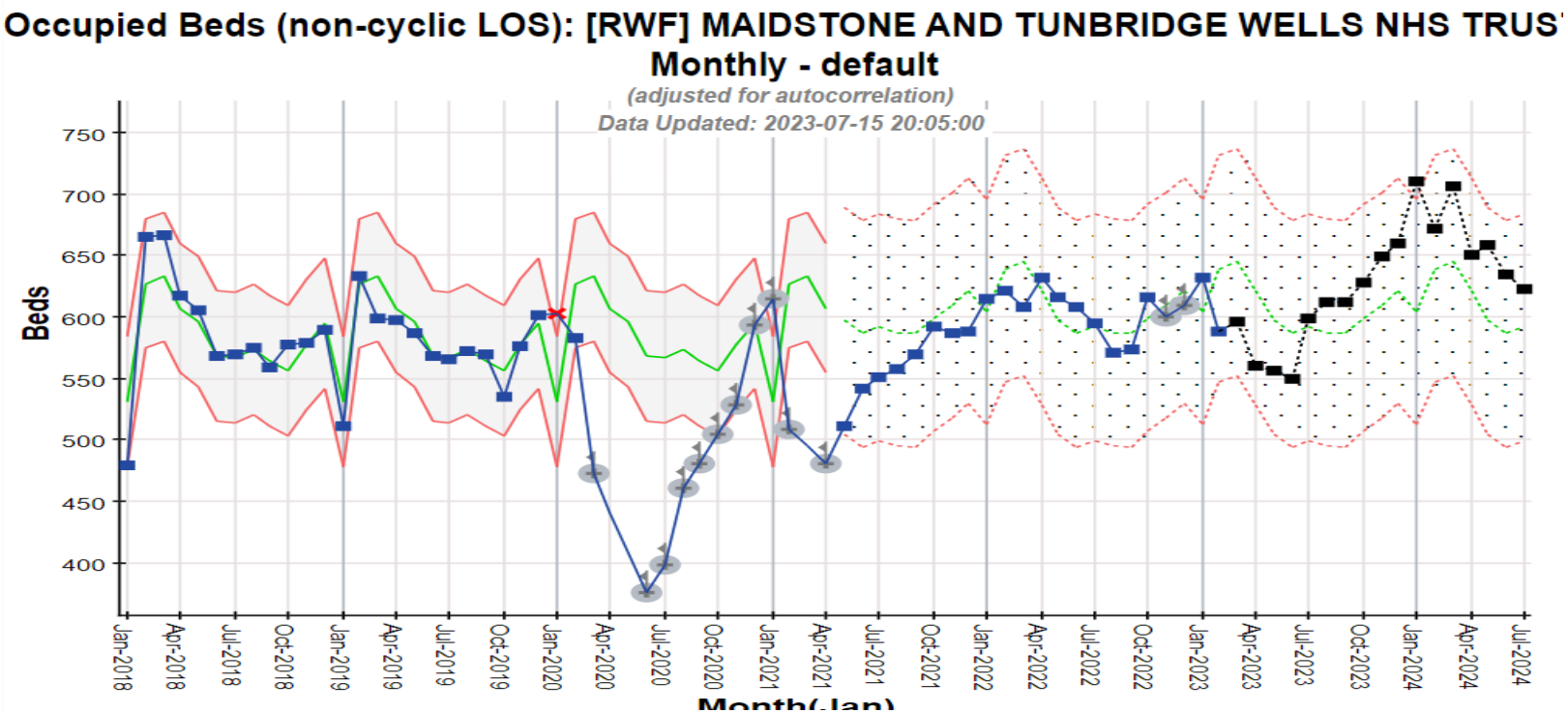
Graph shows patients admitted for a minimum of 1 night, giving overall bed occupancy

There is an increased risk of a severe winter this year – something in the order as twice as likely as normal.. A bad winter could add 50 -100 respiratory patients. 50 patients adds 7% increased bed occupancy.

Bed Modelling – HCP projections: 710 beds

Projections 23/24 (source: West Kent HCP/ Lightfoot data)

- The graph below indicates that the peak occupancy prediction for G&A beds (adult and pediatrics) is 710
- The peak in winter 22/23 was 6th January at 715.



MTW Core & escalation beds (Med/ Surg): 596

Core and Escalation Bed Availability – the calculation below shows a total of 596 non elective core and escalation beds, including escalation wards but not elective capacity from SSSU/ SSU/ MOU. NB please note this includes only core medical and surgical beds.

Core Medical Beds				Core Surgical Beds			
Tunbridge Wells		Maidstone		Tunbridge Wells		Maidstone	
AMU	28	John Day	30	W10	30	Cornwallis	19
CCU	7	Culpepper	13	W32	20		
W2	26	CCU	6	W30	30		
W12	30	Mercer	26	W31	30		
W20	30	Pye Oliver	28				
W21	30	AAU*	22				
W22	32	Stroke Unit**	34				
		Foster Clark	12				
		Whatman	22				
		Edith Cavell	22				
		Peale	14				
TOTAL BEDS	**183**	**TOTAL BEDS**	**229**	**TOTAL BEDS**	**110**	**TOTAL BEDS**	**19**
Winter Escalation		**Winter Escalation**		**Winter Escalation**		**Winter Escalation**	
W11	**30**	**Foster (Stroke/ Med)*** **	**16**	**PPU**	**9**		
INPATIENT TOTAL	**213**	**INPATIENT TOTAL**	**245**	**INPATIENT TOTAL**	**119**	**INPATIENT TOTAL**	**19**
		*incl. A bay		**SSSU**	**25**	**SSU**	**18**
		** new plan				**MOU**	**12**
		*** need to move IR out					

NB Escalation beds available at MGH have been impacted by stroke building delays. The escalation numbers have been decreased from 28 – 16

Medicine non elective bed capacity	**458**
Surgical non elective bed capacity	**138**
total non elective bed capacity	**596**

Closing the gap 710 beds required Total Core/ Esc beds = 596 Total beds released = 90. Overall gap 24 beds

No.	Division	Bed Releasing Scheme	Benefits	Beds Released
OP FLOW/ CCC				
1	CCC	Extended CCC functionality	expansion of CCC hours, oversight of milestones, outstanding issues,, increased use of existing Teletracking functionality	7
2	CCC	Clinical Pathway Hub pilot from Sept 23	Increased admission avoidance and diverting ambulances from ED	10
3	CCC	Expansion of Virtual Ward	Early supported discharge	15
4	Op Flow	P1, 2, repats, Transfer of Care Hub / discharge technology support	Early supported discharge	7
5	Op Flow	Additional out of hospital capacity (RBLI (4), Hawkhurst (5), spot purchase beds (5))	Additional OOH capacity	14
DIVISIONS				
6	MEC	Additional GP cover & respiratory med cover w/e for MGH	Clinical cover for walk ins and earlier discharges for Respiratory patients	*1*
7	Paeds	Additional Paeds capacity	Paediatric escalation (Hedgehog to 27 beds/ Hoglets to 31 beds)	12
8	Haem	Provision of internal brace fitting	Reduction of LOS and improved patient experience	1
9	Cancer	Acute Oncology Service 7 days a week both sites	Admission avoidance, improved patient experience	2
10	SDEC	SDEC improvements incl. Ortho w/e opening / pull through	Admission avoidance, increased SDEC	10
11	Surgery/ MEC	ITU MGH – additional capacity requiring staffing	Medical escalation	6
12	ED	Additional consultant support in ED incl. acute physician, RAP consultant, w/e ED consultant	Senior decision making at front door	5

Flow Improvement Schemes

Admission Avoidance

- Clinical Pathway Hub
- GP in ED capacity
- SDEC optimised
  - Overnight pull ED
  - hours
- Senior decision maker front door

Central oversight driving quality

- 7 day Tactical cover covering evening surge
- Robust manager on call
- Transport/ Facilities/ IDT covering evening surge
- CCC weekend oversight
- R&R Site Team on floor
- Daily P0, milestone identification

Inpatient incl. seasonal surge

- SAFER bundle
  - Board rounds
  - EDN planning
  - Criteria Led
- Medicine w/e (respiratory)
- ED consultant (w/e and RAP evening)
- Paeds capacity
- Bank w/e Pharmacy
- Virtual Ward

Discharge

- Discharge checklist
- TTO delivery
- Transport actions
- Transfer of Care Hub
- Digitally enabled support
- P3 additional capacity
- P1, P2

Closing the gap – development of opportunities

- Review of SDEC capacity in all specialities increasing ED pull
- Increased front door senior decision making
- Scoping a dedicated junior team completing EDNs
- Urgent care plan for Gastroenterology and Cardiology
- CCC - Improved central oversight
- Increased out of hospital capacity
- Scoping safe delivery TTOs to patients to reduce time spent in hospital
- Improving flow basics as part of ongoing work

Winter monies required

Funding bids in priority order – total £2.405m

PRIORITY 1 Escalation wards W11 and Foster	30 beds/ 16 beds for 3 months	£733k plus £442k
MGH additional nursing (6 beds) (ITU space)	2 x B5 24/7	£135k
RN and med cover Paeds escalation		£93k
OOH capacity (Hawkhurst/ RBLI)		£102k
TOTAL		**£1.5m**

PRIORITY 2		
Clinical Pathway hub		£25k
Tactical Commander	2.0wte 8b x 5 days	(£73k funded ICB)
EDN junior doctor team	1300 - 2000 5 days SHO	£30k
AEC dr	13.00 – 2200 5 days a week TW = 40 hours x £50	£40k
ED cover (RAP consultant, Acute Phys, ED w/e consultant)	Acute Phy £5.5k per week for 12 weeks = £66k ED cons 20 hours x 26 w/e day @£133 p/hour £69k RAP cons 3 hours 7 – 10pm x 90 days £185 p/hr £50k	£185k
TOTAL		**£280K**

PRIORITY 3		
Ortho SDEC w/e plus Cancer AOS		£74k plus £15k
GP in ED	(8 hours x 7 days x 2 sites x £75) x 10 weeks	£67k
Additional Resp w/e cover	(1 x cons 4 hrs £130 both days every weekend	£21k
ED triage nurse TW B5/ B3 A&C in RAP	Triage 1400 – 2200 Mon/ Tues/ B3 2.0wte	Triage nurse £10k/ Admin £33k
TOTAL		**£220K**

PRIORITY 4		
Additional mortuary capacity		£120k
External contractor support (Estates & Facilities) – gritting/ 4 x 4 adverse transport winter plan		£35k
Additional domestics and porters to support demand		250k
TOTAL		**£405k**

Workforce

https://padlet.com/staffwelfare/staff-health-wellbeing-jcklvvjnxgss3vwt
Wellbeing hub :: Kent & Medway ICS (kmstaffwellbeinghub.uk)
https://www.kmstaffwellbeinghub.uk/

Wellbeing support

MTW is able to offer the following support to staff as part of an extensive wellbeing approach:

- Continue current offer as Wellbeing Partners, Inreach and Bespoke Support, Employee Assistance and NHS Staff Support, Signposting to Welfare support for staff in Financial difficulties
- Continue to support our staff through the winter period with particular emphasis on signposting, cost of living crisis support, fuel poverty and seasonally affected loneliness and mental health
- Incident response support from Wellbeing and Staff Psychological Support Team
- Flu and Covid Vaccination schemes for staff are in place
- Imminent introduction of financial wellbeing platform WAGESTREAM to support staff, offering live visibility over pay, flexibility to access a percentage of earned pay ahead of payday, rainy-day pot to budget and save, access to a certified financial coach
- Free toast and breakfast cereals to be provided in the canteens throughout winter, organised by Facilities

Vacancy rate

- As part of the Strategic Theme for People within Strategy Deployment Review, the key metrics include sickness absence, appraisal completeness, training and EDI metrics. The vacancy rate for the Trust is 8.5% against target 12% for September 2023, with turnover at 12.8% against 12% target. Work continues on these objectives.
- Senior teams work closely with HR Business Partners and Recruitment to forecast and plan future turnover, gaps and a multi skilled workforce.

Data-driven flow and surge management

Care Coordination Centre

- The CCC will centralise all flow management through site meetings, review of discharge milestones and link in with the Flow Representatives from each Division.
- The Integrated Discharge Team will pilot management support in the CCC to streamline flow to external pathways and the CCC will be supported 24/7 by Site Management and Virtual Ward, and until 1800 by Transport and Tactical Command
- On call managers will be provided with winter training in autumn 2023 to support decision making

Industrial Action

- A standard plan is in place to support industrial action. It is expected that industrial action will continue and this will have a considerable impact on staff/ activity/ finance. As more information becomes available, plans will be coordinated by the CCC with actions being delivered by all clinical Divisions, supported by IT and Workforce. This is overseen by the Deputy COO.

Severe Weather

- The Care Coordination Centre will ensure both severe weather and flood warning information is cascaded to staff in a timely way to ensure maximum amounts of preparedness. The CCC will liaise with Kent Highways to ensure gritting & snow ploughing is carried to maintain essential access to sites.
- Estates & Mitie have plans to keep the access roads clear and the helipad de-iced.
- In the event of severe winter weather resulting in transport disruption the Trust can:
    - Use the existing 4WD vehicles the Trust has with Estates staff and deploy one to each main site at the disposal of the Clinical Site Manager
    - Use the MOU with Kent 4WD to use local trained volunteers with 4WD to assist in getting critical staff in
    - Access the Kent Surrey Sussex Air Ambulance, Children's Air Ambulance and HM Coastguard to transfer patients or emergency supplies
    - Utilise hotel accommodation for stranded staff / Provide hot food and drink for staff at no charge

NHS
Maidstone and Tunbridge Wells NHS Trust

Quarterly report from the Freedom to Speak Up Guardian Chief People Officer

The latest quarterly report from the Freedom to Speak Up Guardian (FTSUG) is enclosed.

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

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

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

Board of Directors (Public)

Freedom To Speak Up Guardian Report Q2 (July 2023 – September 2023)

Action Requested / Recommendation

Discuss the content and recommendations outlined in the report.

Summary

This is the second quarter report for 2023/24 covering the period July 2023 to September 2023 presented to the board by the Chief People Officer. The purpose of this report is to identify trends, issues; and provide a progress report on the Freedom to Speak Up function.

Christian Lippiatt, The Freedom to Speak Up Guardian and Ola Gbadebo-Saba, The Deputy Freedom To Speak Up Guardian, left their roles at the end of July 2023. As an interim measure, Ainne Dolan, the Deputy Chief People Officer is acting as FTSU whilst the post has been advertised. An interim FTSU Guardian, Jack Richardson, has been appointed on a six-month secondment, the post will be advertised substantively at this point. Jack will take up his post in November 2023

The Freedom to Speak Up Guardian received **twelve** concerns raised in the last quarter. In Q2, the splits are between patient safety (**two**) and bullying/ harassment cases (**seven**), health and safety **(one)** and (**two)** in the "other" category.

Concerns were received through various routes including: direct contact via the FTSU inbox and anonymous portal logs.

Author: Ainne Dolan, acting Freedom To Speak Up (FTSU) Guardian

Date: October 2023

Freedom To Speak Up Non-Executive Director	Maureen Choong
Freedom To Speak Up Executive Lead	Sue Steen
Freedom To Speak Up Guardian (Acting)	Ainne Dolan

The FTSU Agenda is to:

- Protect patient safety and quality are
- Improve experience of workers
- Promote learning and improvement

By ensuring that:

- Workers are supported in speaking up
- Barriers to speaking up are addressed
- Encourage a positive culture of speaking up
- Ensure issues raised are used as an opportunity for learning and development

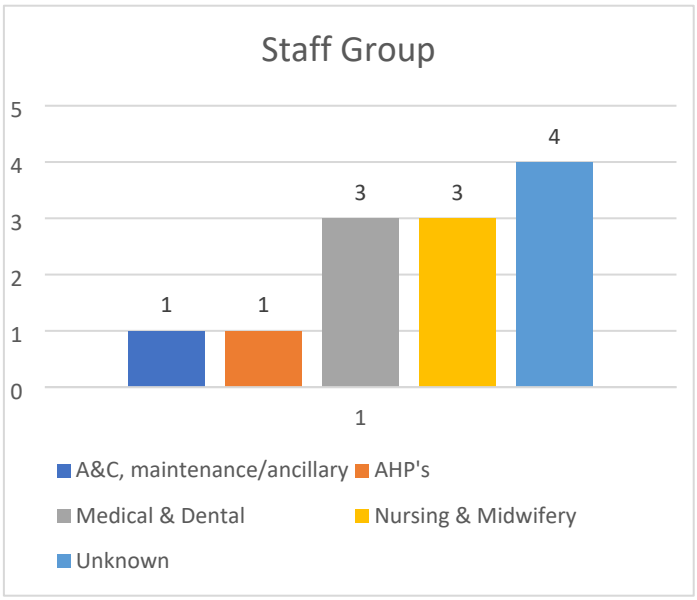
Q2 Review

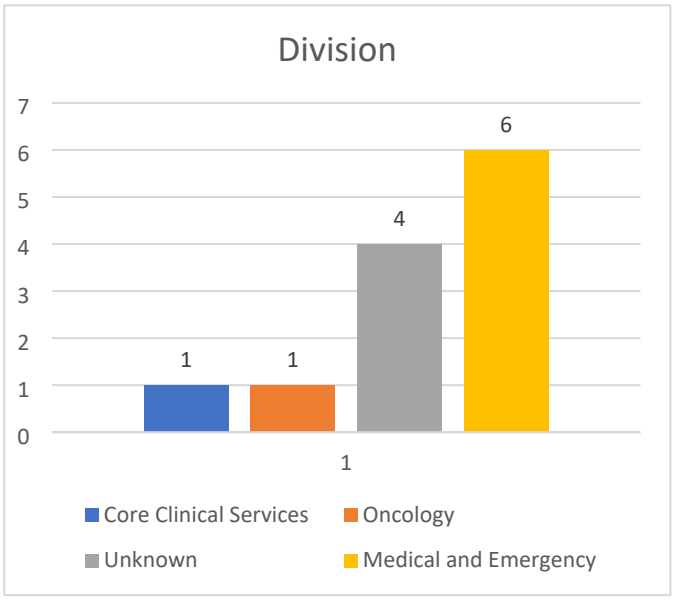
There has been an opportunity to look again at the structure of the FTSU function. The previous structure consisted of 0.2 of a Band 8B FTSU lead and 0.8 of a Band 7 Deputy FTSU Guardian. The funding for both posts has now been combined to create a Band 8a WTE FTSU Guardian. In addition, the Deputy CPO Organisational Development and CPO will also provide FTSU cover to ensure that the function remains resilient.

Whist the role of FTSU is being covered, to ensure a robust and consistent function, the CPO and Deputy CPO covering the role have met weekly with the lead FTSU Ned Maureen Choong.

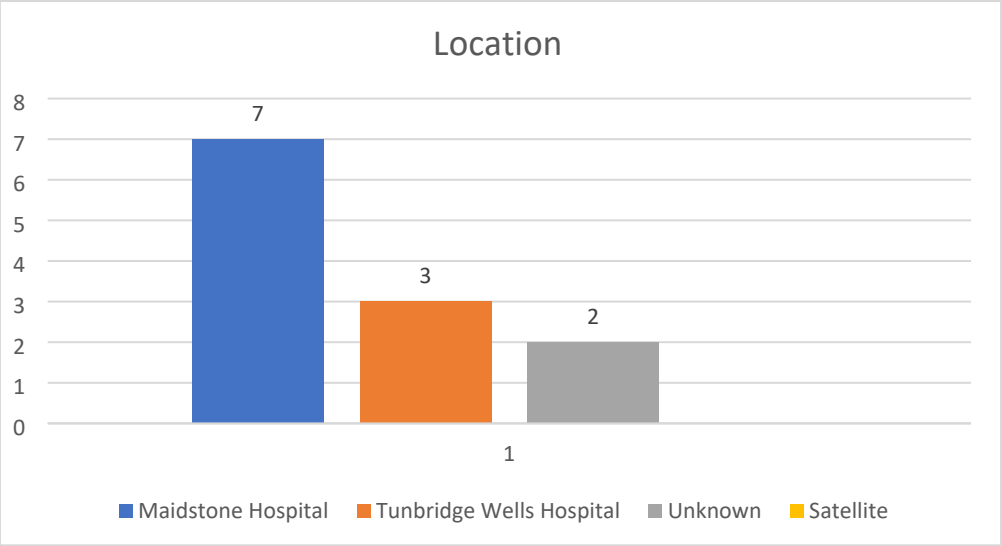
The number of concerns this quarter remains low, however there has been complexity to a number of cases, involving both patient safety concerns and dignity and respect concerns. In addition, national media coverage of sexual assault against staff in the NHS and a subsequent Trust wide communication by the CPO led to the reporting of a historical sexual assault allegation.

2023/24 Q2 data collection





The majority of cases reported this quarter were in Maidstone. More cases came from the Medical and Emergency Division and were raised by medical and nursing/midwifery staff. These are currently being either followed up or escalated. Where concerns have been raised via the anonymous portal or via the safe space champions it has can be difficult to identify staff group which is reflected in the higher number of unknowns in that category.



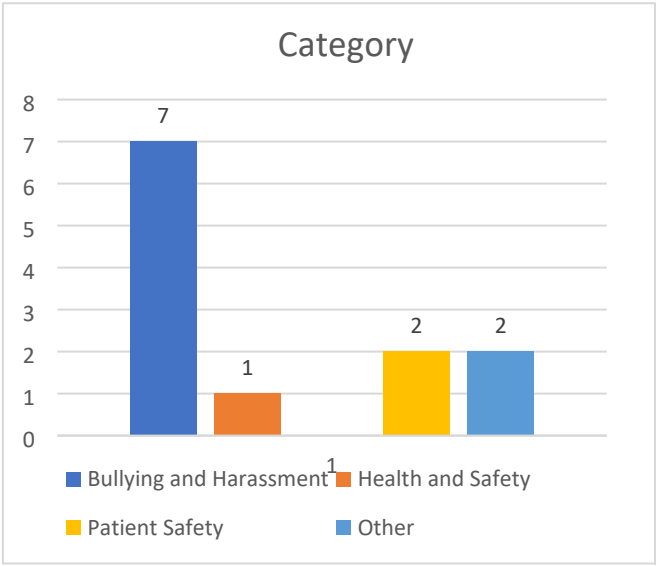
The FTSU function continues to work with the HRBPs and OD in sharing intelligence regarding areas where concerns have been raised. A number of these areas are where OD interventions are in place or being planned. In a bid to improve our ability to look for patterns and trends that might be of concern, conversations are underway with the Director of Quality Governance to develop ways to triangulate data across the People, Quality and FTSU functions.

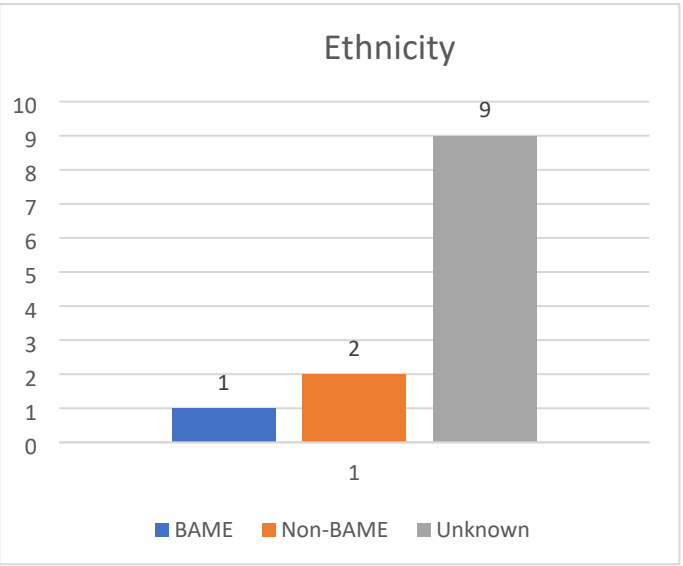
Themes/Issues

Cases of dignity and respect remain a concern as they continue to be the majority of issues raised, followed by patient safety. Therefore, workplace behaviours continue to be an area of focus. As previously, the two themes often being intertwined and as a result we are recording a secondary reason for concerns being raised – though it is only recorded as being one concern raised under the primary issue as identified by the staff member.

Where there are statistics of "unknown" against any of the charts, this is linked to anonymous reports raised through the intranet or incident reporting (InPhase) systems. As such, where no means of contact is provided by the person raising the concern we are unable to explore further any details of the issue.

In the majority of cases it has not been possible to identify whether ethnicity has been a factor in FTSU issues or reporting, although other People data indicate that this may be the case.





*Breakdown of 'Other' category	Number
EV chargers at both MGH and TWH	1
Advice of HR nature	1
Total	**2**

NB: Concerns falling under the "other" category are escalated and raised with relevant Managers as appropriate. In many cases the concern being "closed" upon passing the concern on. In some cases, it may remain open until a response has been received from the Manager.