

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

Thu 28 October 2021, 09:45 - 13:00

Virtual meeting, via webconference

Agenda

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

10-1

To receive apologies for absence

David Highton

10-2

To declare interests relevant to agenda items

David Highton

10-3

To approve the minutes of the 'Part 1' Trust Board meeting of 23rd September 2021

David Highton

 Board minutes, 23.09.21 (Part 1).pdf (9 pages)

10-4

To note progress with previous actions

David Highton

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

10-5

Report from the Chair of the Trust Board

David Highton

 Chair's report.pdf (1 pages)

10-6

Report from the Chief Executive

Miles Scott

 Chief Executive's report - October 2021.pdf (3 pages)

Integrated Performance Report

10-7

Integrated Performance Report (IPR) for September 2021 (incl. an update on the latest position regarding operational pressures within paediatrics)

Miles Scott and colleagues

 Integrated Performance Report (IPR) for September 2021.pdf (32 pages)

Planning and strategy

10-8

Review of the draft winter plan for 2021/22

Sean Briggs

 MTW Winter Plan 21-22 .pdf (37 pages)

10-9

To review a Strategic Outline Case (SOC) for cardiology

Sean Briggs

 To review a Strategic Outline Case (SOC) for cardiology.pdf (42 pages)

10-10

To approve the Outline Business Cases (OBCs) for the new Picture Archiving and Communication System (PACS) and Radiology Information System (RIS)

Sue Forsey and Sue Lang

N.B. This item is scheduled for 11:05am

 To approve the Outline Business Cases (OBCs) for the new PACS and RIS.pdf (78 pages)

Quality Items

10-11

Findings of the national inpatient survey 2020

Joanna Haworth

10-12

Quarterly maternity services report

Sarah Blanchard-Stow

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

Quarterly maternity services report.pdf (7 pages)

Assurance and policy

10-13

Report on the Trust's COVID-19 response

Sean Briggs

Report on the Trust's COVID-19 response.pdf (43 pages)

10-14

Quarterly report from the Freedom to Speak Up Guardian

Ola Gbadebo-Saba

N.B. This item is scheduled for 11:40am

FTSU Quarterly Report - October 2021.pdf (7 pages)

Reports from Trust Board sub-committees

10-15

Quality Committee, 13/10/21

Sarah Dunnett

Summary of Quality C'ttee, 13.10.21.pdf (1 pages)

10-16

People and Organisational Development Committee, 22/10/21

Emma Pettitt-Mitchell

Summary of People and Organisational Development Cttee, 22.10.21.pdf (2 pages)

10-17

Finance and Performance Committee, 26/10/21

Neil Griffiths

10-18

To consider any other business

David Highton

10-19

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 23RD SEPTEMBER 2021, 9:45 A.M, VIRTUAL VIA
WEBCONFERENCE**

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board (from item 09-7)	(DH)
	Maureen Choong	Non-Executive Director (Chair until item 09-7)	(MC)
	Sarah Dunnett	Non-Executive Director (except item 09-10 to 09-13)	(SDu)
	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	(MS)
In attendance:	Karen Cox	Associate Non-Executive Director	(KC)
	Richard Finn	Associate Non-Executive Director	(RF)
	Amanjit Jhund	Director of Strategy, Planning and Partnerships	(AJ)
	Sara Mumford	Director of Infection Prevention and Control (N.B. Left during item 09-8 – refer to the relevant minute for the specific details)	(SM)
	Sue Steen	Chief People Officer	(SS)
	Jo Webber	Associate Non-Executive Director	(JW)
	Lynn Gray	Deputy Chief Operating Officer (representing the Chief Operating Officer)	(LG)
	Kevin Rowan	Trust Secretary	(KR)
	Darren Palmer	Interim Divisional Director of Operations (DDO), Diagnostics & Clinical Support Services (for item 09-12)	(DP)
	Rob Parsons	Risk and Compliance Manager (for item 09-14)	(RP)
	Jelena Pochin	Deputy DDO, Diagnostics and Clinical Support Services (for item 09-12)	(JP)
	Doug Ward	Director of Estates and Facilities (for item 09-9)	(DW)
Observing:	The meeting was livestreamed on the Trust's YouTube channel.		

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

09-1 To receive apologies for absence

MC confirmed that she would preside over the meeting until DH, who was experiencing some IT/technical difficulties, joined the meeting. Apologies were then received from Sean Briggs (SB), Chief Operating Officer; and Neil Griffiths (NG), Non-Executive Director. MC also welcomed JH to her first formal Trust Board meeting, and also thanked LG for attending on behalf of SB.

09-2 To declare interests relevant to agenda items

SDu declared that she was a Non-Executive Director at East Kent Hospitals University NHS Foundation Trust (EKHUFT), which was relevant to item 09-9.

09-3 To approve the minutes of the 'Part 1' Trust Board meeting of 29th July 2021

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

09-4 To note progress with previous actions

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

- **07-15 (“Check and confirm the length of stay details for the patients that were admitted to Hedgehog ward that required a Tier 4 Child and Adolescent Mental Health Services (CAMHS) bed.”)**. JH reported that the Trust had been challenged in relation to patients awaiting Tier 4 beds, and between April and September 2021, 54 inpatients required mental health services and nine had required a Tier 4 bed. JH continued that the average length of stay (LOS) had been 23 days, which compared to an average paediatric LOS of two days. JH added that

the LOS ranged from 0 days to 122 days, so it was a significant issue, which brought challenges to staff, patients and relatives. MS asked whether there was any opportunity to check how long the situation would continue, and what mitigations were in place. JH noted that national mitigations were being considered, and local liaison with CAHMS teams continued, but individuals' requirements were unique. PM confirmed that much work was being done on the subject but emphasised that it was a regional and national issue, and there was no 'magic wand' that could be waved to resolve the staffing and accommodation problems, although he was aware that plans were afoot regarding additional accommodation at the Kent and Medway Adolescent Hospital in Staplehurst and also at Kent and Medway NHS and Social Care Partnership Trust's site next to Maidstone Hospital (MH). MS emphasised that pressures on children's services were an increasing risk to the Trust's continuity of services and the quality of care that the Trust was able to offer, and the pressure was affecting other paediatric services, including Critical Care facilities. JW thanked JH for the update asked that the issue be considered again, with an update in three months' time. MS acknowledged that it would be appropriate for the Tier 4 CAHMS beds issues to be considered again in three months, but proposed that the wider issue of operational pressures within paediatrics should be considered in the next cycle of meetings, including the Quality Committee and Trust Board. This was agreed. MC also agreed that the issue could be considered via the Quality Committee and People and Organisational Development Committee.

Action: Schedule an update at the Trust Board's meeting in December 2021 on the latest position regarding access to Tier 4 Child and Adolescent Mental Health Services (CAMHS) beds (Trust Secretary, September 2021 onwards)

Action: Provide an update at the Trust Board's meeting in October 2021 on the latest position regarding operational pressures within paediatrics (Chief Operating Officer, October 2021)

09-5 Report from the Chair of the Trust Board

MC referred to the submitted report and highlighted the recent consultant appointments. MC also thanked the Trust's staff for all their hard work during the recent challenging circumstances.

09-6 Report from the Chief Executive

MS referred to the submitted report and highlighted the key points therein, which included second phase of senior leaders starting the Exceptional Leaders Programme; the Annual General Meeting and wider work of the Cultural and Ethnic Minorities Network (CEMN); the continued implementation of the Electronic Patient Record (EPR); and the external recognition received by the Trust's teams.

Quality items 1

09-7 Infection prevention and control board assurance framework

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

- A new version of the framework had been issued to reflect updated guidelines, which related to the relaxation of the COVID-19 public restrictions. The new content had been highlighted in red text, while the previous responses had been left in black text.
- The hierarchy of controls model was in place for the risks, and RP should be thanked for his support in applying that model.
- Waiting areas had been reviewed to ensure that spaces were located at least 2 metres apart, A dual role has been applied to the fit testing and Personal Protective Equipment (PPE) team. The fit testing team have now become a permanent feature of the Infection Prevention and Control team, and substantive posts had now been advertised, as the staff were currently temporary.
- The pathway for clinically extremely vulnerable patients had been amended, and all patients were now located in side rooms.
- A '1 metre plus' social distancing framework had been applied to training and face-to-face/in-person meetings.

MC thanked SM for the work involved in producing the framework, but asked whether SM was confident that there were definitely no “Gaps in Assurance”. SM confirmed she was confident, but noted that there was a gap regarding the easy read version of the COVID-19 leaflet, which was referred to on page 21 of 47. The point was acknowledged.

Integrated Performance Report

09-8 Integrated Performance Report (IPR) for June 2021

SM firstly referred to infection control aspects of the “Safe” domain & reported the following points:

- COVID-19 numbers had increased over the summer, and a maximum of 40 inpatients with 4 on ICU had been reached at the peak. However, the numbers had now reduced, so there were now two COVID-19 patients on ICU and 16 COVID-19 inpatients.
- There had been three COVID-19 outbreaks over the summer months, but these had been managed very well, and further spreads had been prevented.
- Other monitored infections were as expected apart from C. diff, which was higher. Cross-site meetings had been established and the issue would be closely monitored. Some of the issues related to cleaning but these had been addressed. The C. diff problem was also not confined to the Trust, and there had been increases across the country, which was likely to be related to general levels of pressure.

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

MS then introduced the report and highlighted the following points:

- The key issue was the operational pressures currently faced by the Trust, which was dealing with higher levels of non-elective and elective activity than ever before.
- Although the number of COVID-19 positive cases had reduced, the Trust still had to have separate streams for such patients, so there was still considerable disruption involved.
- The position was very pressured, and staff were feeling that pressure, which was evident from the performance on a range of Key Performance Indicators (KPIs).
- Despite that, there was continued good performance on the cancer access targets and the Emergency Department (ED) 4-hour waiting time target, and the Trust had retained its position within the top 10 Trusts in the country for the latter.

JH then referred to the “Safe” domain and reported the following points:

- Staffing had been particularly challenging from a nursing and midwifery perspective, and that had been affected by sickness, COVID-19 isolation and Annual Leave (A/L). It was however an absolute priority and a resourcing ‘Task Force’ which involved SS, SB, SO and JH had been established by SS.
- The aforementioned increased prevalence in C. diff had resulted in a Trust-wide incident being raised. Staffing was likely to be a factor, and a range of actions were being taken, which included replacing existing commodes and antimicrobial stewardship.
- There had been an increase in patient falls that month, mainly at Tunbridge Wells Hospital (TWH), and the majority of falls had been unwitnessed. Two falls had resulted in significant harm, and these were being reviewed via the Serious Incident (SI) process. Falls was one of the Trust’s breakthrough objectives, for which PM was the lead, and a multidisciplinary event would be held in October 2021, to promote awareness of the role all staff could play in reducing falls.

PM added further details regarding the plans to reduce falls, and gave assurance that he expected to see an improvement in the position.

JH then continued that a never event would be declared for September 2021, which involved the insertion of a vascular catheter, and was currently being investigated. JH however confirmed that that the patient involved had not come to any harm.

EPM noted that staffing had been discussed in detail at the latest People and Organisational Development Committee meeting, which JH had attended, but asked for assurance that there were sufficient resources and staff to support the recruitment that was required. JH acknowledged that there was currently a gap, so JH had just completed developing a Job Description for a Lead Matron for recruitment and retention, which would help the position. SS supported JH’s intention to

recruit such a Matron, and noted that further work was underway to ensure there were sufficient resources to support the Trust's recruitment intentions. DH also welcomed the recruitment of a Matron, but queried whether the need to recruit staff quickly, including from overseas, had stretched the Trust's practice development and other resources. JH agreed, and gave details of the further work being planned to support the existing staff in clinical areas, and also support the new recruits.

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

- A separate report on mortality had been submitted under item 9-10.
- The performance on stroke Best Practice Tariff (BPT) remained strong, as did that on the Sentinel Stroke National Audit Programme (SSNAP), and PM was confident the Trust would perform well on the forthcoming SSNAP Organisational Audit.

DH referred to the number of virtual outpatient appointments, which had reduced, and queried whether the target was a realistic aspiration. LG confirmed that SB had acknowledged that a 30% target was more realistic, given the circumstances. PM added that it needed to be stressed that the decision to use a telephone, virtual, or face-to-face consultation was a clinical decision, so the Trust would not solely focus on meeting targets. The point was acknowledged.

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

- The complaints response rate had improved, despite there being a significant increase in complaints across the year (although the number had reduced in August).
- A data issue had arisen regarding the Friends and Family Test (FFT), which was being addressed, and it was intended to make better use of technology, including SMS and QR codes, to improve the position. The findings from the FFT were however generally positive.
- The outpatient FFT response rate target seemed too high, and unachievable, so JH had asked the Business Intelligence Unit to explore what targets were in place at other Trusts.

LG then referred to the "Responsive" domain and reported the following points:

- Performance against the ED 4-hour waiting time target had been challenged, given the aforementioned pressures, and was circa 85%, but the Trust was retaining its relative position against other Trusts. The Trust had also been commended by South East Coast Ambulance Service NHS Foundation Trust for being the best in Kent for ambulance handovers.
- NHS England/Improvement (NHSE/I) had commissioned a poll from Ipsos MORI to try and understand why patients were attending EDs, to understand why such attendances had increased over the past few months, so the findings from the survey would be used to inform the development of the Trust's winter plan.
- The cancer access targets had been met every month for the last two years, but there were some pressures in particular areas, which were being addressed.
- The elective activity backlog was now around 40, which had reduced from circa 1000 at the start of the year. The clinical priority of referrals was being reviewed weekly, to ensure that patients with the highest clinical priority were seen.
- Outpatient performance varied, but there were some good signs for telephone response performance, particularly within the Medicine & Emergency Care Division.

EPM referred to the Ipsos MORI survey and asked whether the Trust had internal data that helped explain the large increases in ED attendances. LG stated that the Trust's internal data indicated that the increase was primarily driven by increases in 'minors' rather than 'majors' ED activity.

JW welcomed the reduction in the patients waiting beyond 52 weeks for treatment, but noted that the overall waiting list had increased, so asked whether the low number of patients waiting a long time could be maintained. LG acknowledged that was a challenge, and the Trust was working hard to protect the elective activity flows, but there was caution as to whether that could be achieved, as it was very dependent on inpatients being discharged in a timely manner, which in turn was reliant on social care. MS added further details, and DH emphasised the need to also ensure outpatient waiting times were monitored closely.

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

- The Trust was delivering a small surplus in month and was performing in accordance with its plan for the first half on 2021/22.
- Agency expenditure was higher than expected, given the current staffing issues.
- The Elective Recovery Fund (ERF) had been in place for the first six months of the year, and for the first four months where there was completed and nationally validated information, the Trust had delivered circa 107% of activity compared to the 2019/20 comparator. The Trust was also the best performing Trust in Kent and Medway in terms of elective activity.
- The threshold to achieve the ERF had however increased for month 5, and the threshold was applied across the Integrated Care System (ICS), so that had adversely affected the Trust's ability to achieve the funds.

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

- The vacancy rate was currently 15%, and on average 65 staff were leaving per month, so recruiting at 800 people per month was a standstill position.
- The aforementioned Task Force had been established to understand the specific needs of certain key areas, which included medicine, ED, critical care, radiology, midwifery and pathology; reviewing current recruitment activity; improving the marketing reach and Trust branding, and also using executive search agencies.
- 70 international nurses had joined the Trust in the past few months, and 24 more were in the recruitment pipeline, but the need to increase the infrastructure and support for this work was acknowledged.
- Retention was a further area of focus, and the work related to this included reviewing the exit surveys and also responding to the finding that when staff left to join another Trust, they often returned to the Trust after a short period, so work was being done to communicate some of the Trust's key attractions to staff.

RF commended the work being done and noted that SS had given assurance at the latest People and Organisational Development Committee meeting, but stated that he was concerned at the number of KPIs in the "Hit and Miss" section of the IPR. SO noted that a revised version of the IPR had been shared with some of the Non-Executive Directors, and work was underway to refine that version, to enable it to be formally introduced. SO continued that it was hoped to be able to do that for the Trust Board meeting in October 2021, but it may need to be after that point. SO then elaborated on the content of the revised IPR, but also stated that the members of the Executive Team needed to be better at critically evaluating the KPIs in the "Hit and Miss" section, and those with "Common Cause" variation, rather than focus on the polar ends of the positive and negative performance.

DM commended JH's eloquent highlighting of the concerns regarding staffing, but noted that the relevant page of the IPR did not reflect the situation JH had described, and the IPR was not therefore drawing attention to the pertinent issues. DM continued that a significant amount of work was involved in revising the IPR, so queried whether there was sufficient senior time and resource available to undertake the work required. SO acknowledged DM's points but explained the difficulties in members of the Executive Team focusing on what the Statistical Process Control (SPC) data showed, rather than on the KPIs that had changed since the last report they gave to the Trust Board. DH noted that the Non-Executive Directors felt that the targets needed to be revised, as continuing with the number of KPIs in "Common Cause" variation was not beneficial, but confirmed that the work needed to proceed via the Non-Executive Director group that had been established. The point was acknowledged.

SDu asked whether the Trust had a 'plan B' for recruitment, if all Trusts were competing in a dwindling pool of potential staff and there were insufficient staff to provide safe staffing levels i.e. was the Trust planning to upskill/train its existing workforce to meet its needs differently. SS elaborated on the work of the aforementioned Task Force, and the wider work planned on role design, apprenticeships, and the potential to appoint international recruits in midwifery. MS emphasised that the Trust did not so much have a 'plan A' and 'plan B' but had a plan with lots of parallel work, so there was not a reliance on international recruitment. JH added that as a newcomer, she believed the Trust had done a lot more than others in relation to extended roles, so there were lots of opportunities, but these would take time to come to fruition.

Planning and strategy 1

09-9 To approve the Trust's Estates Strategy

AJ introduced the item by noting that the Strategy had been informed by the discussion at the Trust Board 'Away Day' on 12/07/21. DW then referred to the submitted report and firstly thanked AJ and his team for their work on the Strategy, particularly in relation to the production of the Site Development Control Plans. DW then highlighted that the Strategy was a live document, and would be updated regularly.

DH commended the creation of the Site Development Control Plans, which had been the culmination of a lot of cohesive planning work.

MC referred to the Hyper Acute Stroke Unit (HASU) and noted that proceeding with the plans was challenging. DW acknowledged that the final decision currently sat with the Secretary of State for Health and Social Care, but the Trust was ready to implement the HASU once it was able to. MC encouraged a continued focus and DW gave assurance that he was in regular liaison with the Trust's Programme Director and the stroke team. DH also noted that he had discussed the issue at a recent meeting with the Regional Director (South East) at NHSE/I, and he understood that there were active discussions, as it was now two and a half years on from the Committee in Common of what was then ten Clinical Commissioning Groups made the recommendation.

The Strategy was approved as submitted.

Quality items 2

09-10 Quarterly mortality data

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

- The report had been considered at the 'main' Quality Committee in mid-September.
- Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) performance was as expected
- COVID-19 mortality was a concern, and that had resulted in a review of clinical coding. The next step was to undertake an in-depth review of individual records.
- There had been some turnover in the staff within the mortality surveillance service, which was likely to be related to the space they need to undertake the role, and the engagement with medical staff. However, the backlog in cases needing review had reduced.

Planning and strategy 2

09-11 To approve the Business Case for gastroenterology inpatient centralisation

DH introduced the item by noting that although the expenditure involved did not require Trust Board approval, it was felt appropriate to seek such approval because of the service change. AJ then referred to the submitted report and highlighted the following points:

- The Case was the next step from the surgical reconfiguration service change that had been approved previously.
- The plan was to implement the Case within the next four to six weeks.
- The only outstanding issue was to introduce a gastroenterologist of the week rota, but a solution had now been agreed with the Chief of Service for Medicine and Emergency Care.
- There were no other outstanding issues, so Trust Board approval was requested.

The Business Case for gastroenterology inpatient centralisation was approved as submitted.

09-12 To approve the Business Case for the development of a Community Diagnostic Hub

DH introduced the item by noting that the Case had been considered at the Finance and Performance Committee on 21/09/21, and the Committee had recommended that the Case be approved by the Trust Board. DP added further context for the development of the Case.

MC asked about access to the site, as that would likely be raised at the Patient Experience Committee. DH noted that there would be 25 car parking spaces, and access to spaces in the adjacent location, so the Finance and Performance Committee had been assured by the plans. MS however acknowledged that public transport would need to be provided to the site, so work would be undertaken regarding that aspect. MC welcomed such work as that would support green issues. DH asked about access by staff. MS replied that there would, as a minimum, be a staff shuttle from MH, as the Hub was located on a busy road with no crossing. DP also noted that those that wished to park on the site could do so. JP added that a site visit had been undertaken on 22/09/21, and although there was a train station almost opposite the site, the absence of a road crossing had been highlighted, although the site owners had confirmed they would support the Trust's efforts to have such a crossing introduced.

The Business Case for the Development of a Community Diagnostic Hub was approved as submitted.

Assurance and policy

09-13 Responsible Officer's Annual Report 2020/21

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

- The report had responded to the action from when the Trust Board considered the Responsible Officer's Annual Report 2019/20.
- All of the appraisals had been reviewed, and doctors, in general, did not feel COVID-19 had adversely affected their health; feeling unsupported was rare; and work-life balance was discussed often.
- 108 doctors did not complete their appraisal, but the General Medical Council had confirmed that the vast majority of these would still be re-validated, although three doctors had not responded to efforts to engage with the process, so further efforts were being made.
- Work was needed to ensure the correct number of appraisers were in the right discipline, and to continue to ensure a high level of appraisal experience.
- A medical engagement survey had been done and PM was content for the Trust Board to consider that survey should it wish to see the findings. However, one of the findings was to explore using a web-based appraisal platform, so the Trust had responded.

RF asked for further details on the content of the appraisals regarding doctors' behaviour. PM responded by illustrating an example from one of his own previous appraisals, in relation to the behaviour of medics towards the appraisal process. RF clarified that he was more interested in whether the appraisals explored a medic's behaviour with patients, colleagues, managers etc. PM stated that as part of the five-year appraisal cycle, some colleagues were chosen for a 360° appraisal survey with selected patients and other colleagues, and the findings were considered in the appraisal. PM clarified that there was no particular focus on behaviour towards managers, but that could be added to the survey and PM had included that aspect in his own 360° appraisal. RF noted that SS was reviewing the appraisal process for other staff and he was querying the similarities between the two. MS however pointed out that medical appraisal was not undertaken by the individual's line manager.

The Trust Board approved the "Statement of Compliance" in Annex D, which confirmed that the Trust, as a designated body, had complied with the regulations.

09-14 Health & Safety Annual Report, 2020/21 and agreement of the 2021/22 programme (including Trust Board annual refresher training on health & safety, fire safety, and moving & handling)

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

- The appointment of a Health and Safety Adviser had given a new impetus.
- There was a more robust Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) incident investigation assurance process.
- Reporting of non-patient incidents had reduced by 11.5%.

- 22 RIDDOR incidents had been reported and seven of these occurred within the Facilities Directorate.
- The Trust had reported 924 COVID-19 occupational disease RIDDOR reports. Different Trusts reported such data differently, as it required a decision based on the balance of probability that the staff member had acquired COVID-19 while undertaking work-related activities.

EPM asked how the increasing number of staff who were undertaking home working would affect health and safety, and what provisions had been made by the Trust. RP explained that the correct processes and self-assessments should be undertaken but the Trust had a duty to ensure that the same principles that applied to office working applied to home working. EPM clarified that she was seeking further details of the Trust's approach. RP stated that the same processes would be applied, including identifying which staff used Display Screen Equipment (DSE) etc.

DM noted the use of SPC in the IPR, and queried whether SPC methods would be beneficial to apply to the monitoring of health and safety data. RP welcomed anything that would improve the report. SO therefore confirmed he would liaise with RP outside the meeting to advise him.

Action: Liaise with the Risk and Compliance Manager to advise on how Statistical Process Control (SPC) methods could be applied to the monitoring of health and safety-related statistics (Deputy Chief Executive/Chief Finance Officer, September 2021 onwards)

JW then referred to the fire stopping survey on page 34 of 35 and asked for further details. RP noted that the Trust's Head of Fire & Safety was part of the Estates team, so RP would expect that individual to be involved in all relevant projects.

The Health & Safety programme for 2021/22 was then agreed as submitted.

09-15 Approval of Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment

LG referred to the submitted report and highlighted the key points therein, which included that the Trust was compliant with all 48 the relevant standards, but partially compliant in two of the sub areas within the 'Deep Dive' standards.

DH asked whether the areas where the Trust was partially compliant were at MH. LG confirmed that was the case. DH noted that the new vacuum insulated evaporator (VIE) was presumably not installed in time to affect the compliance and LG confirmed that was correct.

SDu referred to the "Mass Casualty" standards on page 5 of 20 and asked how confident the Trust was in managing such a situation. LG confirmed that other activity would be halted to ensure the Trust had sufficient staff to manage a mass casualty event.

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

Reports from Trust Board sub-committees

09-16 Charitable Funds Committee, 27/07/21

DM referred to the submitted report, noted that the main points had been covered verbally at the last Trust Board meeting, and invited questions or comments. None were received.

09-17 Audit and Governance Committee, 04/08/21 (incl. the External Auditor's Annual Report for 2020/21)

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

- The Committee had requested further assurance regarding senior managers involvement in risk assessment and identification, as a gap in assurance had been identified, so work was ongoing.
- The external auditors gave an unqualified audit opinion, and the submitted report included the auditors annual report which contained five recommendations.

Questions were invited. None were received.

09-18 Finance and Performance Committee, 25/08/21 and 21/09/21 (incl. approval of revised Terms of Reference)

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

- The meeting on 25/08/21 had been a single item meeting that had approved a Business case for a Magnetic Resonance Imaging (MRI) managed service, although NHSE/I approval was still required, and DH believed that was still outstanding.
- Some amendments to the Committee's Terms of Reference had been approved at the meeting on 21/09/21.

SO confirmed that the MRI managed service Business Case still required approval by NHSE/I, and added that the Trust believed it had provided all the information NHSE/I had requested, but a definitive timeline for approval had not yet been provided. SO added that the Trust was supporting several projects and was prioritising. DH noted the importance of obtaining approval before the introduction of International Financial Reporting Standards (IFRS) 16 (Leases). The point was acknowledged.

The Finance and Performance Committee's revised Terms of Reference were then approved as submitted.

09-19 Patient Experience Committee, 02/09/21

MC referred to the submitted report and invited questions or comments. None were received.

09-20 Quality Committee, 15/09/21

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

- Critical Care had some concerns regarding the challenge of discharging patients from the ICU, which had caused some potential patient safety issues.
- JH had suggested there should be an amnesty of very old patient safety incidents, given that it was very difficult to establish the facts for some very old incidents. JH would therefore assess the impact of such an amnesty before a decision was made.
- A Non-Executive Director had highlighted the importance of disseminating the learning from appearing in HM Coroner's court, and using that experience for the benefit of other staff.

09-21 People and Organisational Development Committee, 17/09/21 (incl. approval of the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) action plans and national data submissions)

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

- The three corporate objectives on the A3 had been reviewed;
- Retention and recruitment had been discussed
- The latest Guardian of Safe Working Hours report was enclosed.

The Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) action plans and national data submissions were approved as submitted.

Other matters

09-22 To consider any other business

There was no other business.

09-23 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
09-14	Liaise with the Risk and Compliance Manager to advise on how Statistical Process Control (SPC) methods could be applied to the monitoring of health and safety-related statistics.	Deputy Chief Executive / Chief Finance Officer	September 2021 onwards	A verbal update will be given at the meeting.

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
07-13	Formalise the establishment of the Green Committee as a sub-committee of the Finance and Performance Committee; and the disestablishment of the Sustainable Development & Environment Committee.	Trust Secretary	October 2021	The establishment of the Green Committee as a sub-committee of the Finance and Performance Committee was formalised when the Trust Board approved revised Terms of Reference for the Finance and Performance Committee at its meeting in September. The Sustainable Development & Environment Committee was then formally disestablished by the Trust Management Executive (TME), on 20/10/21.
09-6a	Schedule an update at the Trust Board's meeting in December 2021 on the latest position regarding access to Tier 4 Child and Adolescent Mental Health Services (CAMHS) beds.	Trust Secretary	September 2021	An item has been scheduled for the Trust Board in December 2021.
09-6b	Provide an update at the Trust Board's meeting in October 2021 on the latest position regarding operational pressures within paediatrics.	Chief Operating Officer	October 2021	A verbal update will be provided under the Integrated Performance Report (IPR) item.

Actions not yet due (and still 'open')

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

1

Not started

On track

Issue / delay

Decision required

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

I want to take this opportunity to thank our management teams, our clinicians and all our support staff for their dedicated efforts to maintain safe care, patient flow through the hospitals, and maintaining elective recovery in the face of great pressures. The level of Emergency Department attendances coupled with ambulance volumes, and the difficulty of in discharging medically fit patients because of capacity constraints in the care sector has created a series of challenges across the Trust. On behalf of the whole Board and I would like to formally record our recognition of these challenges and the resilience of our teams to respond.

I am delighted to confirm that Maureen Choong has been reappointed to the Board as a Non-Executive Director for four more years, until 15th November 2025. This news gives me the opportunity to thank Maureen for her contribution to the work of the Trust in a range of areas and to affirm how much her supportive style is valued by many staff.

I am also giving early warning that our Vice-Chair Sarah Dunnett comes to the end of her second and final four year term on 31st December 2021 and we will shortly be advertising to recruit a new Non-Executive Director to the vacant post. Sarah has been an immense support to me personally and to the whole Trust and we will have the opportunity to thank her more formally in December.

Consultant appointments

I and my Non-Executive colleagues are responsible for chairing Advisory Appointment Committees (AACs) for the appointment of new substantive Consultants, and 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?
22/09/21	Consultant Physician with an interest in Care of the Elderly	Katherine Elizabeth Madeleine	Lynch	Frailty	TBC	New
22/09/21	Consultant Physician with an interest in Care of the Elderly	Peter Edward	Springbett	Frailty	TBC	New
22/09/21	Consultant Physician with an interest in Care of the Elderly	Clare	Hunt	Frailty	TBC	New
29/09/21	Consultant Cardiologist with an Interest in Coronary Intervention	Timothy Mark	Williams	Cardiology	TBC	New

Which Committees have reviewed the information prior to Board submission?

N/A

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

Information

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

Report from the Chief Executive**Chief Executive**

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

1. We are holding a 12-week engagement period, which will run from 20 October 2021 until midnight on 11 January 2022 to understand what patients, the public, staff and stakeholders think about proposed changes to our Cardiology services. It is important to state that these proposed changes will not change how or where we deliver cardiology outpatient clinics and outpatient cardiology diagnostic services. At the moment our cardiology services are split across our two main hospital sites. This often leads to patients being transferred from one site to another during an inpatient stay. It also means our specialist cardiology teams are thinly stretched across two sites and we can't consistently provide a seven-day service at either site. Nor can we care for all heart patients on a dedicated, specialist cardiology ward. Despite the hard work of our fantastic staff we are struggling to meet national best practice standards in some areas because of how our cardiology services are organised. You can find out more about our proposals on our website mtw.nhs.uk/cardiology-engagement. Alternatively, information can be requested in hard copy by emailing mtw-tr.cardioreconfig@nhs.net. There are several opportunities for patients, the public, staff and stakeholders to get involved in discussions on the future shape of cardiology services over the next 12-weeks, including some virtual public listening events. Further details of how to get involved can be found on our website, where there is also a short survey to help us gather feedback on the proposals. In addition, we are also carrying out some telephone polling and targeted focus group discussions to ensure a wide range of views are captured. After the engagement period ends, an independent agency will compile and review the feedback. The final decision about the proposals is expected next year.
2. Our Covid-19 vaccine booster clinics for all staff opened on 5 October with the option for colleagues to also book their annual flu jabs in the same slot to help ensure colleagues are able to keep themselves, their patients and families as protected as much as possible. This is extremely important going into the winter months combined the recent small increase in Covid-19 patients at our hospitals and rise in infections in the community. In the two weeks alone of the clinics opening, our teams were able to vaccinate approximately 1,400 colleagues and we'll be supporting every staff member at the Trust to receive their jab in the coming weeks.
3. Staffing pressures across the organisation continue to be our number one priority and work has started to publish and deliver a comprehensive staffing plan. In recent weeks we have taken action to make sure we can provide colleagues with the staffing support our teams need during these challenging times. These have included:
 - Reviewing our Agenda For Change bank rates and increasing them to the top of the band, effective 1 Nov and backdated to 1 Oct which will apply to all non-medical bank staff and will include both substantive staff, working additional bank hours, and bank only staff.
 - Establishing a formalised plan for enhancements including percentage uplifts in some areas and the introduction of a bonus scheme over Christmas and Easter
 - Focusing on national campaigns to support our recruitment plans to help fill all vacancies across the Trust.

We are also encouraging managers to hold regular meetings with their teams to listen to any concerns in terms of work demands but also to feedback with any ideas or comments from colleagues on what else the Trust can action to provide better support.

4. We have now achieved the 62 day cancer standard for 24 consecutive months – a feat matched by only three other Trusts, meaning we are providing some of the fastest access to treatment in the country. This is a fantastic achievement from teams across all divisions who have enabled us to provide support to cancer patients throughout the pandemic. The achievement also marks a huge turnaround in performance for us as a Trust - until August 2019 we had not hit the target for five years and were ranking as the worst performing trust. Achieving the target has allowed for new services, investment and attract new staff to help put MTW at the forefront of cancer care. We are now looking to sustain our service and look to improve further and we would like thank all teams across the organisation for achieving this.

5. As previously reported, work has begun on the new medical school building at Tunbridge Wells Hospital. The overall Undergraduate governance structure has been agreed and we are announcing a number of recent senior appointments, including:

- Dr Pamela Laventis - Director of Undergraduate Medical Education (DUME)
- Dr Clive Lawson - Head of Year 3
- Dr Owen Ingram - Care of the Elderly Module Lead
- Mr Charles Bailey – Surgical Lead
- Dr Katherine Smith – Medicine Lead

If you have any questions or concerns about what is happening on site, please email mtw-tr.medicalstudentaccommodation@nhs.net

6. Our Acute Stroke Unit Team have been awarded the highest performance rating by the Sentinel Stroke National Audit Programme (SSNAP) for our clinical audit results for Quarter 4 and Quarter 1. The 'A' rating, which was last achieved by the hospital in 2019, means patients are being admitted on to the unit quicker, receiving high quality specialist care earlier and treatment faster when they arrive on the unit. Improvements in the following areas helped the team to achieve the top rating:

- The creation of a new four bedded assessment bay (opened in April 2020) so patients who arrive in the emergency department (ED) can be admitted on to the unit quickly and assessed by stroke specialist staff as soon as they arrive.
- Increased the number of acute beds on the unit from 22 to 46 beds to cope with an increase in patients following the closure of stroke services at Medway Maritime Hospital in July 2020 and Tunbridge Wells Hospital in September 2019.
- Two new stroke rehabilitation initiatives in the community to help enable shorter stays for patients in hospital.
- Consultants now working seven days a week as opposed to five days a week meaning specialist care is now delivered to patients on a daily basis - meeting best practice for a consultant delivered service.

It is only thanks to the hard work of our exceptional staff working on the Acute Stroke Unit that continue make improvements to ensure we provide outstanding care to our patients in partnership with other colleagues across the Trust, as well as external agencies, that this rating has been achieved.

7. The annual national NHS survey officially opened earlier this month giving an opportunity for our staff to have their say about what they like and don't like about working at MTW and use their voice to shape our Trust. We want MTW to be a workplace where staff have a healthy work/life balance, are safe and respected and feel fulfilled. It's only by speaking out that we can collectively create change and make a difference. The results from the survey enable us to focus on improving the things that matter to our staff by identifying areas where we can do more to support. This year the survey has been redeveloped to align with the NHS [People Promise](#). A promise to each other to improve the experience of working in the NHS for everyone. We're looking for as many colleagues as possible to have their say with a target of 65% before the survey closes on 26 November.

8. In September the Trust has celebrated two important milestones. Firstly, we marked ten years of Tunbridge Wells Hospital being fully operational and within this time the hospital has cared for 742,000 people via its Emergency Department, carried out 142,000 operations, delivered 1,874,000 outpatient appointments and delivered some 53,000 babies. It was also the turn of the Maidstone Birth Centre to mark ten years, in which the centre has seen nearly 4,500 babies born and it's fantastic to see that ten original members of staff are still working at the centre until this day forming part of such a close-knit team. A huge thank you to anyone who has worked at the sites over the years for making the last decade such a success.
9. Congratulations to our Learning and Development Team who won the Public Sector Employer of the Year award at Qube Learning Awards 2021 on Thursday 14 October. Qube Learning are one of our apprenticeship providers and the award recognises the hard work that our apprentices have carried out despite the pandemic. The bid also highlighted the support they were given by the team despite redeployments, which included pivoting sessions online, working out of hours to meet shift patterns and adapting to provide a higher level of pastoral care and increasing their contact with mentors and managers.
10. Congratulations to the winner of the Trust's Employee of the Month scheme for September Louise Millson, Clinic Co-Ordinator for Patient Services in Oncology. On behalf of the Trust Board I would like to say thank you to Louise for their fantastic work to help support our colleagues and patients.

Which Committees have reviewed the information prior to Board submission?

N/A

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

Information and assurance

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

**Integrated Performance Report (IPR) for September 2021
(incl. an update on the latest position regarding operational
pressures within paediatrics)**

**Chief Executive / Members of
the Executive Team**

The IPR for month 6, 2021/22, is enclosed, along with the monthly finance report and the latest 'planned vs actual' nurse staffing data. A verbal update on the latest position regarding operational pressures within paediatrics will also be provided at the meeting.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 19/10/21
- Finance and Performance Committee, 26/10/21 (IPR)

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

Review and discussion

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

Integrated Performance Report

September 2021

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- Key to Icons and scorecards explained Page 3
- Radar Charts by CQC Domain & Executive Summary Page 4
- Summary Scorecards Pages 5-7
- CQC Domain level Scorecards and escalation pages Pages 8-22

Appendices (Page 23 onwards)

- Supporting Narrative
- Implementing a Revised Perinatal Tool

Note: Detailed dashboards and a deep dive into each 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	'Pass' Variation indicates consistently - (P)assing of the target	'Hit and Miss' Variation indicated inconsistency - passing and failing the target	'Fail' Variation indicates consistently - (F)ailing of the target	Data Currently unavailable or insufficient data points to generate SPC

Escalation Rules:

Areas are escalated for reporting if:

- They have special cause variation (positive or negative) in their performance
- They have a change in their assurance rating (positive or negative)

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.

Scorecards explained

Name of the Metric / KPI	Latest				Previous			YTD		Assurance
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	
Single Sex Accommodation Breaches	0	0	Jun-20		0	0	May-20	0	0	

This section shows 'actual' performance against plan for the latest month

This icon indicates the variance for this metric

This section shows 'actual' performance against 'plan' for the previous month

This section shows 'actual' performance against 'plan' for the Year to date (YTD)

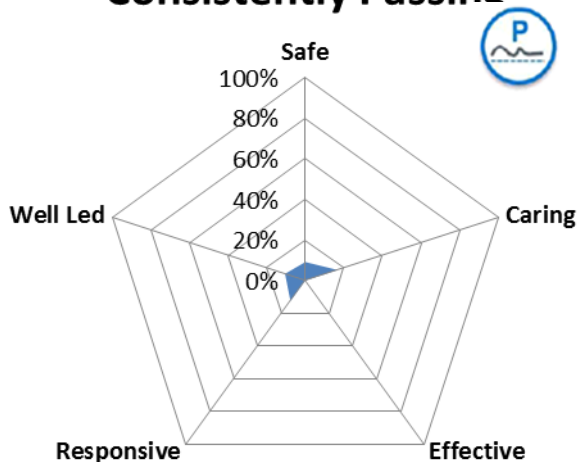
This icon indicates the assurance for this metric, so shows the likelihood of this KPI achieving

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>

Executive Summary

Consistently Passing



Consistently Passing:

The following Key Performance Indicators are all consistently achieving the target:

Safe:

- Trust Mortality (HMSR)

Caring:

- Mixed Sex Accommodation Compliance
- % VTE Risk Assessment

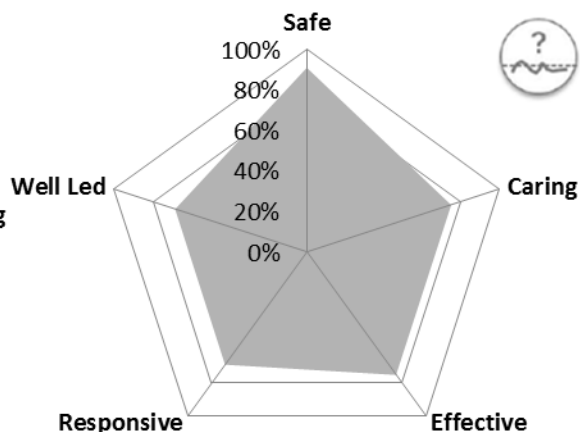
Responsive:

- Cancer 62 Day Waiting Times Standard
- Cancer 2 week Waiting Times Standard

Well-Led:

- Mandatory Training Compliance
- Number of Advanced Practitioners

Hit and Miss



Hit and Miss:

The following Key Performance Indicators are experiencing inconsistency (passing or failing target)

Safe:

- Safe Staffing, Infection Control Indicators, Incident Reporting, Harm Free Care Indicators, Never Events

Effective:

- Outpatients DNA Rates and Hospital Cancellations, Readmissions & Stroke Indicators,

Caring:

- Complaints Indicators, Friends & Family Percentage Positive, Friends & Family Response Rates – Inpatients, Maternity & Outpatients

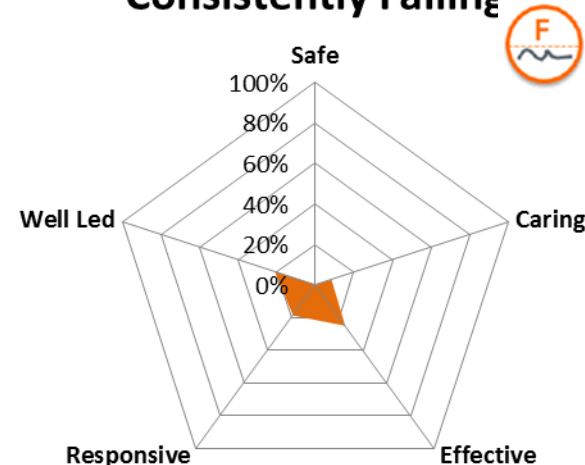
Responsive:

- RTT Number of >52 week Waiters, Cancer 31 Day Standard, A&E 4hr Standard, Ambulance Handovers, Super-Stranded Patients, Bed Occupancy, NE LOS, Cancer PTL – size of Backlog

Well-Led:

- Capital Expenditure, Agency Spend, Sickness Rate, Appraisals, Staff FFT Recommended to work, Staff FFT Recommended Care and Health and Well-Being

Consistently Failing



Consistently Failing:

The following Key Performance Indicators are all consistently failing the target:

Caring:

- OP Friends & Family Response Rate

Effective:

- Outpatient Utilisation
- Outpatient – Calls answered within 1 min
- Outpatient – Calls Abandoned

Responsive:







- RTT performance
- RTT Number of >40 week Waiters
- Diagnostics Waiting Times
- Theatre Utilisation




Well-Led:

- Agency Staff used
- Turnover Rate
- Vacancy Rate
- Number of Specialist Services to London
- Percentage of Trust policies within review date

Matrix Summary

September 2021

		Assurance		
		Pass 	Hit and Miss 	Fail 
Variance	Special Cause - Improvement 	Stat and Mandatory Training (W)	Infection Control - Hospital Acquired Covid (S), Infection Control - Number of Hospital acquired MRSA (S), Outpatient Hospital Cancellation (E) Outpatient Cancellations <6 weeks (E) 52 week breaches (including those reported last month) (R) A&E Friends & Family (FFT) % Positive (C), Staff Friends and Family % recommended care (W),	Calls Answered in under 1 min (E) Turnover (W), Percentage of Trust policies within review date (W),
	Common Cause 	Standardised Mortality HSMR (S), Single Sex Accommodation Breaches (C), Cancer - 2 Week Wait (R), Cancer - 62 Day (R), Number of advanced practitioners (W)	See box (right)	Percentage of Calls abandoned (E), RTT (Incomplete) performance against trajectory (R), Access to Diagnostics (<6weeks standard) (R), Number of patients waiting over 40 weeks (R), Theatre Utilisation (R) Number of specialist services (W), Vacancy Rates (W), Use of Agency (WTE) (W)
	Special Cause - Concern 	% VTE Risk Assessment (C)	OP New DNAs (E) OP Follow UP DNAs (E) Mat Resp Rate Recmtd to Friends & Family (C) A&E 4 hr Performance (R) Bed Occupancy (R) Size of backlog (R), Nursing vacancies (W) Agency Spend (£k) (W) Staff Friends and Family % recommended work (W)	Percentage OP Clinics Utilised (slots) (E), OP Resp Rate Recmtd to Friends & Family (C),


Hit & Miss /



Never Events (S), Safe Staffing Levels (S) Sickness Rate - Covid (S) Infection Control - Rate of Hospital C.Difficile per 100,000 occupied beddays (S), Infection Control - Rate of Hospital E. Coli Bacteraemia (S), Number of New SIs in month (S), Rate of Total Patient Falls per 100,000 occupied beddays (S), Rate of Hospital Acquired Pressure Ulcers per 1,000 admissions (S), Percentage of Virtual OP Appointments (E) Total Readmissions <30 days (E), Non-Elective Readmissions <30 days (E), Elective Readmissions < 30 Days (E), Stroke Best Practice Tariff (E), Rate of New Complaints (C), % complaints responded to within target (C), IP Resp Rate Recmtd to Friends & Family (C), IP Friends & Family (FFT) % Positive (C), A&E Resp Rate Recmtd to Friends & Family (C),	Maternity Combined FFT % Positive (C), OP Friends & Family (FFT) % Positive (C), Access to Diagnostics (<6 weeks standard) (R), Average for new appointment (R), Super Stranded Patients (R), Ambulance Handover Delays Rate > 30mins (R), NELOS (R), Cancer - 31 Day (R), 28 day Target (R), Health and Wellbeing: How many calls received (W) Health and Wellbeing: What percentage of Calls related to Mental Health Issues (W), Covid Positive - number of patients (W), Capital Expenditure (£k) (W), Elective Spells in London Trusts from West Kent (W) Research grants (E) (W) Sickness (W) Appraisal Completeness (W)
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Items for escalation based on those indicators that are Failing the target or are unstable ('Hit & Miss') and showing Special Cause for Concern by CQC Domain are as follows:

- Safe:**
- Caring:** OP Response Rate Recommended to Friends and Family, Maternity Response Rate Recommended to Friends and Family
- Effective:** OP Utilisation, OP Follow Up DNAs, OP New DNAs
- Responsive:** A&E 4 hr Performance, Bed Occupancy, Size of 62 day Cancer backlog
- Well-Led:** Nursing Vacancies, Staff FFT % recommended work, Agency Spend

Executive Summary Scorecard

Current Month Overview of KPI Variation and Assurance Icons

Trust Domains	Variation					Assurance				Total
CQC Domain Safe										
Infection Control	2				2				4	4
Harm Free Care	2								2	2
Incident Reporting	2								2	2
Safe Staffing	2								2	2
Mortality					1	1				1
Safe Total	8	0	0	3	0	1	0	10	0	11
CQC Domain Effective										
Outpatients	4	2	1		1		3	5		8
Quality & CQC	4							4		4
Strategy - Estates									5	5
Effective Total	8	2	1	0	1	0	3	9	5	17
CQC Domain Caring										
Complaints	2							2		2
Admitted Care	3	1				2		2		4
ED Care	2							2		2
Maternity Care	1	1						2		2
Outpatient Care	1	1					1	1		2
Caring Total	9	3	0	0	0	2	1	9	0	12
CQC Domain Responsive										
Elective Access	4				1		3	2		5
Acute and Urgent Access	3	1						4	1	5
Cancer Access	4			1		2		3		5
Diagnostics Access	1						1			1
Bed Management				1				1		1
Responsive Total	12	1	2	0	1	2	4	10	1	17
CQC Domain Well-Led										
Staff Welfare	2							2	4	6
Finance and Contracts				2				2	4	6
Leadership		1			1			2	1	3
Strategy - Clinical and ICC	5			1		1	2	4	1	8
Workforce	2			1	2	1	3	2		6
Well-Led Total	9	1	4	2	3	2	5	12	10	29
Trust Total	46	7	7	5	5	7	13	50	16	86

Corporate Scorecard by CQC Domain

Safe						Responsive					
ID	Key Performance Indicators	Plan	Actual	Variation	Assurance	ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
S2	Number of cases C.Difficile (Hospital)	4	9			R1	Emergency A&E 4hr Wait	95.0%	82.3%		
S6	Rate of Total Patient Falls	6.00	7.90			R4	RTT Incomplete Pathway	86.7%	73.1%		
S7	Number of Never Events	0	0			R6	% Diagnostics Tests WTimes <6wks	99.0%	76.4%		
S8	Number of New SIs in month	11	9			R7	Cancer two week wait	93.0%	94.4%		
S10	Overall Safe staffing fill rate	93.5%	86.3%			R10	Cancer 62 day wait - First Definitive	85.0%	85.3%		

Effective					
ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
E2	Standardised Mortality HSMR	Lower conf <100	85.0		
E3	% Total Readmissions	14.6%	14.8%		
E6	Stroke: Best Practice (BPT) Overall %	50.0%	50.0%		
R11	Average LOS Non-Elective	6.50	7.37		
R12	Theatre Utilisation	90.0%	83.4%		

Well-Led					
ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
W1	Surplus (Deficit) against B/E Duty	0	-18		
W2	CIP Savings (£k)	434	192		
W7	Vacancy Rate (%)	9.0%	13.6%		
W8	Total Agency Spend (£k)	1,333	2,599		
W10	Sickness Absence	3.3%	3.7%		

Caring					
ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
C1	Single Sex Accommodation Breaches	0	0		
C3	% complaints responded to within target	75.0%	56.8%		
C5	IP Friends & Family (FFT) % Positive	95.0%	97.7%		
C7	A&E Friends & Family (FFT) % Positive	87.0%	83.3%		
C10	OP Friends & Family (FFT) % Positive	84.0%	82.2%		

Variation			Assurance				
Special cause of concerning nature or higher pressure due to (H)higher or (L)lower values	Special cause of improving nature or higher pressure due to (H)higher or (L)lower values	Common cause - no significant change	'Pass' Variation indicates consistently - (P)assing of the target	'Hit and Miss' Variation indicated inconsistency - passing and failing the target	'Fail' Variation indicates consistently - (F)ailing of the target	Data Currently unavailable or insufficient data points to generate SPC	

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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.

Safe - CQC Domain Scorecard

Reset and Recovery Programme: Patient and Staff Safety

Outcome Measure	Latest				Previous			YTD		Assurance
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	
Safe Staffing Levels	93.5%	86.8%	Sep-21		93.5%	86.3%	Aug-21	93.5%	89.1%	
Sickness Rate - Covid	0.0%	0.3%	Aug-21		0.0%	0.2%	Jul-21	0.0%	0.3%	
Infection Control - Hospital Acquired Covid	0	0	Sep-21		0	2	Aug-21	0	0	
Infection Control - Rate of Hospital C.Difficile per 100,000 occupied beddays	22.7	47.4	Sep-21		22.7	37.3	Aug-21	22.7	30.3	
Infection Control - Number of Hospital acquired MRSA	0	0	Sep-21		0	0	Aug-21	0	0	
Infection Control - Rate of Hospital E. Coli Bacteraemia	19.0	31.6	Sep-21		19.0	16.0	Aug-21	19.0	20.2	
Number of New SIs in month	11.0	9	Sep-21		11	3	Aug-21	66	47	
Rate of Total Patient Falls per 1,000 occupied beddays	6.0	7.9	Sep-21		6.0	8.4	Aug-21	6.0	7.4	
Rate of Hospital Acquired Pressure Ulcers per 1,000 admissions	2.3	2.9	Sep-21		2.3	2.5	Aug-21	2.3	2.0	
Standardised Mortality HSMR	100.0	85.0	Jun-21		100.0	85.2	May-21	100.0	85.0	
Never Events	0	1	Sep-21		0	0	Aug-21	0	4	

Effective - CQC Domain Scorecard

Reset and Recovery Programme: Outpatients

Outcome Measure	Latest				Previous			YTD		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Percentage of Virtual OP Appointments	30.0%	25.4%	Sep-21		30.0%	25.0%	Aug-21	30.0%	29.2%	
Percentage OP Clinics Utilised (slots)	85.0%	51.2%	Sep-21		85.0%	52.9%	Aug-21	85.0%	52.7%	
OP New DNAs	5.0%	7.4%	Sep-21		5.0%	7.1%	Aug-21	5.0%	7.2%	
OP Follow UP DNAs	5.0%	8.1%	Sep-21		5.0%	8.0%	Aug-21	5.0%	7.5%	
Outpatient Hospital Cancellation	20.0%	24.3%	Sep-21		20.0%	22.9%	Aug-21	20.0%	22.1%	
Outpatient Cancellations < 6 weeks	10.0%	18.6%	Sep-21		10.0%	17.7%	Sep-21	10.0%	17.9%	
Calls Answered in under 1 min	95.0%	51.2%	Sep-21		95.0%	45.6%	Sep-21	95.0%	48.2%	
Percentage of Calls abandoned	0.0%	8.0%	Sep-21		0.0%	12.1%	Sep-21	0.0%	10.3%	

Organisational Objectives: Quality and CQC

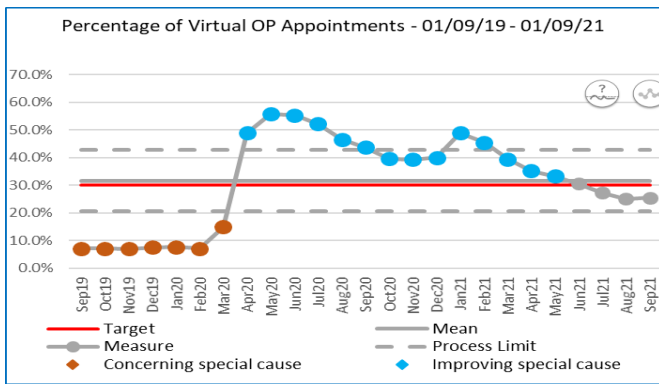
Outcome Measure	Latest				Previous			YTD		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Total Readmissions <30 days	14.6%	17.0%	Aug-21		14.6%	15.0%	Jul-21	14.6%	15.8%	
Non-Elective Readmissions <30 days	15.2%	17.5%	Aug-21		15.2%	15.7%	Jul-21	15.2%	16.3%	
Elective Readmissions < 30 Days	7.8%	89.7%	Aug-21		7.8%	93.0%	Jul-21	7.8%	91.3%	
Stroke Best Practice Tariff	50.0%	50.0%	Sep-21		50.0%	64.7%	Aug-21	50.0%	61.5%	

Effective - CQC Domain Scorecard

Organisational Objectives: Strategy - Estates

Outcome Measure	Latest				Previous			YTD		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Utilised and unutilised space ratio	Under review	100	Sep-21	No SPC	Under review	100	Aug-21	Under review	100	No SPC
Footprint devoted to clinical care vs non clinical care ratio	Under review	4.4:1	Sep-21	No SPC	Under review	4.4:1	Aug-21	Under review	4.4:1	No SPC
Admin and clerical office space in (sqm)	Under review	5808	Sep-21	No SPC	Under review	5808	Aug-21	Under review	5808	No SPC
Staff occupancy per m2	Under review	21.2	Sep-21	No SPC	Under review	21.1	Aug-21	Under review	21.8	No SPC
Energy cost per staff	Under review	£ 459.44	Sep-21	No SPC	Under review	£ 510.72	Aug-21	Under review	£3,467.5	No SPC

EFFECTIVE- Reset and Recovery Programme: Outpatients

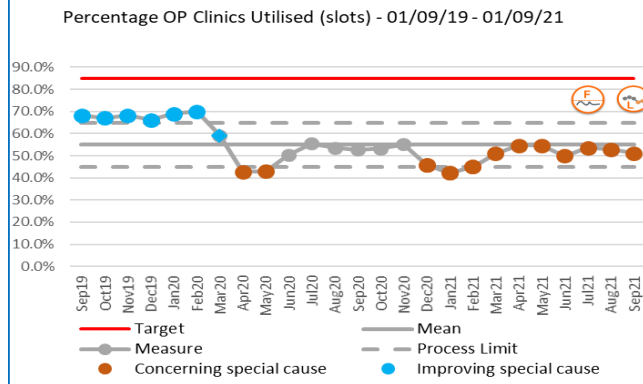


Sep-21
25.4%

Variance Type
Metric is currently experiencing common cause variation

Target (Internal)
30%

Target Achievement
Metric is experiencing variable achievement

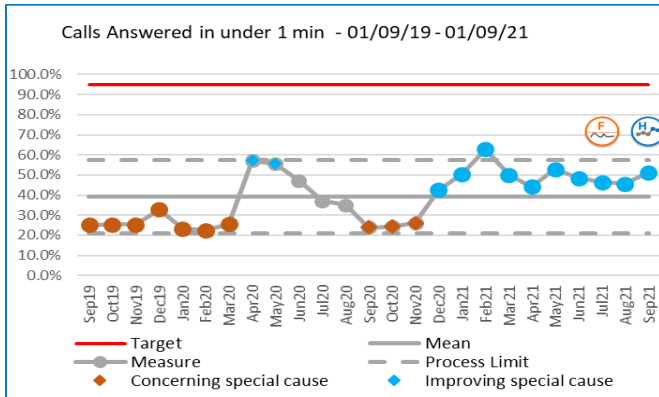


Sep-21
51.2%

Variance Type
Metric is currently experiencing special cause variation of a concerning nature

Target (Internal)
85%

Target Achievement
Metric is consistently failing the target

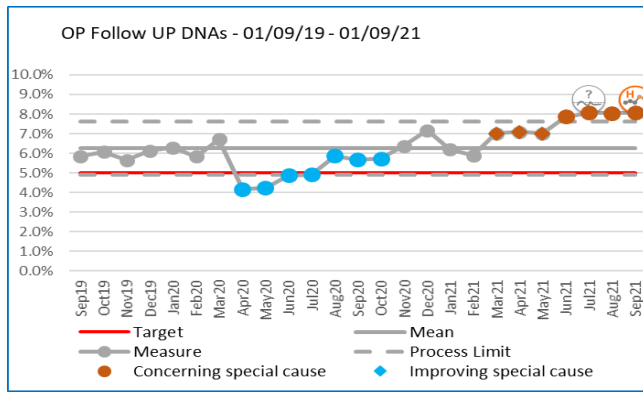


Sep-21
51.2%

Variance Type
Metric is currently experiencing special cause variation of an improving nature

Target (Internal)
95%

Target Achievement
Metric is consistently failing the target



Sep-21
8.1%

Variance Type
Metric is currently experiencing special cause variation of a concerning nature

Max Target (Internal)
5%

Target Achievement
Metric is experiencing variable achievement

Summary:

% Virtual OP Appointments: The percentage of virtual OP appointments has stabilised in September and is now experiencing common cause variation.

Calls Answered: The number of calls answered in less than 1 minute is now experiencing special cause variation of an improving nature but continues to consistently fail the target.

Outpatient Utilisation: Continues to experience special cause variation of a concerning nature as well as consistently failing the target

DNA Rates: DNA rates for Follow-ups continue to be in special cause variation of a concerning nature and variable achievement of the target. New Appointments has also dropped into common case variation.

Actions:

% Virtual OP Appointments: The current Virtual Platform can be challenging for consultants to use and feel an improved platform would be more beneficial.

Outpatient Utilisation: The Clinical System Development Managers have reviewed over 90% of the clinic templates on Allscripts, this includes viewing the individual microsession templates and removing any historic clinics that are no longer required to ensure that utilisation is a true reflection. Once complete the utilisation figures will be correct to do further analysis on how to improve this.

Calls: Currently investigating spacing options in which to house call operatives for the outpatient communication centre pilot which will improve this.

Assurance:

The Outpatient team are currently working with clinicians and patient representatives to demo various virtual platforms to ensure that we find the right fit for MTW and to improve clinician and pathway uptake.

Specialty clinic templates are being reviewed to ensure that all templates are correct and have received GM and CD sign off. Further analysis of utilisation will then be completed to understand the impact and reasonings for DNA's.

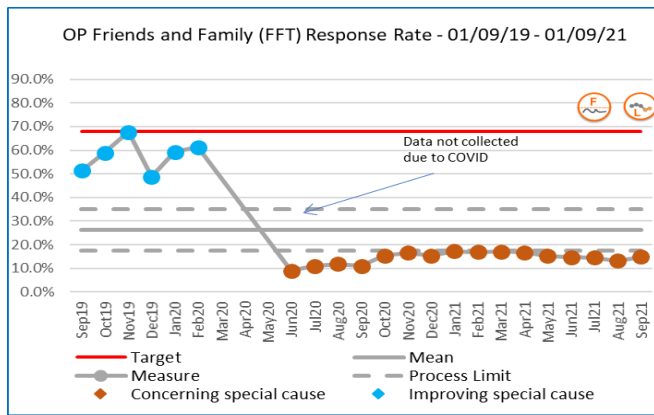
Weekly meeting with specialties are undertaken to go through all of our KPI's to understand areas for improvement and reasonings for poor performance. This includes calls, DNA's and Cancellations.

Caring - CQC Domain Scorecard

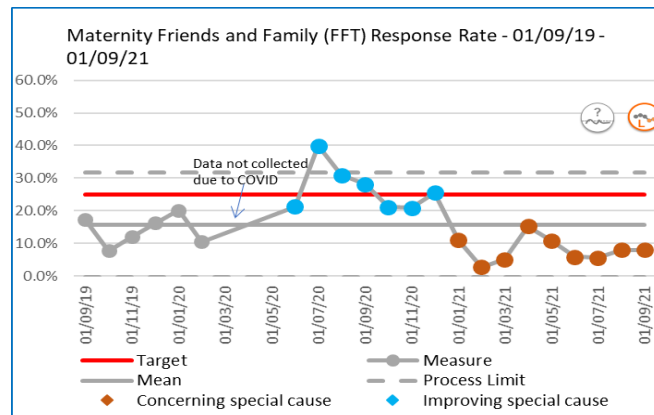
Organisational Objectives – Quality & CQC

Outcome Measure	Latest				Previous			YTD		Assurance
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	
Single Sex Accommodation Breaches	0	0	Sep-21		0	0	Aug-21	0	0	
Rate of New Complaints	3.9	2.9	Sep-21		3.9	2.1	Aug-21	3.9	2.8	
% complaints responded to within target	75.0%	56.8%	Sep-21		75.0%	82.9%	Aug-21	75.0%	73.5%	
IP Resp Rate Recmd to Friends & Family	25.0%	6.7%	Sep-21		25.0%	7.5%	Aug-21	25.0%	9.9%	
IP Friends & Family (FFT) % Positive	95.0%	97.7%	Sep-21		95.0%	98.3%	Aug-21	95.0%	98.0%	
A&E Resp Rate Recmd to Friends & Family	15.0%	0.1%	Sep-21		15.0%	0.2%	Aug-21	15.0%	2.3%	
A&E Friends & Family (FFT) % Positive	87.0%	83.3%	Sep-21		87.0%	96.7%	Aug-21	87.0%	96.0%	
Mat Resp Rate Recmd to Friends & Family	25.0%	8.0%	Sep-21		25.0%	5.6%	Aug-21	25.0%	8.9%	
Maternity Combined FFT % Positive	95.0%	100.0%	Sep-21		95.0%	100.0%	Aug-21	95.0%	99.6%	
OP Friends & Family (FFT) % Positive	84.0%	82.2%	Sep-21		84.0%	81.7%	Aug-21	84.0%	82.3%	
OP Resp Rate Recmd to Friends & Family	68.0%	13.5%	Sep-21		68.0%	15.1%	Aug-21	68.0%	14.9%	
VTE Risk Assessment	95.0%	95.7%	Sep-21		95.0%	96.7%	Aug-21	95.0%	94.2%	

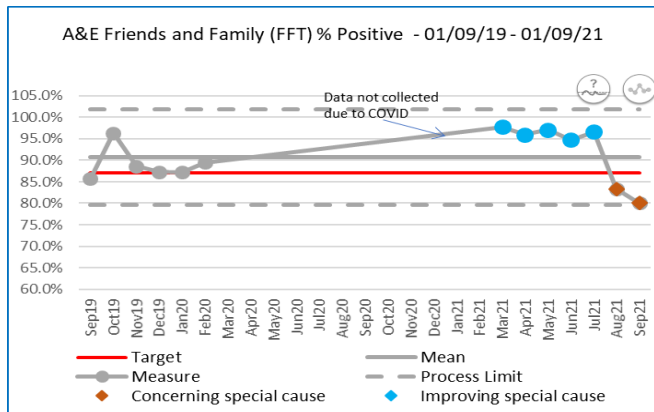
Caring - Organisational Objective: Quality and CQC



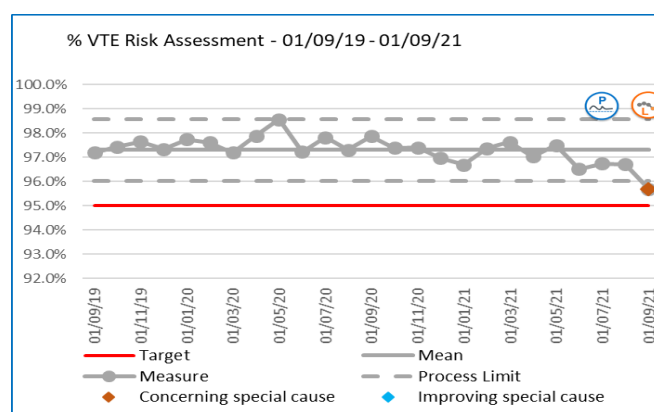
Sep-21
14.9%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Max Target (Internal)
68%
Target Achievement
Metric is consistently failing the target



Sep-21
8%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
25%
Target Achievement
Metric is experiencing variable achievement



Sep-21
80%
Variance Type
Metric is currently experiencing common cause variation
Target
87%
Target Achievement
Metric is experiencing variable achievement



Sep-21
95.7%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (National)
95%
Target Achievement
Metric is consistently achieving the target

Summary:

Outpatient Friends and Family Response Rate continues to experience special cause variation of a concerning nature.

A&E Friends and Family % Positive: Of the responses received those that are positive decreased in September but remain in common cause variation. The level of those responding remains significantly lower than expected levels (0.2% in September)

Maternity Friends and Family Response Rate: The rate of responses remain in special cause variation of a concerning nature.

VTE: VTE performance has returned to special cause variation of a concerning nature, however this indicator continues to consistently achieve the national target.

Actions:

OP FFT: iPads now installed for face to face appointments and online submission. Proforma provided to assist patient partners and volunteers to assist with live feedback and FFT

FFT: Further decline in submissions in the month due to continued site pressure. IPADS with IT and software being built to assist departments with timely submission.

Assurance:

OP FFT: Communication Hub run by volunteers has commenced, this will promote the use of technology and assist with live feedback and FFT.

FFT: Continued engagement in FFT working group. Update in executive team brief to promote focus on FFT. Targeting specific clinical departments to assist with issues that reduce the engagement and submission of surveys.

Increasing FFT response rates and maintaining the percentage that are positive are both one of the visions and breakthrough objectives being focussed on for improvement as part of the new Strategy Deployment Improvement Process.

Responsive - CQC Domain Scorecard

Reset and Recovery Programme - Elective Care











Outcome Measure	Latest				Previous			YTD		Assurance
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	
RTT (Incomplete) performance against trajectory	86.7%	73.1%	Sep-21		86.7%	73.6%	Aug-21	86.7%	73.1%	
Number of patients waiting over 40 weeks	222	718	Sep-21		222	926	Aug-21	222	718	
52 week breaches (including those reported last month)	0	42	Sep-21		0	49	Aug-21	0	42	
Access to Diagnostics (<6weeks standard)	99.0%	76.4%	Sep-21		99.0%	77.5%	Aug-21	99.0%	76.4%	
Average for new appointment	10.0	7.8	Sep-21		10.0	7.3	Aug-21	10.0	7.8	
Theatre Utilisation	90.0%	83.4%	Sep-21		90.0%	84.4%	Aug-21	90.0%	83.4%	

Reset and Recovery Programme – Acute & Urgent Care

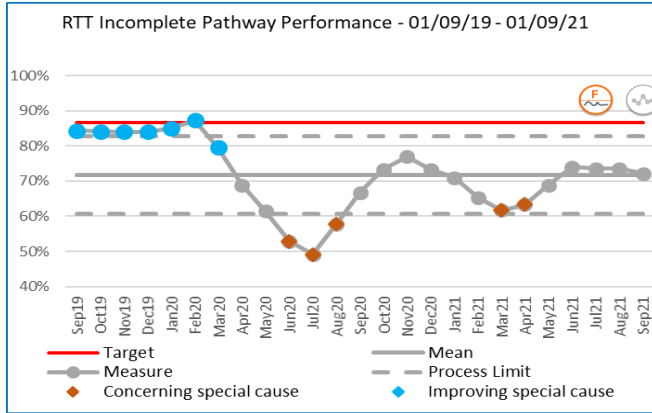
Outcome Measure	Latest				Previous			YTD		Assurance
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	
Referrals to ED from NHS 111	TBC		Sep-21		TBC		Aug-21	TBC		
A&E 4 hr Performance	95.0%	82.3%	Sep-21		95.0%	84.1%	Aug-21	95.0%	86.3%	
Super Stranded Patients	80	96	Sep-21		80	90	Aug-21	80	80	
Ambulance Handover Delays Rate > 30mins	7.0%	10.8%	Sep-21		7.0%	10.3%	Aug-21	7.0%	8.8%	
Bed Occupancy	90.0%	93.0%	Sep-21		90.0%	90.8%	Aug-21	90.0%	89.9%	
NE LOS	6.5	7.4	Sep-21		6.5	7.0	Aug-21	6.5	7.4	

Responsive - CQC Domain Scorecard

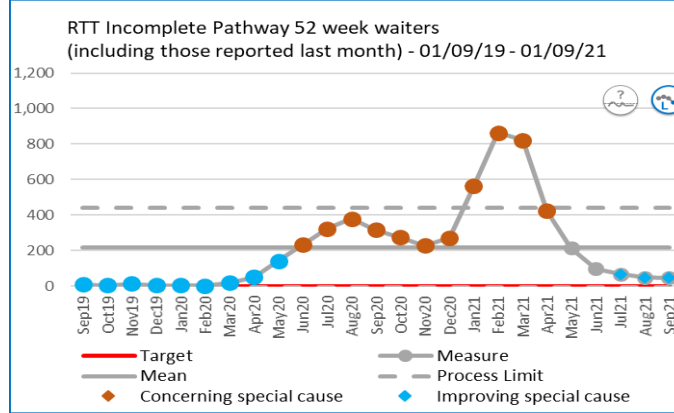
Reset and Recovery Programme – Cancer Services

Outcome Measure	Latest				Previous			YTD		Assurance
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	
Cancer - 2 Week Wait	93.0%	94.4%	Aug-21		93.0%	94.7%	Jul-21	93.0%	94.4%	
Cancer - 31 Day	96.0%	97.8%	Aug-21		96.0%	97.0%	Jul-21	96.0%	97.8%	
Cancer - 62 Day	85.0%	86.1%	Aug-21		85.0%	85.0%	Jul-21	85.0%	86.1%	
Size of backlog	30	120	Sep-21		30	113	Aug-21	30	120	
28 day Target	75.0%	73.9%	Aug-21		75.0%	77.5%	Jul-21	75.0%	73.9%	

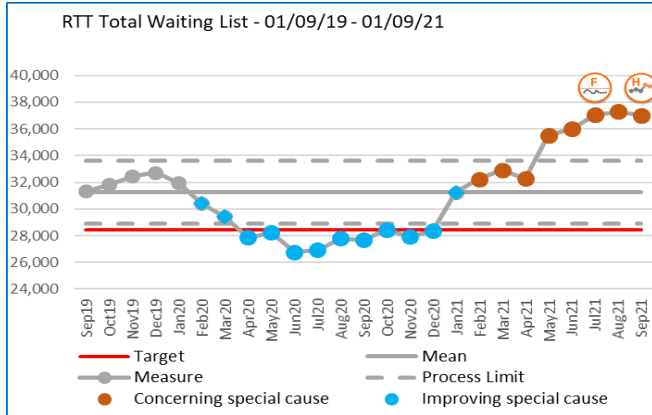
Responsive - Reset and Recovery Programme: Elective



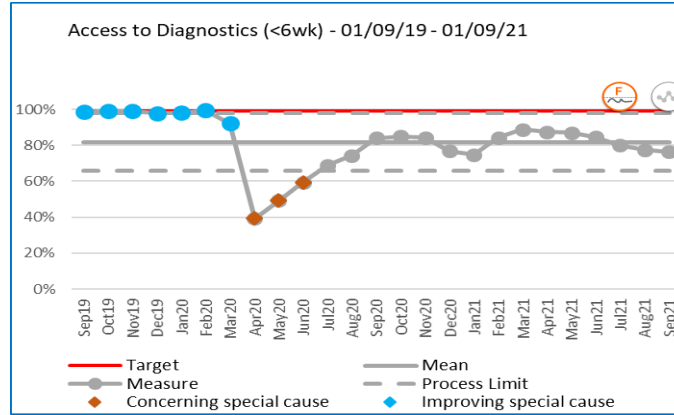
Sep-21	73.1%
Variance Type	Metric is currently experiencing common cause variation
Target (Internal)	86.3%
Target Achievement	Metric consistently failing the target



Sep-21	42
Variance Type	Metric is currently experiencing special cause variation of an improving nature
Max Target (Internal)	0
Target Achievement	Metric is experiencing variable achievement



Sep-21	37,179
Variance Type	Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)	28,412
Target Achievement	Metric consistently failing the target



Aug-21	76.4%
Variance Type	Metric is currently experiencing common cause variation
Target	99%
Target Achievement	Metric consistently failing the target

Summary:

RTT: Performance has remained steady, with September's provisional performance sitting at 72.1%.

RTT 52 wk waiters: There has been huge efforts made to reduce the number of 52 week waiters since the peak in February reducing by 818 waiters over the last 8 months.

Elective Activity: 94% of August's elective activity levels were achieved. The current estimate for September (including IS Activity predictions) is 86% of September 2019 elective activity levels as endoscopy activity is not at the 1920 levels due to a change in the service. Outpatients are at 96% of 1920 levels overall with first outpatients estimated to be at 88% for September (excluding IS activity). This activity has been affected by a changing in coding for Paediatric Ward Attenders (now recorded as Day Case) which equates to a 3.5% reduction in OP New Activity.

Diagnostic Activity: CT Scans in September were at 118% of 2019/20 Activity levels, MRI is at 109% of 2019/20 Activity levels and NOUS is at 103% of 2019/20 Activity.

Diagnostic Waiting Times performance has been affected by Echocardiography staffing shortages and a lack of DEXA capacity.

Actions:

RTT: Continued focus on long waiting patients, pre operative assessment performance, patient cancellations, scheduling and utilisation.

Efficiency: Robust monitoring of patients in order to maximise clinic & theatre time & increase productivity. HVLC action plan has been implemented across Ophthalmology, ENT and T&O.

Diagnostics: To increase capacity & improve the waiting times for MRI and NOUS. The cardiology team have implemented an improvement plan for echophysiology. Capital monies has been awarded to radiology in order to purchase a new DEXA machine. The old one is now obsolete.

Assurance:

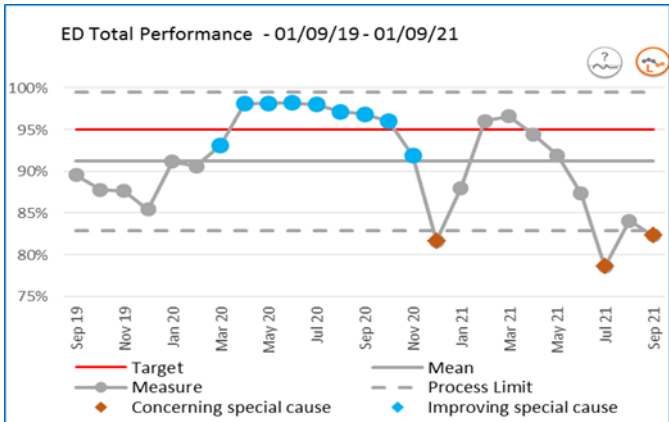
RTT and Elective Activity: Weekly performance meeting in progress, 6-4-2 and scheduling meetings, cancellations RCA's completed to identify trends. TUB in progress.

RTT Long Waiters: Clinical Prioritisation of waiting lists continues in line with national recommendations. Long waiting patients are in the process of being treated or are being scheduled for treatment.

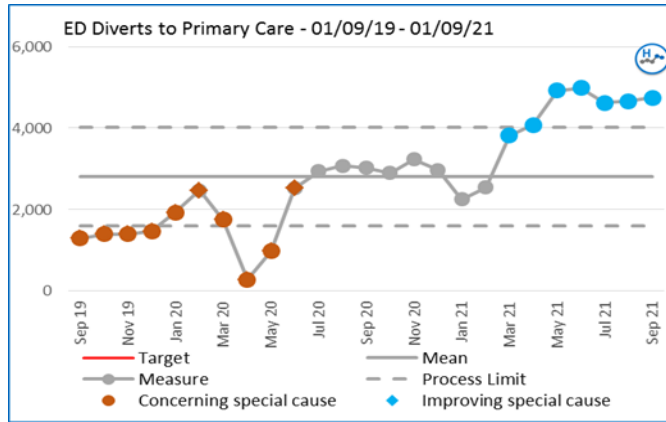
Diagnostics: Work is ongoing on the managed MRI project and is on track to deliver. DEXA continues to be outsourced to DGT.

Elective Activity: We continue to work closely with ISP partners. Work continues to streamline process and link with ISP where appropriate

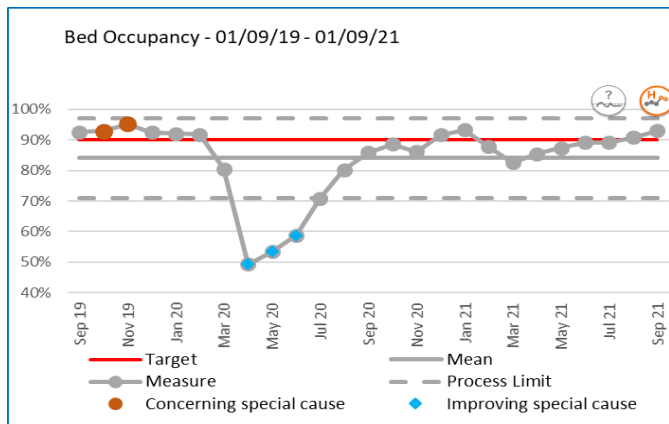
Responsive - Reset and Recovery Programme: Emergency Care



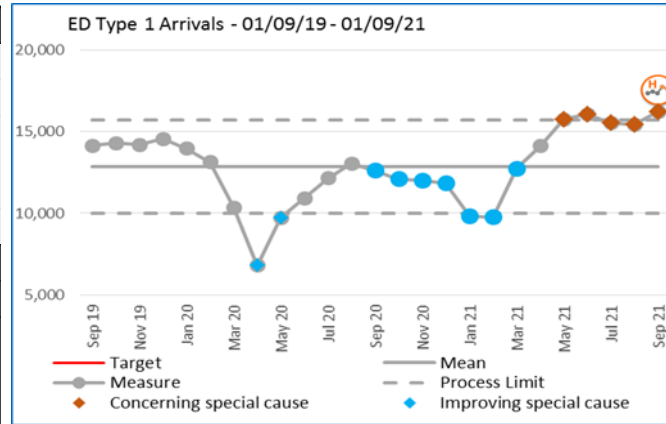
Sep-21
82.3%
Variance Type
Metric is currently experiencing Special Cause Variation of a concerning nature
Target
95%
Target Achievement
Metric is experiencing variable achievement



Sep-21
10.3%
Variance Type
Metric is currently experiencing Special Cause Variation of an improving nature
Max Limit (Internal)
Target Achievement
N/A



Sep-21
93.0%
Variance Type
Metric is currently experiencing Special Cause Variation of a concerning nature
Max Limit (Internal)
90%
Target Achievement
Metric is experiencing variable achievement



Sep-21
16,101
Variance Type
Metric is currently experiencing Special Cause Variation of a concerning nature
Max Limit (Internal)
Target Achievement
N/A

Summary:

ED 4hr performance (inc MIU): A&E 4hr performance had seen a deterioration which has been partly due to the implementation of the new Sunrise System as well as the continued high level of attendances. This indicator continues to experience special cause variation of a concerning nature at 82.3% in September. Bed Occupancy has moved to special cause variation of a concerning nature, hitting 93% occupancy in September. Type 1 ED Attenders Were significantly (6.6%) up on model in September, particularly in the latter half of the month. 16,101 is a new record, and 10 days in the month were more than 10% above model ED Diverts to Primary Care are experiencing special cause variation of an improving nature.

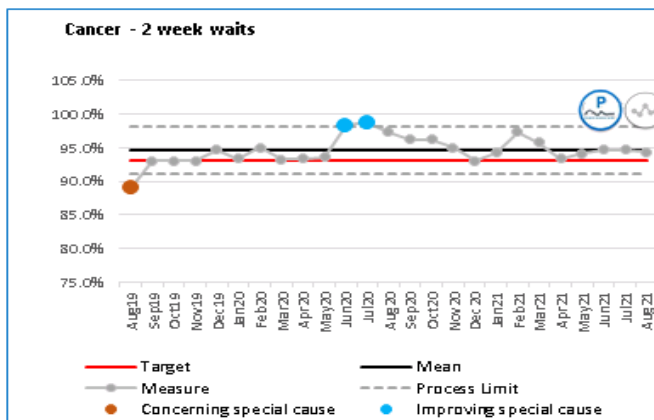
Actions:

- Flow Coordinators to be developed into cover until 2am. Business Case to be submitted for 24/7 cover to support minors flow in addition to majors flow.
- 111/ UTC – development of direct referral to SDEC pathways
- New ED standards – to be reported from beginning of December.
- Increased staffing for Minors/ GP on both sites including change in shift pattern.
- 3 new ED consultants in post. Paramedic recruitment for Resus/ RAP. Development of Band 2/3 Housekeeper post to support nursing workforce.
- PIN input earlier in ambulance handover at clinician handover.

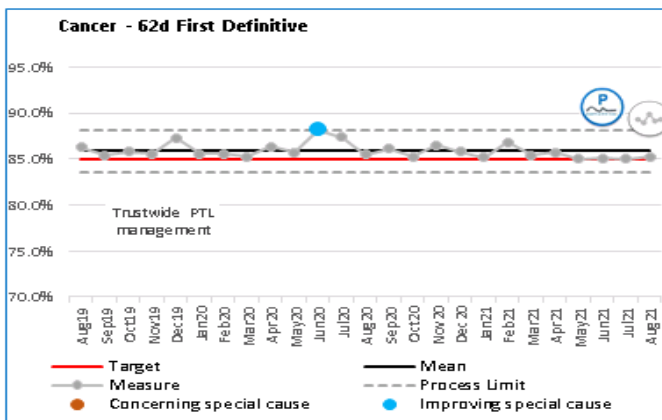
Assurance:

- Directorate/ Divisional meetings to review figures, with appropriate escalation.
- New Divisional Governance Matron lead in post
- A3 project underway – key areas incl. R&R/ Staff Wellbeing; demand and capacity; Front Door; onward referrals for admitted patients
- 5th Rota Coordinator appointed to support ED nursing rota
- Good working relationship with SECamb and Site Management team
- Consultants leading on transformation of referral process
- Governance in place to support Sunrise changes where required

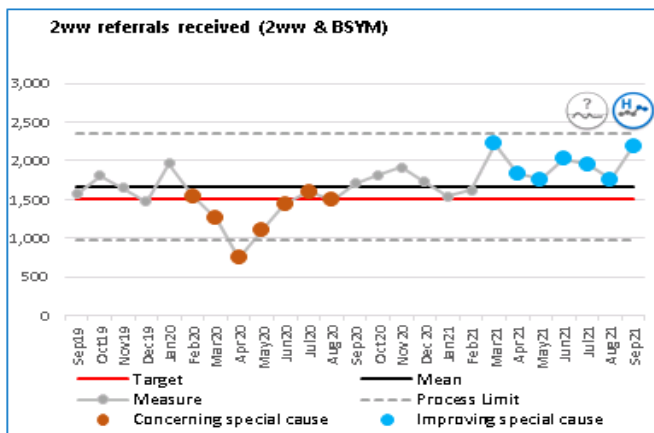
RESPONSIVE- Reset and Recovery Programme: Cancer



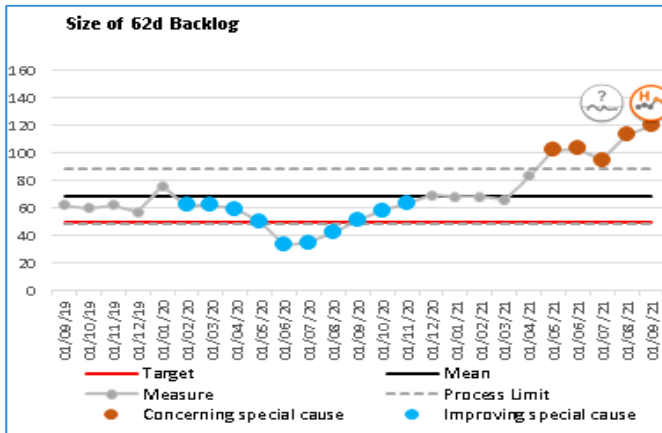
Aug-21	94.4%
Variance Type	Process change Sept 2019 now showing common cause variation
Max Target (Internal)	93%
Target Achievement	Metric is currently achieving the target



Aug-21	85.3%
Variance Type	Process change Aug 2019 now showing common cause variation
Max Target (Internal)	85%
Target Achievement	Metric is currently achieving the target



Sept-21	2186
Variance Type	Improving Special cause – numbers with 7 months above the mean
Max Target	1500
Target Achievement	Metric is experiencing variable achievement of locally set target



Sept-21	120
Variance Type	Concerning Special Cause variation with last 4 points above the upper process limit
Max Target (Internal)	50
Target Achievement	Metric is experiencing variable achievement of locally set target

Summary: Actions: Assurance:

2ww: The 2ww standard continues to achieve the 93% target, and the process remains within expected levels of variation.

Referrals: The Trust is receiving higher numbers of 2ww referrals than pre-Covid and is showing improving special cause due to the last 7 months with numbers above the calculated mean.

62 day: The Trust has continued achievement of the 62 day standard for 2 years (from Aug 2019) reporting 85.3% this month.

62 day PTL Backlog: As the numbers on the 62d PTL continue to grow, the backlog has seen an increase in the past 5 months. Overall the process is showing concerning special cause variation, with May to September sitting at the upper process limit due to unprecedented 2ww referral numbers. At the time of reporting the backlog has reduced to 103, which is 5.7% of the total 62 day PTL

Cancer PTL: 1.) Increased focus on backlog patients on a daily basis. 2.) Introduction of F2F PTLs on a Monday afternoon to support services further. 3.) Validation of all backlog and tip-over patients this week in order to ensure all patients in the backlog are appropriate referrals and on the right pathway. 4.) Training with coordinators and teams to ensure prioritisation and recording of 'risk' patients for demand management within our supporting services.

Referrals: Services are reviewing baseline 2ww provision in line with trajectory of demand and implementing various models to support. The CCG and Cancer Alliance have supported in prioritising patient referrals and ensuring we are appropriately appointing those at highest risk of cancer within the national guidelines.

Cancer Performance and PTL: Management of the daily PTLs continues to give oversight and hold services to account for patient next steps. Diagnostic services attend these huddles to escalate booking or reporting delays on the day.

28 Day FDS Standard: 28 day FDS meetings have been implemented to manage data completeness and ensure we are submitting a representative view of our performance.

Weekly triumvirate meetings help to support key areas of concern and give clinical guidance across services. Daily Cancer Performance huddles with the teams and weekly senior MDT coordinator huddles to support the team working.

Well Led - CQC Domain Scorecard

Reset and Recovery Programme: Staff Welfare

Outcome Measure	Latest				Previous			YTD		Assurance
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	
Climate Survey - Engagement: Number of people completing the Climate survey	Improving Quarterly	473	Aug-21	No SPC	Improving Quarterly	634	Jun-21	Improving Quarterly	473	No SPC
Climate Survey - Percentage of staff who feel fully supported in their role		52.2%	Aug-21	No SPC		56.4%	Jun-21		52.2%	No SPC
Climate Survey - Percentage of staff who feel the Trust has a genuine concern for their safety		53.4%	Aug-21	No SPC		61.9%	Jun-21		53.4%	No SPC
Climate Survey - Percentage of staff who feel able to cope with the demands that are being placed on		52.2%	Aug-21	No SPC		54.0%	Jun-21		52.2%	No SPC
Health and Wellbeing: How many calls received	40	79	Sep-21		40	74	Jun-21	480	450	
Health and wellbeing: what percentage of Calls related to Mental Health Issues	44%	42%	Sep-21		44%	42%	Jun-21	44%	46%	

Organisational Objectives: Workforce

Outcome Measure	Latest				Previous			YTD		Assurance
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	
Sickness	3.3%	3.7%	Aug-21		3.3%	4.1%	Jul-21	3.3%	0.0%	
Turnover	10.0%	11.0%	Sep-21		10.0%	10.9%	Aug-21	10.0%	11.0%	
Vacancy Rates	9.0%	13.6%	Sep-21		9.0%	14.1%	Aug-21	9.0%	13.6%	
Use of Agency (WTE)	81	326	Sep-21		81	212	Aug-21	81	326	
Appraisal Completeness	95.0%	84.2%	Sep-21		95.0%	55.7%	Aug-21	95.0%	84.2%	
Stat and Mandatory Training	85.0%	91.2%	Sep-21		85.0%	91.2%	Aug-21	85.0%	91.2%	

Well Led - CQC Domain Scorecard

Reset and Recovery Programme: Finance & Contracts

Outcome Measure	Latest				Previous			YTD		Assurance
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	
Surplus (Deficit) against B/E Duty (£k)	0	-18	Sep-21		-	-	21 Aug-21	0	-58	
CIP Savings (£k)	434	192	Sep-21		434	196	Aug-21	2602	1363	
Cash Balance (£k)	36,386	35,734	Sep-21		39,319	42,715	Aug-21	36,386	35,734	
Capital Expenditure (£k)	1,686	869	Sep-21		651	364	Aug-21	4,009	1,908	
Agency Spend (£k)	1,333	2,599	Sep-21		1,333	1,795	Aug-21	1,333	2,599	
Use of Financial Resources	No data		Sep-21		No data		Aug-21	No data		

Reset and Recovery Programme: ICC

Outcome Measure	Latest				Previous			YTD		Assurance
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	
Nursing vacancies	13.5%	18.9%	Sep-21		13.5%	19.3%	Aug-21	13.5%	18.9%	
Covid Positive - number of patients	0	80	Sep-21		0	86	Aug-21	0	312	

Well Led - CQC Domain Scorecard

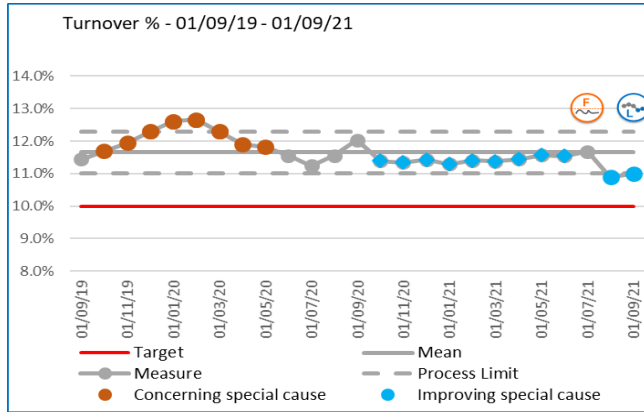
Organisational Objectives - Strategy – Clinical

Outcome Measure	Latest				Previous			YTD		Target
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Number of specialist services	35	30	Sep-21		35	30	Aug-21	35	35	
Elective Spells in London Trusts from West Kent	329	439	Sep-21		329	403	Aug-21	329	439	
Service contribution by division	TBC		Sep-21		TBC		Aug-21	TBC		
Research grants (£)	114	110	Sep-21		114	151	Aug-21	114	110	
Number of advanced practitioners	25	31	Sep-21		25	31	Aug-21	25	31	
Percentage of Trust policies within review date	90.0%	74.6%	Sep-21		90.0%	72.6%	Aug-21	90.0%	74.6%	

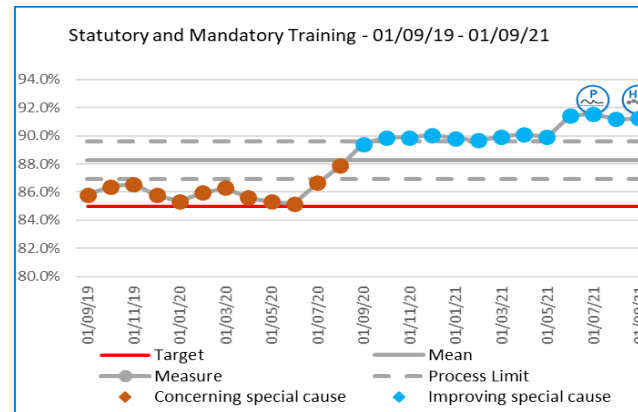
Organisational Objectives – Exceptional People

Outcome Measure	Latest				Previous			YTD		Assurance
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Staff Friends and Family % recommended work	70.0%	62.9%	Aug-21		70.0%	62.9%	Jul-21	70.0%	62.9%	
Staff Friends and Family % recommended care	80.0%	81.0%	Aug-21		80.0%	81.0%	Jul-21	80.0%	81.0%	
Equality, Diversity and Inclusion reducing inequalities metrics / dashboard	TBC		Aug-21		TBC		Jul-21	TBC		

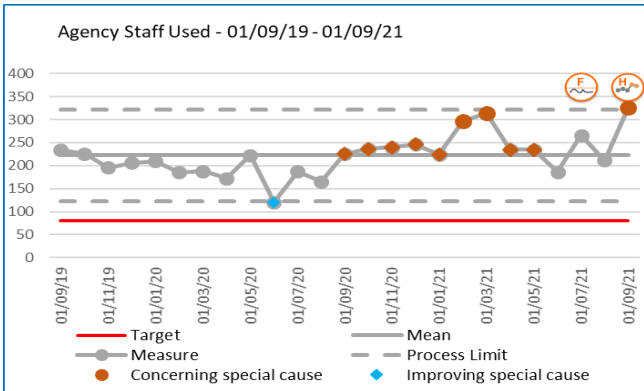
WELL LED- Operational Objective: Workforce



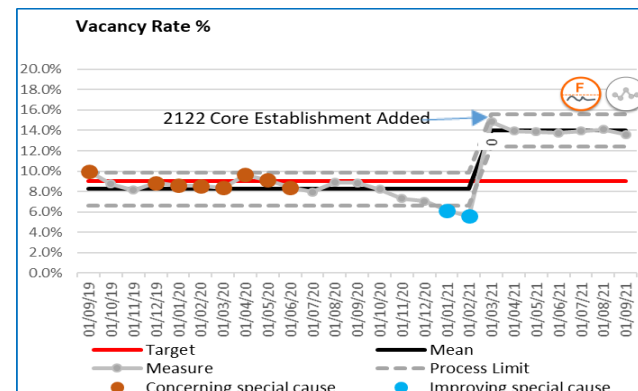
Sep-21	11.0%
Variance Type	Metric is currently experiencing Special Cause Variation of an improving nature
Max Target (Internal)	10%
Target Achievement	Metric is consistently failing the target



Sep-21	91.2%
Variance Type	Metric is currently experiencing Special Cause Variation of an improving nature
Max Target (Internal)	85%
Target Achievement	Metric is consistently passing the target



Sep-21	326
Variance Type	Metric is currently experiencing Special Cause Variation of a concerning nature
Target (Internal)	81
Target Achievement	Metric is consistently failing the target



Sep-21	13.6%
Variance Type	Metric is currently experiencing Special Cause Variation of a concerning nature
Max Limit (Internal)	9.0%
Target Achievement	Metric is consistently failing the target

Summary:

Turnover: The Turnover rate stayed level in September and has moved into Special Cause Variation of an improving nature but is also consistently failing the target.

Statutory and Mandatory Training: This indicator continues to perform well and is consistently achieving the target.

Agency Staff Used: The level of Agency staff increased in September. This indicator has moved into Special Cause Variation of a concerning nature, and continues to consistently fail the target

Vacancy Rate: This continues to experience special cause variation of a concerning nature.

Actions:

Turnover: Turnover has remained similar this month. This will continue to be monitored.

Agency / Vacancy Rate: Nursing demand level remains considerably higher than the same period last year (similarly the same for CSW's). Medical demand is comparable to the same period last year. In the last 12 month period we have seen the temporary staffing demand increase by almost 33% compare to the same period the year before, with bank fill increasing by 26.8%. Agency usage, although higher than plan has continued to reduce year on year, but we are beginning to see an upturn in usage, albeit still lower than pre-covid usage. A further update will be provided in the next IPR.

The Trust has introduced a new improved bank rate to be more consistent with other Trusts and have agreed a formal escalation process for bank enhancement to help with demand.

Assurance:

Recruitment are continuing to work with the following "hot spot areas" to assist in improving their vacancy rate: Medicine, ED, Critical Care, Midwifery, Radiology and Therapies. This includes social media campaigns, virtual events, international recruitment and retention strategies. The Senior Nursing team are currently creating a divisional recruitment officer Job Description. Which will support the nursing teams move forward some of the administration tasks related to recruitment activity for nursing.

The Recruitment team have booked several external recruitment events within the next few months which targets Staff Nurses and CSW. A external marketing company "Alcatica" has been awarded in working with MTW to enhance our branding externally and will be working closely with the Recruitment and communication teams for attraction initiatives and recruitment campaigns.

We currently have 46 WTE CSW in the pipeline and 145.4WTE nurses and midwives. We have 50 International nurses in the pipeline. We have over 557 international CV's awaiting to be screened however majority wards have explained that they are unable to support larger numbers due to having a junior workforce. The senior nursing team have identified what support roles are needed and will be recruiting into these soon.

The Trust continues to scope out plans for a Staffing Hub to provide a centralised view of staffing across the Trust, to help improve care by providing the resource required and access to real time data. The bank team continue to work closely with the site team and matrons on finding solutions to reduce agency spend including paying enhanced rates for Bank staff working within Rapid Response Pool ward to mitigate staff shortages, with a review of future incentives taking place. Various options are currently being explored to provide support with the additional requirement for RMN's.

Appendices

Supporting Narrative

Executive Summary

The Trust continues to achieve both the National Cancer 62 Day FDT Standard and the 2 week wait standard, reporting 85.3% and 94.4% respectively, however achievement of these standards is becoming increasingly challenging with the continued high number of 2ww referrals and increasing 62 Day Backlog. A&E 4hr performance has seen a deterioration since April 2021 which has been impacted partly by the implementation of the new Sunrise System as well as the continued high level of attendances. This indicator remains in special cause variation of a concerning nature at 82.3%. RTT performance has remained similar in as elective activity continues to recover. Activity levels (which include the activity being undertaken in the Independent Sector) have been above the national target for April to July (just under for first outpatient attendances in July), August was just below the target and the estimate for September is currently showing 86% of 1920 levels for Elective Activity and 96% for Total outpatients. The high level of non-elective emergency admissions as well as the high level of elective activity being undertaken is therefore putting pressure on the bed capacity across with Trust. Total Bed Occupancy continues its increasing trend back to pre-Covid levels and is now experiencing special cause variation of a concerning nature (93% for September 2021). The level of Mothers Delivering is experiencing special cause variation with August and September at record levels for the last three years (539). Patient safety and quality indicators remain in common cause variation despite the high bed occupancy and challenges in staffing levels.

Key Performance Items:

- **Infection Control:** Both the rate of C.Difficile and E.Coli are experiencing common cause variation and variable achievement of the target. However there has been an increase in C.Diff numbers over the last few months with the rate now being the highest it has been over the last two years. A Trust-wide Incidents meeting has been arranged to review the number of cases of C.Difficile. The Trust admitted 80 patients with Covid-19 infection during September, with no cases of probable or definite hospital acquired infection. Assurance of compliance continues through the IPC BAF.
- **Falls:** The overall rate of falls continues to experience common cause variation and variable achievement of the target. One SI relating to Falls was reported. A Stakeholder Event has been arranged for 19th October 2021 to increase awareness and further involve the wider multi-disciplinary teams. Local ad-hoc training continues for staff on multifactorial risk assessment and documentation of assessment and care. Resources for assessment of patient at risk of falls made available to support with early identification of falls risk to aid identification and implementation of measures to reduce risk. Achieving a reduction in Falls is one of the key breakthrough objectives being focussed on for improvement as part of the new Strategy Deployment Improvement Process.
- **Pressure Ulcers:** The rate of hospital acquired pressure ulcers remains in common cause variation and variable achievement of the target. Total pressure ulcers (including inherited) also remains in common cause variation. The Pressure Ulcer group continues to discuss learnings from recent incidents to ensure that they are shared across Directorates. The Trust continues to monitor patients admitted with pressure ulcers and liaise with the local community and neighbouring acute trusts to identify themes and trends.
- **Incidents and SIs:** The level of SIs reported increased to 9 (1 relating to Falls, 1 diagnostic, 1 Infection Control, 1 Maternity, 1 Medication, 1 pressure ulcer, 2 Sub-optimal Care, 1 Surgical and **1 Never Event**). This never event is currently under investigation in line with the SI framework. The CCG and CQC have also been informed as per process. Senior members of the Patient Safety Team continue to carry their own caseload of SIs to ensure that investigations are completed thoroughly and in a timely manner to support our staff, patients and their families. The team continues to work with the divisions to allocate investigators to these SIs.
- **Stroke:** The overall Best Practice Indicator continues to experience common cause variation and variable achievement of the target (reported one month behind due to delays in coding).
- **A&E 4 hour Standard and Flow:** Overall ED Performance has deteriorated by ~2% in September and remains in special cause variation of a concerning nature (82.3% in September) driven by continued high attendance volumes and the rollout of Sunrise. The Trust continues to implement the ED improvement action plan to support flow throughout the Trust with all of flow indicators continuing to remain in common cause variation. Development of 111/Urgent Treatment Centre (UTC) is in progress to extend the service. Emergency admissions remain high and have returned to common cause variation following the record levels in July. The level of Same Day Emergency Care (SDEC) attenders continues to rise and is experiencing special cause variation.
- **Ambulance Handover Delays:** Delays increased slightly in September but this indicator continues to experience common cause variation and variable achievement of the target (10.8% in September).

Supporting Narrative Continued

- **Referral to Treatment (RTT) Incomplete Pathway:** Performance remained similar at 72.1% (not finalised). Elective activity continues to recover achieving the targets April to July 21 and slightly below target in August. The estimate for September is 86% for Elective and 96% for total outpatients. Day case activity is being affected by the reduction in endoscopy demand.. There has been huge efforts made to reduce the number of 52 week waiters since the peak in February reducing by 818 waiters over the last 8 months. Diagnostics waiting <6 weeks has decreased further to 76.4% mainly due to Echocardiography staffing shortages and a lack of DEXA Capacity.
- **Cancer 62 Day:** From August 2019 the 62 day standard has shown an improved performance and has consistently achieved the 85% standard (reporting 85.3% for August 2021). A process step change was therefore applied. The calculated mean up to August 2019 was 66.7% and is now 85.9% - which is consistently in line with the target of 85% for the 62 day standard. The updated chart now reports a common cause variation as confirmation of a process within expected levels of variation.
- **First Seen Cancer 2weeks (2ww):** From September 2019, there has been a continued improvement in the achievement of the 2ww first seen standard, consistently achieving target (94.4% for August), despite the pressure experienced from the increased numbers of 2ww referrals from March 2021. A process step change has been applied to this metric. The calculated mean up to September 2019 was 86.7% and is now 94.9% , which remains consistently in line with the target of 93% for the 2ww standard.
- **Size of 62 day Backlog:** Following the decrease in 2019 of the number of patients being managed on the 62 day PTL, the PTL numbers have continued to increase again, with an average of 1749 in April, increasing to 1803 in August but currently averaging at 1713 through September 2021. This is impacting on the number of patients being managed with pathways over 62 days. Overall the size of the 62d backlog is concerning special cause variation, with May, June, July and August being above the upper process limit. Currently the backlog averaged at 120 patients in September 2021 – which is 7.0% of the overall PTL. A continuation of this backlog increase will impact the sustainability of cancer performance in the upcoming months.
- **Cancer 2weeks (2ww) Referrals:** After the drop in referral numbers at the beginning of April 2020 due to COVID-19, the incoming referral numbers have increased through the remainder of 2020, into 2021. Following the significant increase in numbers seen in March 2021, the incoming referral numbers have returned to expected levels of variation, however remain above the calculated mean with 2186 referrals in September 2021. Overall this metric is reporting special cause variation of an improving nature.
- **Finance:** The Trust is £0.1m favourable to plan generating a Surplus of £0.1m. The Trusts key favourable variances to the plan are: Independent Sector usage (£3.2m), Pay underspends (£2.9m), underspends within clinical supplies and drugs (£1.4m) due to lower activity than funded levels, non recurrent income benefit (£0.7m) and Elective recovery fund (£0.6m). The Trusts key adverse variances to plan are: Re-phasing of top up and non recurrent income support (£6.6m), CIP slippage to stretch target (£1.2m) and other operating income (£0.6m - RTA (£0.3m), Car Parking (£0.2m) and Private Patients (£0.1m).
- **Workforce:** The Safe Staffing Nursing Fill Rate reported remains in common cause variation, which impacts the overall fill rate. Regular staffing huddles with divisional leads and staff bank continue to ensure safe staffing levels across the Trust. Increased multi professions representation are on the wards to help support the nursing staff. The Trust has introduced a new improved bank rate to be more consistent with other Trusts and have agreed a formal escalation process for bank enhancement to help with demand. The bank team continue to work closely with the site team and matrons on finding solutions to reduce agency spend. Recruitment continue to work with “hot spot” areas to assist in improving their vacancy rate. This includes social media campaigns, virtual events, international recruitment, head hunting and retention strategies. The Recruitment team have booked several external recruitment events within the next few months which targets Staff Nurses and CSWs. A external marketing company “Alcatica” has been awarded in working with the Trust to enhance our branding externally and will be working closely with the Recruitment and communication teams for attraction initiatives and recruitment campaigns. The Turnover rate remained similar in August and continues to experience special cause variation of an improving nature but also consistently failing the target. Climate survey and the “Moving On” survey data is being used to drive local interventions to aid retention. Sickness levels decreased by 0.4% in August and have moved into special cause variation of an improving nature at 3.7%. Of the 3.7% reported 0.2% was COVID related sickness. Non-Covid Sickness remains at expected levels.

Implementing a Revised Perinatal Tool

CQC Maternity Ratings (NB - Maternity Department full inspection in 2014)	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Requires improvement	Requires improvement	Requires improvement	Good	Good	Requires improvement

Maternity Safety Support Programme	No	If No, enter name of MIA (?)				
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	2021									
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
Findings of review of all perinatal deaths using the real time data monitoring tool	2 cases Themes: - Extreme prematurity x 1 - HSIB case x 1	1 case Themes: - HSIB case x 1	3 cases Themes: - HSIB case x 2 - MTOP - fetal anomaly x 1	5 cases Themes: - MTOP fetal abnormality x 2 - Unexplained death x 2	1 case Themes: - MTOP fetal anomaly x 1	3 cases Themes: - Prematurity x 4 - Unexplained death x 1	2 cases Themes: - Prematurity x 2 - Unexplained death x 2	3 cases Themes: - Extreme prematurity x 1 - Unexplained stillbirth x 1 - Term stillbirth - placental abnormalities, GDM on Insulin		1 case Themes: - Covid infection at 23 weeks - IUD at 24 weeks
Findings of review of all cases eligible for referral to HSIB	2 cases Themes: Case 1 - Escalation during neonatal resuscitation Case 2 - No safety concerns	1 case Themes: Patient information - fetal movements in labour Guideline for risk assessment in Triage	2 cases Investigations in progress	0 cases	1 case Investigation in progress	0 cases	1 case Investigation in progress	0 cases		1 case Investigation in progress

Report on:

*The number of incidents logged as moderate or above and what actions are being taken	4 moderate incident 1 serious incident Learning shared: - MDT Communication - Guidelines updated	1 moderate incident 1 serious incident Learning shared: - 1:1 feedback - situational awareness	1 moderate incident 1 serious incident Learning shared: - 1:1 feedback - obstetric cover for Triage - review of guideline for care in latent phase of labour	0 moderate incident 1 serious incident Learning shared: - reminder to staff to follow fetal growth assessment programme	5 moderate incident 2 serious incident Learning shared: - reminder to follow ED pathway for unwell maternity patients - review of process for follow up of investigation results - review of pathway for	1 moderate incident Learning shared: - importance of timely follow up of urgent investigation results - importance of MDT working and clinical overview	2 moderate incidents 1 serious incident Learning shared: - assess risk of bladder injury at LSCS - ensure staff with appropriate experience available for complex surgery	0 moderate incident 0 serious incident	1 moderate harm 0 serious incident Learning shared: - consider FSE if loss of contact on CTG - rotate from OP to OA, if possible, for instrumental births - provide 1:1 care in labour in any location.
*Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training - MDT Emergency Skills	66%	73%	82%	91%	98%	99%	98%	89%	0.84
*Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training - Fetal Monitoring in labour	50%	56%	53%	53%	69%	74%	68%	67%	0.65
*Minimum safe staffing in maternity service to include obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively									
Service User Voice Feedback - number of IQVIA (FFT) responses	179	74	282	254	243	191	145	106	82
Service User Voice Feedback - % positive responses	98%	99%	96%	99%	97%	97%	96%	92%	0.92
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	No	No	HSIB quarterly engagement meeting	CQC engagement meeting	Letter from NHS requesting additional support for staff involved in investigations (based on feedback from one)	HSIB quarterly engagement meeting	No	No	No
Coroner Reg 28 made directly to Trust	No	No	No	No	No	No	No	No	No
Progress in achievement of CNST 10							Declaration of compliance submitted 22/07/2021	Maternity Incentive Scheme - Year 4 guidance published. Action planning commenced	Kick off and planning meetings arranged with leads for each safety action and project lead

Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend the Trust as a place to work or receive treatment (Reported Annually)	75%
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Proportion of specialty trainees in Obstetrics and Gynaecology responding with 'Excellent' or 'Good' on how would they rate the quality of clinical supervision out of hours (Reported Annually)	78%
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REVIEW OF LATEST FINANCIAL PERFORMANCE

- The Trust has generated a year to date surplus of £0.1m which is £0.1m favourable to plan.
- The Trust delivered a breakeven position in September which was on plan.
- In line with NHSE/I guidance additional income (£3m) has been included in the position to offset additional costs for PCR swabbing, Rapid testing and vaccination centre. The Trust received £1.6m to cover the full costs incurred in quarter one.
- The year to date position includes £11.1m associated with the Elective Recovery Fund (ERF), which is £0.6m favourable plan. This includes unconfirmed ERF income of £2.2m reported within the year to date which relates to Infectious Diseases challenge (£1.7m) and missing independent Sector activity (£0.5m). The Trust has a mitigation for this risk which will involve reinstating Top-Up income.
- The key year to date variances is as follows:
 - **Favourable Variances**
 - Independent Sector usage (£3.2m),
 - Pay underspends (£2.9m)
 - Clinical supplies and drugs (£1.4m) due to lower activity than funded levels
 - Non recurrent income benefits (£0.7m)
 - Elective recovery fund overperformance (£0.6m).
 - **Adverse Variances**
 - Rephasing of top up and non-recurrent income support (£6.6m)
 - CIP slippage to stretch target (£1.2m)
 - Underperformance within other operating income (£0.6m)
- The key current month variances are as follows:
 - Income under performed by £2.3m in September. The main underperformance relates to rephasing of Top up income and non-recurrent income support (£1.2m), prime provider activity less than plan (£0.3m) and a year to date adjustment relating to Stroke reconfiguration (£0.3m). Swabbing income was £0.3m below plan however this is offset by a reduction in expenditure.
 - Expenditure budgets underspent by £2.2m, £0.4m within pay and £1.8m in non pay budgets. The key underspends to plan were: Independent sector usage (£1.2m), Drugs (£0.4m), one off adjustments relating to NHS provider to provider contracts (£0.3m) and £0.3m reduction to YTD reported costs associated with the IVE programme.
- The Trust has the following key income assumptions included within the position which are pending confirmation from Kent and Medway CCG
 - Prime Provider (Patient Choice activity) income of £2.7m has been incorporated to offset the costs reported in the month, confirmation from Kent and Medway CCG is pending.
 - ERF - The Trust has unconfirmed ERF income of £2.2m reported within the year to date which relates to Infectious Diseases challenge (£1.7m) and missing independent Sector activity (£0.5m). The Trust has a mitigation for this risk which will involve reinstating Top-Up income.
- The cash balance at the end of September is £35.7m compared to the closing balance at August of £42.7m. The first 6 months (H1) of SLA block payments are based on 2020/21 quarter 3 position extended for a 6 months period, which covers the initial base position. Discussions are ongoing regarding final adjustments for 2021/22 H1 as well as the H2 income expectation. The current cash flow forecast for H2 is based on similar values to the first 6 months with some minor adjustments; this will be updated alongside the H2 Income & Expenditure planning.
- The current cash balance is higher than expected due to the capital programme being back-ended within the financial year. Additionally, the Trust is chasing Roche relating to the managed service contract for invoices relating to quarters 1 and 2 totalling c.£3.8m.
- The cashflow reduces throughout the year as commitments are realised with the closing cash balance currently assumed at £5m, this will need to be updated to reflect H2 assumptions.
- The Trust's capital plan agreed with the ICS/STP for 2021/22 is £10.57m comprising of net internal funding £8.9m, PFI lifecycle per Project model of £1.2m and donated assets of £0.4m. In addition to the Plan the STP has agreed to finance £411k of Diagnostic Equipment

from the National Diagnostic Fund that it has control over, plus a balancing £19k from System PDC. A Memorandum of Understanding (MoU) has been received to confirm the National funding. The Trust has also received confirmation of funding for 2 core Linacs (£1.85m each) in 21/22, although they will both be installed in early 22/23, MoU's have been received. The STP has supported a bid for additional System capital of £452k of enabling work to complete the first Linac replacement. The Trust has also bid for £350k for the ancillary equipment.

- The Plan includes;
 - **Estates:** The Backlog schemes include contractual commitments from 20/21 relating to enabling works for CT Simulator, Pharmacy Robot, MRI, Interventional Radiology and Mammography equipment. General Backlog Maintenance works relating to statutory requirements and condition survey, to be prioritised. Development schemes include the Annex Modular Development (ICC), KMMS enabling work and Paeds ED modular build.
 - **ICT:** The EPR costs relate to contractual commitments. Other ICT schemes include wireless controllers replacement, over-age laptops/PCs, switches, hubs and servers.
 - **Equipment:** The Linac machine was delivered to the Canterbury site at the end of March, this year's costs include ancillary equipment and commissioning. Trustwide equipment has been prioritised.
- The year to date capital spend is £1.9m compared to the Plan of £3.2m. The majority of the spend relates to: **Estates** - the completion of the MRI and Interventional Radiology installation, ongoing works to The Annex and KMMS enabling; **Equipment** - the completion of the Canterbury Linac; **IT** - the ongoing EPR project. There were also elements of carry forward spend from projects commenced in 2020/21. The YTD

1. Dashboard

September 2021/22

	Current Month				Year to Date			
	Actual £m	Plan £m	Variance £m	RAG	Actual £m	Plan £m	Variance £m	RAG
Income	53.5	55.8	(2.3)	Yellow	296.7	304.2	(7.6)	Yellow
Expenditure	(50.8)	(53.0)	2.2	Green	(280.3)	(288.1)	7.7	Green
EBITDA (Income less Expenditure)	2.7	2.7	(0.0)	Green	16.3	16.2	0.1	Green
Financing Costs	(2.7)	(2.8)	0.0	Yellow	(16.6)	(16.5)	(0.1)	Yellow
Technical Adjustments	0.0	0.0	0.0	Green	0.3	0.3	0.0	Green
Net Surplus / Deficit (Incl Top Up funding support)	0.0	(0.0)	0.0	Green	0.1	(0.0)	0.1	Green
Cash Balance	35.7	36.4	(0.7)	Yellow	35.7	36.4	(0.7)	Yellow
Capital Expenditure (Incl Donated Assets)	0.9	1.7	0.8	Yellow	1.9	4.0	0.8	Yellow

Summary Current Month:

- The Trust was on plan generating a breakeven position.
- Income under performed by £2.3m in September. The main underperformance relates to rephasing of Top up income and non recurrent income support (£1.2m), prime provider activity less than plan (£0.3m) and a year to date adjustment relating to Stroke reconfiguration (£0.3m). Swabbing income was £0.3m below plan however this is offset by a reduction in expenditure.
- Expenditure budgets underspent by £2.2m, £0.4m within pay and £1.8m in non pay budgets. The key underspends to plan were: Independent sector usage (£1.2m), Drugs (£0.4m), one off adjustments relating to NHS provider to provider contracts (£0.3m) and £0.3m reduction to YTD reported costs associated with the IVE programme.
- In line with NHSE/I guidance additional income (£0.3m) has been included in the month 6 position to offset additional costs for PCR swabbing, Rapid testing and vaccination centre.

Year to date overview:

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

Favourable Variances:

- Independent Sector usage (£3.2m), Pay underspends (£2.9m), underspends within clinical supplies and drugs (£1.4m) due to lower activity than funded levels, non recurrent income benefit (£0.7m) and Elective recovery fund (£0.6m).

Adverse Variances:

- Rephasing of top up and non recurrent income support (£6.6m), CIP slippage to stretch target (£1.2m) and other operating income (£0.6m - RTA (£0.3m), Car Parking (£0.2m) and Private Patients (£0.1m).
- In line with NHSE/I guidance additional income (£3m) has been included in the position to offset additional costs for PCR swabbing, Rapid testing and vaccination centre. The Trust received £1.6m in August to cover the full costs incurred in quarter one.

CIP (Savings)

- The Trust has a external CIP target of £0.8m (between April and September (H1)) and a stretch CIP target of £2.6m. To date the Trust has identified savings of £1.4m which is £0.6m more than the external target but £1.2m below the stretch savings target.

Risks within reported financial position:

- The Trust has the following key income assumptions included within the position which are pending confirmation from Kent and Medway CCG
- **Prime Provider** (Patient Choice activity) income of £2.7m has been incorporated to offset the costs reported in the month, confirmation from Kent and Medway CCG is pending.
- **ERF** - The Trust has unconfirmed ERF income of £2.2m reported within the year to date which relates to Infectious Diseases challenge (£1.7m) and missing independent Sector activity (£0.5m). The Trust has a mitigation for this risk which will involve reinstating Top-Up income.

2. COVID 19 Expenditure and Income Impact

2020/21 Summary of Cost Reimbursement

Expenditure

Breakdown by Allowable Cost Type	£000s
Segregation of patient pathways	3,433
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	320
Backfill for higher sickness absence	1
Remote working for non-patient activities	18
Existing workforce additional shifts to meet increased demand	69
PPE associated costs	12
Additional Sick pay at full pay for all staff policy - full pay for COVID-related	16
Other -Not detailed on NHSI return	631
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	1,536
Long COVID	395
Total 'In Envelope'	6,431
COVID-19 virus testing- rt-PCR virus testing	2,744
COVID-19 - Vaccination Programme - Provider/ Hospital hubs	5
COVID-19 virus testing - Rapid / point of care testing	249
COVID-19 virus testing (NHS laboratories)	0
NIHR SIREN testing - research staff costs	7
NIHR SIREN testing - antibody testing only	4
Total 'Out of Envelope'	3,009
Total Expenditure (£000s):	9,441

Income

Free staff car parking	284
Catering - Income loss	23
Total Income	307
Grand Total (£000s):	9,748

Commentary:

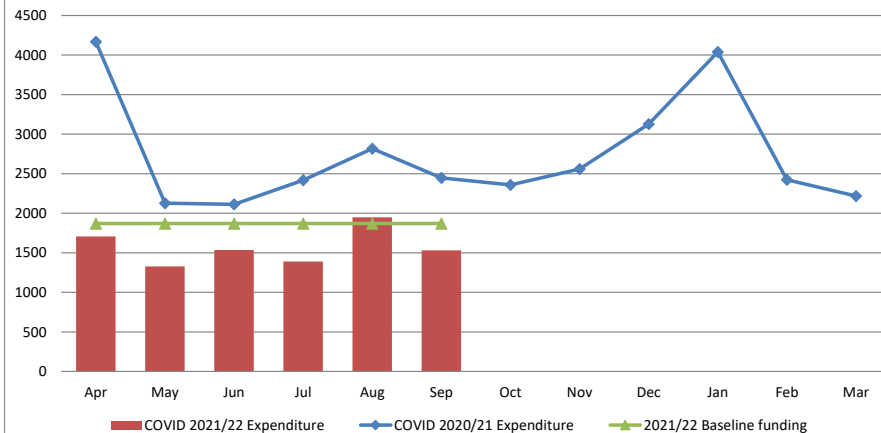
The Trust has identified the year to date financial impact relating to COVID to be £9.7m.

The main cost includes costs associated with virus testing , staff welfare such as providing meals, additional shifts required in ED to support patient flow and escalation of Edith Cavell and Peale Wards and the expansion of ITU.

Costs deemed to be 'within envelope' are £4.8m less than the baseline funding included within the block payment from Kent and Medway CCG.

The Trust has included £3m income in the position to offset the costs for 'Out of envelope' which include COVID swabbing , rapid testing and vaccination programme. NHSE/I has paid in full the costs identified relating to April to June, the remainder is expected to be confirmed over the next few months.

COVID Expenditure £000



Hospital Site name	Health Roster Name	May 21		DAY						NIGHT			TEMPORARY STAFFING		Bank / Agency Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand (unfilled RN/M (number of shifts))	Overall Care Hours per pt day	Nurse Sensitive Indicators				Financial review			
		Planned Hours Registered (Day)	Actual Hours Registered (Day)	Average fill rate registered Nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Bank/Agency Usage	Agency as a % of Temporary Staffing	FFT Response Rate					FFT Score % Positive	Falls	PU ward acquired	Budget £	Actual £	Variance (overpend)	£	
MAIDSTONE	Stroke Unit (M) - NK551	4,370.00	3,161.50	72.3%	98.9%	-	100.0%	72.4%	105.0%	-	-	23.2%	34.3%	273	17.95	87	7.3	0.9%	100.0%	16	1	315.30	280,922	34,558		
MAIDSTONE	Coronwallis (M) - NS559	1,199.50	955.58	79.7%	93.9%	-	100.0%	99.4%	254.5%	-	-	70.5%	45.5%	166	11.41	36	6.2	0.0%	0.0%	5	1	0	112,814	(112,814)		
MAIDSTONE	Culpeper Ward (W) - NS551	708.00	695.07	98.2%	79.7%	-	-	98.3%	106.2%	-	-	28.1%	39.5%	50	3.46	9	4.6	3.2%	100.0%	0	0	127,548	123,899	3,649		
MAIDSTONE	John Day Respiratory Ward (W) - NT151	1,813.50	1,850.17	102.0%	89.0%	-	-	113.5%	121.1%	-	-	42.4%	51.2%	168	11.78	39	6.7	12.5%	100.0%	5	1	166,769	196,223	(29,454)		
MAIDSTONE	Intensive Care (M) - NA251	3,127.67	3,378.58	108.0%	112.9%	-	-	84.5%	98.5%	-	-	9.2%	5.3%	104	6.37	41	46.4	600.0%	100.0%	0	0	289,677	258,421	31,256		
MAIDSTONE	Pye Oliver (Medical) - NK259	1,574.00	1,528.50	97.1%	106.5%	-	-	124.4%	108.9%	-	-	30.6%	55.9%	141	9.61	47	6.6	0.0%	0.0%	13	0	141,257	181,015	(39,758)		
MAIDSTONE	Whitman Ward - NK959	2,101.67	1,784.33	84.9%	76.7%	-	100.0%	110.1%	119.0%	-	-	37.4%	49.0%	137	9.74	39	7.4	0.0%	0.0%	5	1	107,773	145,189	(37,416)		
MAIDSTONE	Lord North Ward (M) - NK651	1,627.50	1,320.00	81.1%	107.6%	-	100.0%	92.7%	92.0%	-	-	11.3%	26.1%	57	4.02	27	6.8	0.0%	0.0%	1	0	128,483	119,002	9,481		
MAIDSTONE	Mercer Ward (M) - NJ251	1,417.50	1,539.50	108.6%	83.5%	-	-	149.7%	111.7%	-	-	34.4%	73.4%	157	11.27	53	6.2	6.1%	100.0%	4	0	128,924	162,294	(33,370)		
MAIDSTONE	Edith Cavell - NS459	1,071.00	1,179.50	110.1%	61.8%	-	100.0%	101.2%	111.4%	-	-	35.9%	52.6%	107	7.70	39	7.2	5.3%	100.0%	1	0	142,919	111,821	31,098		
MAIDSTONE	Acute Medical Unit (M) - NG551	2,375.00	2,226.00	93.7%	81.3%	-	-	136.5%	213.8%	-	-	43.6%	31.3%	159	11.17	55	10.1	0.0%	0.0%	5	1	186,739	185,543	1,196		
TWH	Ward 22 (TW) - NG332	1,801.50	1,183.22	65.7%	85.7%	-	No Hours	124.4%	90.1%	-	-	29.8%	47.3%	167	12.24	83	5.2	0.0%	0.0%	12	3	149,606	159,284	(9,678)		
TWH	Coronary Care Unit (TW) - NP301	1,164.00	883.08	75.9%	90.2%	-	-	72.1%	-	-	-	21.9%	24.3%	122	7.49	77	10.3	12.5%	100.0%	0	0	79,691	69,025	10,666		
TWH	Ward 33 (Gynaec) (TW) - N0302	721.50	593.50	82.3%	90.0%	-	-	86.7%	93.3%	-	-	28.9%	9.7%	57	3.91	20	9.0	51.0%	100.0%	0	0	131,488	119,405	12,083		
TWH	Intensive Care (TW) - NA301	4,592.92	4,877.92	106.2%	84.7%	-	-	115.6%	88.9%	-	-	13.1%	1.9%	132	8.80	26	32.7	25.0%	100.0%	0	0	439,003	344,043	94,960		
TWH	Acute Medical Unit (TW) - NA801	3,213.00	2,709.00	84.3%	87.6%	-	100.0%	92.9%	95.3%	-	-	11.1%	30.8%	142	10.45	81	8.7	0.0%	0.0%	17	0	249,933	240,772	9,161		
TWH	Surgical Assessment Unit (TW) - NE701	1,079.00	1,098.25	101.8%	118.8%	-	-	11.9%	0.0%	-	-	19.4%	11.9%	91	6.28	52	66.8	1.2%	100.0%	0	0	81,732	56,031	25,701		
TWH	Ward 32 (TW) - NG130	1,652.00	1,264.00	76.5%	71.5%	-	100.0%	57.5%	72.7%	-	100.0%	15.4%	31.3%	112	7.78	66	6.8	8.5%	100.0%	0	0	161,577	98,425	63,152		
TWH	Ward 10 (TW) - NG131	2,058.00	1,747.50	84.9%	84.8%	-	100.0%	89.0%	113.1%	-	-	37.7%	28.6%	183	11.76	79	5.4	0.9%	100.0%	2	0	157,469	192,137	(34,728)		
TWH	Ward 11 (TW) Winter Escalation 2019 - NG144	1,832.50	951.50	52.0%	86.2%	-	-	84.5%	78.2%	-	-	48.1%	29.1%	231	15.20	104	5.1	0.0%	0.0%	3	0	0	101,684	(101,684)		
TWH	Ward 12 (TW) - NG132	1,851.00	1,553.00	83.9%	99.2%	-	100.0%	143.4%	75.5%	-	-	38.6%	54.5%	254	16.26	126	6.1	0.0%	0.0%	8	0	159,756	172,404	(12,648)		
TWH	Ward 20 (TW) - NG230	1,764.00	1,264.00	71.7%	110.9%	-	No Hours	121.6%	103.6%	-	-	24.2%	33.5%	148	9.89	79	6.8	1.3%	100.0%	13	1	187,145	169,243	17,902		
TWH	Ward 21 (TW) - NG231	2,037.00	1,921.00	94.3%	88.6%	-	100.0%	81.1%	100.0%	-	-	21.9%	35.0%	114	7.76	52	6.1	0.0%	0.0%	5	3	168,481	154,072	14,409		
TWH	Ward 2 (TW) - NG442	1,452.50	1,053.00	72.5%	110.2%	-	100.0%	106.7%	110.2%	-	-	32.2%	15.9%	161	10.25	92	6.3	10.4%	80.0%	10	2	186,691	159,214	27,477		
TWH	Ward 30 (TW) - NG330	1,861.50	1,690.50	90.8%	91.9%	-	100.0%	102.2%	95.5%	-	-	22.7%	5.8%	73	4.26	34	6.1	6.4%	100.0%	10	0	143,797	157,538	(13,741)		
TWH	Ward 31 (TW) - NG331	1,906.50	1,461.17	76.6%	107.6%	-	100.0%	78.3%	127.8%	-	-	27.7%	16.7%	132	8.16	56	6.4	6.3%	100.0%	3	1	159,200	160,026	(826)		
Crowborough	Crowborough Birth Centre (CBC) - NP775	2,334.00	1,199.42	51.4%	81.4%	-	-	0.0%	0.0%	-	-	3.6%	0.0%	8	0.31	0	0	0.0%	0.0%	0	0	81,809	59,777	22,032		
TWH	Midwifery (multiple rosters)	27,364.25	20,398.18	74.5%	52.2%	-	-	84.4%	98.8%	-	-	13.8%	5.7%	691	40.14	207	12.6	15.7%	97.6%	4	0	936,044	884,092	51,952		
TWH	Hedgehog Ward (TW) - ND702	3,757.50	3,168.38	84.3%	62.6%	-	-	89.9%	-	-	-	41.0%	84.9%	345	23.88	109	11.4	1.2%	100.0%	1	0	159,752	258,193	(98,441)		
MAIDSTONE	Midstone Birth Centre - NP751	847.50	882.42	104.1%	91.3%	-	-	95.7%	96.7%	-	-	17.1%	0.0%	37	1.63	0	35.9	79.6%	100.0%	0	0	82,619	95,520	(12,901)		
TWH	SCBU (TW) - NA101	3,863.50	2,483.25	64.3%	70.7%	-	100.0%	93.9%	-	-	-	17.1%	0.0%	131	7.34	16	11.5	18.8%	100.0%	0	0	203,842	215,039	(11,197)		
TWH	Short Stay Surgical Unit (TW) - NE901	1,843.50	1,371.92	74.4%	70.6%	-	-	80.6%	100.0%	-	-	17.5%	33.4%	65	4.31	28	10.7	2.8%	100.0%	0	0	86,934	82,096	4,838		
MAIDSTONE	Accident & Emergency (M) - NA351	4,792.58	4,224.83	88.2%	109.9%	-	-	98.6%	91.7%	-	-	44.7%	45.1%	495	34.36	109	0	0.2%	68.8%	8	0	324,295	430,647	(106,352)		
TWH	Accident & Emergency (TW) - NA301	5,202.50	4,452.93	85.6%	57.2%	-	100.0%	89.2%	79.6%	-	-	34.0%	58.4%	490	34.03	121	0	0.1%	100.0%	7	0	446,000	491,631	(45,631)		
MAIDSTONE	Midstone Orthopaedic Unit (M) - NP951	780.00	734.00	94.1%	96.9%	-	100.0%	92.7%	-	-	-	12.0%	13.1%	15	1.04	3	12.5	61.5%	100.0%	1	0	77,319	63,007	14,312		
MAIDSTONE	Isle Ward COVID - NS451	1,199.33	1,033.00	86.1%	109.3%	-	100.0%	113.2%	121.3%	-	-	30.9%	59.4%	115	7.98	47	9.7	6.7%	100.0%	5	0	126,534	111,589	14,945		
MAIDSTONE	Foster Clark - NS251	1,814.00	1,540.00	84.9%	88.6%	-	100.0%	90.8%	88.2%	-	-	14.2%	10.0%	52	3.52	25	8.1	0.0%	0.0%	1	0	173,314	163,271	10,043		
MAIDSTONE	Short Stay Surgical Unit (M) - NE751	1,069.50	986.50	92.2%	101.1%	-	No Hours	76.8%	No Hours	-	-	15.5%	3.4%	30	1.78	12	19.6	33.2%	99.1%	0	0	60,690	66,636	(5,746)		
				Total Established Wards																6,950,030	7,151,744	(201,714)				
				Additional Capacity beds																Cath Labs	64,232	49,923	14,309			
																				Chaucer	0	372	372			
																				Foster Clarke Winter Escalation	0	3,521	(3,521)			
				Other associated nursing costs																5,191,465	5,056,062	135,403				
																				12,205,727	12,260,877	(55,150)				

RAG Key
Under fill
Overfill
Green: Greater than 90% but less than 110%
Amber: Less than 90% OR greater than 110%
Red: Less than 80% OR greater than 130%

Trust Board meeting – October 2021

Review of the draft winter plan for 2021/22**Chief Operating Officer**

The draft version of the Trust's winter plan for 2021/22 is enclosed, for review and discussion.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive (TME) meeting, 20/10/21
- Finance and Performance Committee, 26/10/21

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

Maidstone & Tunbridge Wells

Winter Plan

2021/22

V5.0 DRAFT

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1. Executive summary

Purpose

- The purpose of the Winter Plan is to bring together all relevant activities across the Trust which relate to planning for winter 2021/22, to ensure that all associated actions are being progressed to deliver safe and effective care for our patients whilst delivering performance and finances as planned

Development of the Winter Plan

- The Plan is a live document that will be continuously updated, especially in light of demand and capacity modelling and further waves of Covid-19
- The Trust's Winter Plan is overseen by the Winter Resilience Strategic Group and led by the Deputy Chief Operating Officer. More detailed work is undertaken by each Division, who hold their own Winter Planning meetings
- The usual Winter De-Brief for last winter was cancelled due to Covid-19 however Lessons Learnt from the winter period have been collated and fed into the planning process
- A Kent & Medway System Exercise Event took place on 10th September with a West Kent winter meeting having taken place on 19th October
- All Divisions have provided leads that have been supporting the development of the Trust Winter Plan
- The Plan is under constant review and development and identifies the actions that will maintain patient safety and clinical quality over the period of expected surge in demand during winter
- The Draft Trust Winter Plan has been shared with K&M CCG colleagues in line with the Winter Framework 2021/22

Executive summary (cont.)

- The Trust recognises that the winter period will be challenging with anticipated continuing high demand, continued Covid-19 presentations, influenza, paediatric respiratory viruses and possible severe weather. The Trust is committed to working together to manage these challenges, learning from our experience of previous winters and the Covid-19 pandemic
 - **Data driven management:** we will use real-time information systems to anticipate capacity pressures and manage them effectively to support best possible flow through our sites for all patients
 - **Effective co-ordination:** This year, the Trust has transitioned from an Incident Control Centre (ICC), set up to manage the Covid-19 pandemic, to an Operational Control Centre (OCC). This function is now Business As Usual and will continue over the winter period to ensure maximum use of resources, clear communication, rapid resolution to issues and promote effective partnership working
 - **Proactive communications:** We will work with system partners to implement a Communications Plan which includes promotion of alternatives to the Emergency Department through targeted use of social media and other channels for specific population groups
 - **Demand management:** we will continue to build on demand management initiatives (NHS111)
 - **Acute capacity:** we will put increased focus on the current work being undertaken to maximise Same Day Emergency Care (SDEC) services. Unlike previous years, the Trust does not have empty wards to open for escalation.
 - **Hospital Flow and discharge:** The launch of the 'Safer Better Sooner' programme of work is designed to reduce length of stay (LOS) on inpatient wards, improve flow and ensure the right patient is in the right bed for their condition.
 - **Festive weeks:** we will produce detailed operational plans for the Christmas and New Year period
- Covid-19 and Influenza:** assumptions of the timing, impact and management of a resurgence of Covid-19 cases within the acute trust will be detailed within the Winter Plan along with any prediction on influenza presentations. Details of the vaccination programme for both covid booster and influenza will be incorporated within the Winter Plan
- **Severe weather:** Notification of adverse weather will be proactively communicated by the Emergency Planning team

2. Emergency Department (ED) Activity

The Covid pandemic has significantly altered ED attendances since March 2020 resulting in activity for the being difficult to model. Factors including potential further waves of Covid, public confidence and behavior, vaccination rates especially of younger people, success of the Think 111 First campaign, flu and severe weather will all impact on the level of attendances.

Capacity modelling for this year has been undertaken using the following methodology:

- Weekly attendances between Jan 2010 and Dec 2019 have been plotted out, and a 'line of best fit' applied to reveal the underlying growth in the system, which is 3.9% per year. This inflation is assumed to still apply for the next few years, and this represents the raw baseline for demand
- Recent actuals are compared to the raw baseline to predict a 'where are we now' factor and to work out how much above or below the raw baseline the current activity is. Ideally this combines 12-month, 6-month, 3-month and 6 week comparisons, but for now it's only useful to go back to Apr-21, and during the Covid Pandemic, only the 6 week average was used to make it as responsive as possible. According to this, the Trust is currently (since April) around 3.0% above the raw baseline, so the raw baseline has been 'hitched up' by another 3.0% for this week, and all subsequent weeks moving forwards
- The seasonal phasing worked out in a separate exercise is then overlaid on top

So, in practice, the weekly non- elective attendance forecast for Jan-22 is around 3,360. This is made up of:

- Raw baseline, extrapolating Jan-10 to Dec-19, line forwards puts us around 3,466 per week
- Amended baseline, hitched up by the 3.0% currently being seen increases this to 3,572 per week
- Mid-January is typically 5.9% down, so this drops the forecast to 3,362 for that week
- The 80% confidence interval is 4.5%, so we estimate an 80% probability that the actual will be between 3,157 and 3,567

Table 1 – Graph showing predicted Trust ED attendances Apr-19 to Mar-22 (Updated 3rd October)

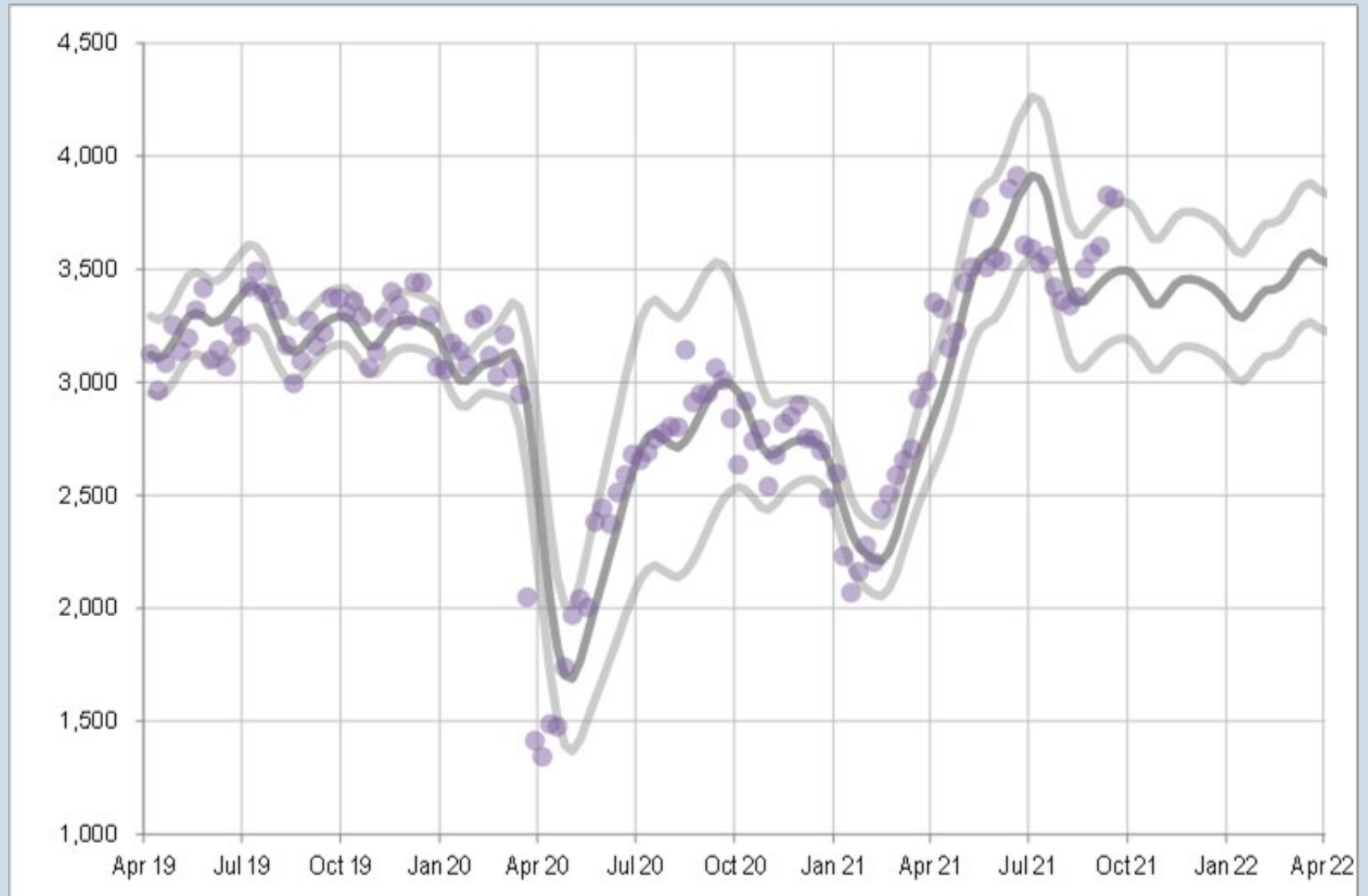


Table 2 – Graph showing predicted Maidstone ED attendances Apr-19 to Mar-22 (Updated 3rd October)

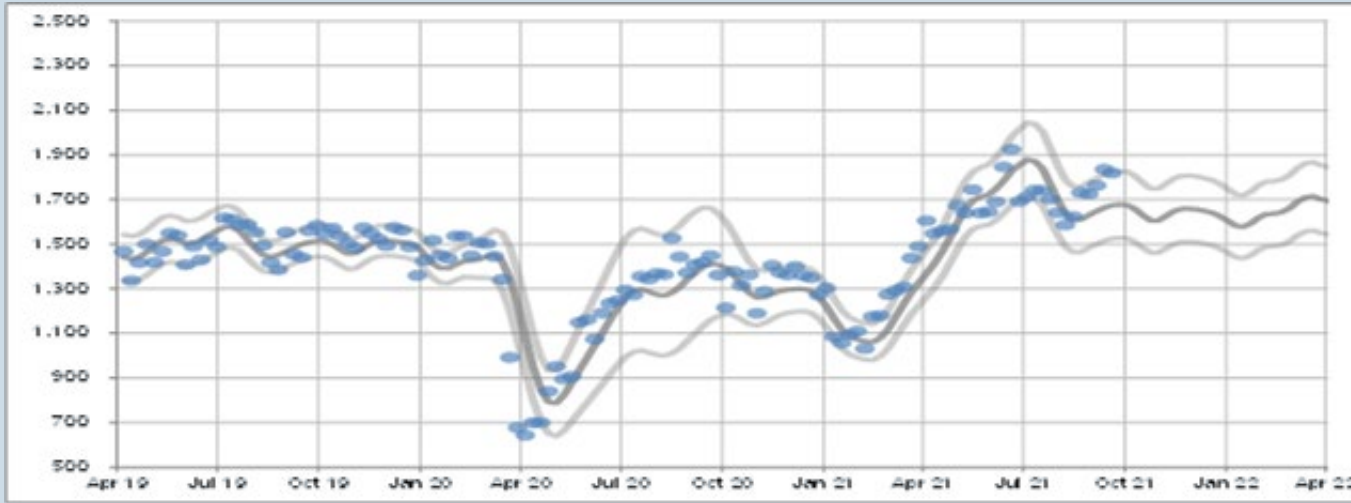
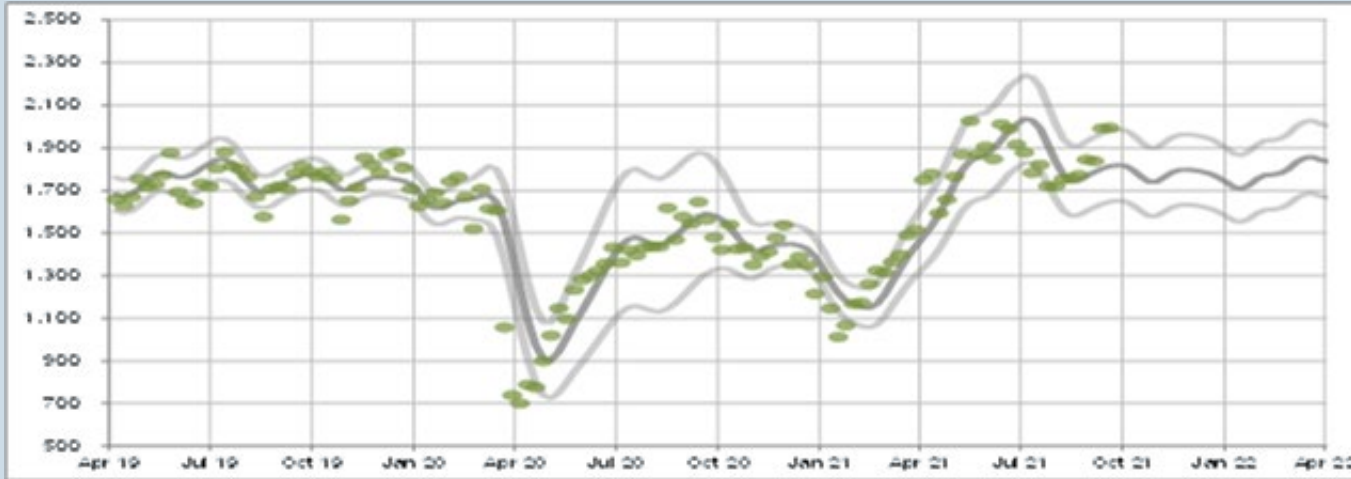
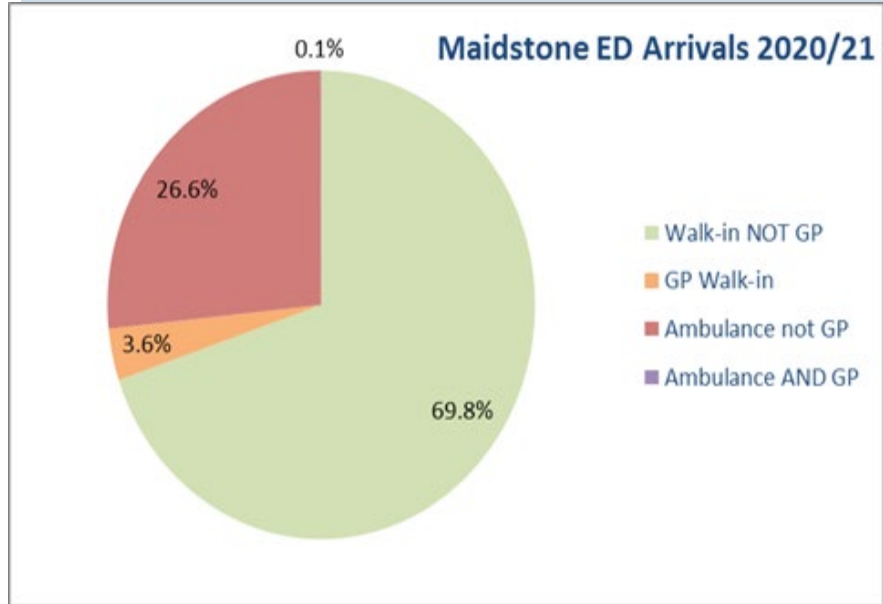


Table 3 – Graph showing predicted TWH ED attendances April 19 – March 22 (Updated 3rd October)

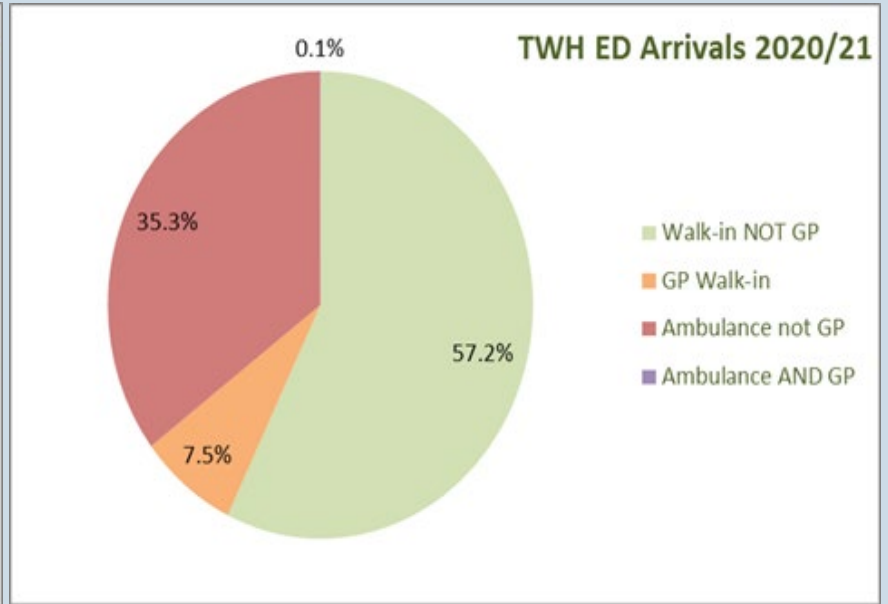


3. Trust ED attendances split by Ambulance – GP – Walk In Activity



Maidstone : 64,308 total

Table 1: MH ED attendance by source April 20 – March 21



TWH : 69,070 total

Table 2: TWH ED attendances by source April 20 – March 21

4. Walk in Attendances

Introduction

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

System Approach

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

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

Walk in Attendance (cont.)

As can be appreciated, this approach is confusing for patients and healthcare professionals alike. By filtering all requests for Urgent Care through 111, and as the Direct Booking system develops, 111 will be able to direct patients to the most appropriate service for their needs reducing the pressure on the Acute Trust sites ED's. The CCG 's expectation is to provide virtual clinics (calls or video) to reduce footfall and improve patient experience for this winter. Funding and resources needed to operationalize this are currently being worked through. Anticipated start date 1st December.

Also, the introduction of Digital Streaming using NHS Pathways at the front door, using a screen or tablet is starting in December. The benefit of this is to redirect and prioritise walk in patients to the most suitable service.

Modelling

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

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

Risks

- Limited national press regarding "Think 111 First" campaign, public unaware of the new pathway to access emergency and urgent care
- CAS's ability to manage the increase in call volumes
- GP provision at Sevenoaks remains stable at present but concerns over sustainability over winter

5. Ambulance Attendances

Focused work has been undertaken by the Trust and South East Coast Ambulance Trust (SECAMB) to improved handover delays at both ED sites over the past 3 years. Significant improvement has been made until id summer this year when handover delays were experienced in line with a surge in attendances and more significant workforce shortfall.

Monthly meetings take place with SECAMB to monitor performance, evaluate new processes and ensure handovers are minimised.

SECAMB present a report at the Local A&E Delivery Board.

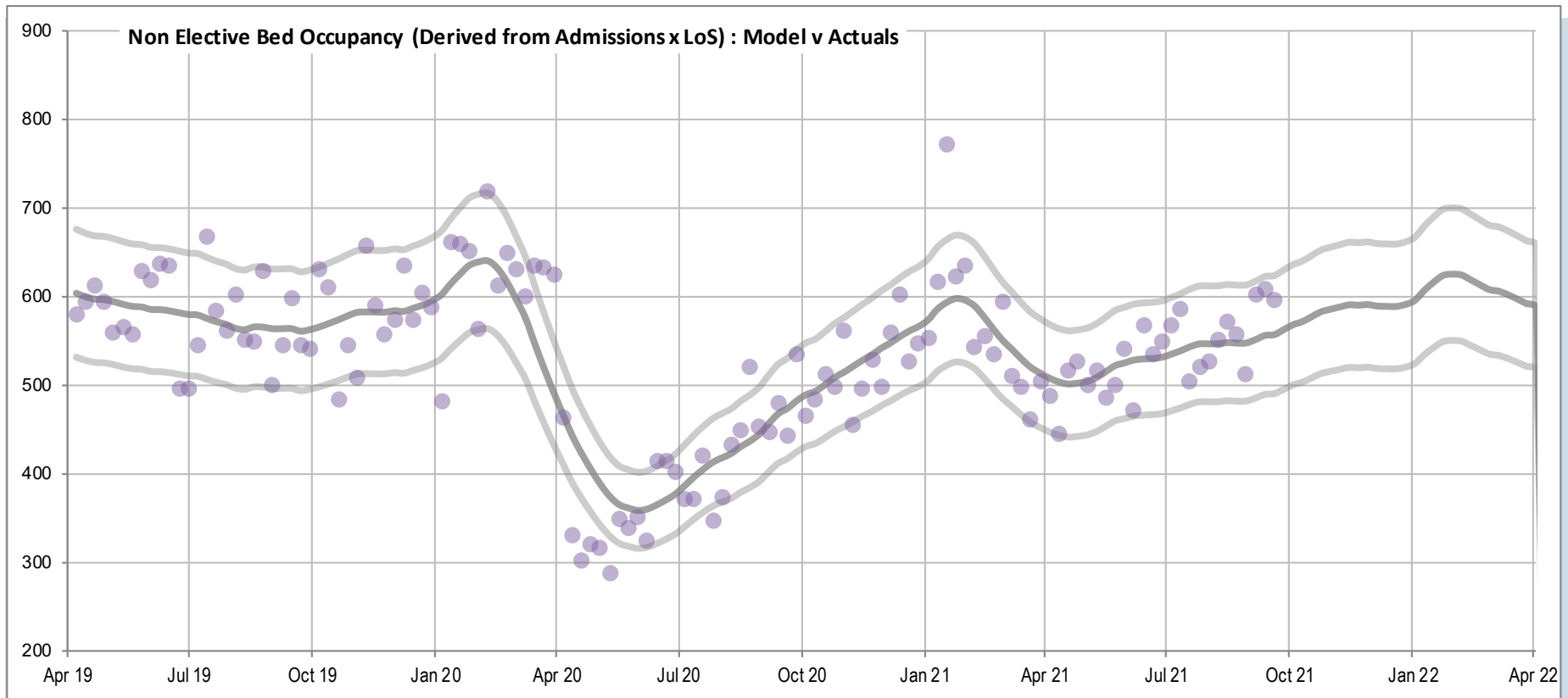
Plans to support offloading ambulances without delay over the winter period include:

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

Total Ambulance handover delays from 1st April to 30th September 2021

Upto 14th October	Total Conveyances	Less Than 15		15 - 30 Mins		30 - 45 Mins		45 - 60 Mins		Over 60	
MTW	22841	44.7%	10217	39.1%	8928	5.9%	1348	1.8%	409	0.6%	146
TWH	13928	42.7%	5947	37.9%	5280	7.0%	976	2.4%	341	0.9%	124
MGH	8913	47.9%	4270	40.9%	3648	4.2%	372	0.8%	68	0.2%	22

6. Bed Modelling



Modelling for the beds required for non-elective patients this winter are shown in the above table. This is the total for the Trust and all specialties. The model suggests a requirement of 600 beds during January peaking at 624 in February (upper confidence level of 700).

Bed Modelling (cont.)

Table 2: Maidstone Hospital non elective beds required

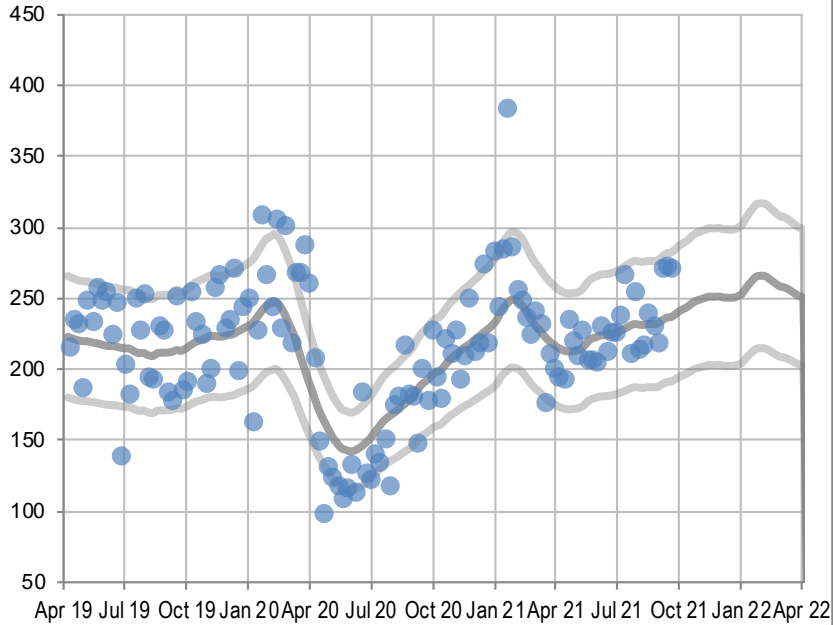
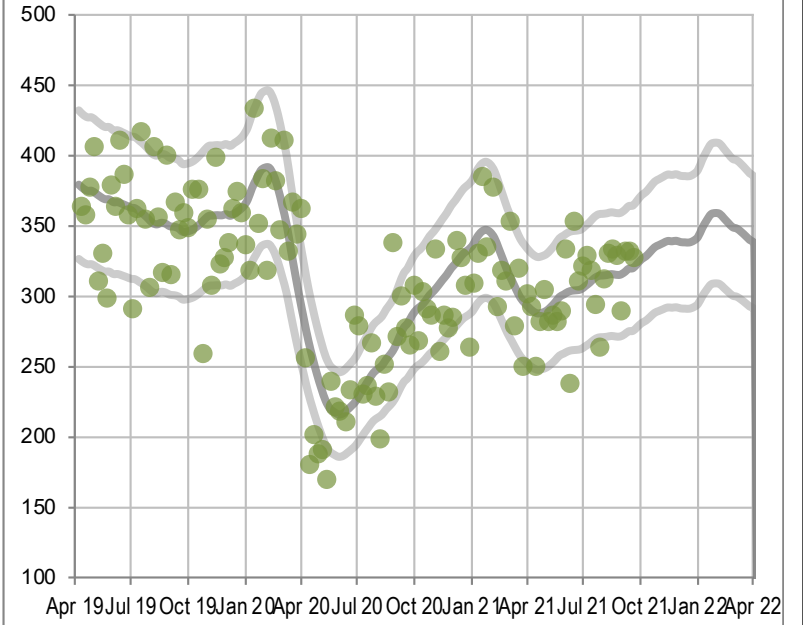


Table 3: Tunbridge Wells Hospital non elective beds required



7. Elective Modelling

Summary of all elective spells below

	April 2021	May 2021	Jun-21	Jul-21	Aug-10	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022
Electives												
Ordinary spells												
Day case Spells												
Total Elective spells												

8. Bed Capacity

Core Medical Beds				Core Surgical Beds			
Tunbridge Wells		Maidstone		Tunbridge Wells			
AMU	38	John Day	30	W10	30		
CCU	7	Culpepper	13	W30	30		
W2	26	CCU	6	W33	15		
W12	30	Mercer	26				
W20	30	Pye Oliver	28				
W21	30	AAU	22				
W22	32	Stroke Unit	46	Maidstone			
		Whatman	22	Foster Clark	28		
		Edith Cavell	22				
		Peale	14				
Total beds	193	Total beds	229				
Escalation in use		Escalation in use		Escalation in use			
W11	30	Cornwallis	19	The Wells Suite	10		
				SSSU 1-9	9		
Inpatient total	223	Inpatient total	248	Inpatient total	122		
MEDICINE NON-ELECTIVE CAPACITY BEDS (a)						471	
MEDICINE & SURGERY NON-ELECTIVE TOTAL CAPACITY BEDS (b)						593	
JANUARY MEAN DEMAND (c)						624	
FEBRUARY WORSE CASE MODELLED DEMAND (d)						700	
SHORTFALL OF BEDS ON JANUARY MEAN DEMAND (c-b)						31	
SHORTFALL OF BEDS ON FEBRUARY WORSE CASE DEMAND (d-b)						107	

9. Closing the Gap – Mitigation of Shortfall

On the modelling undertaken to date, the Trust has a shortfall of non-elective beds of between 31 and 107 beds over the coming winter

Both W11 at TW and Cornwallis at MH are currently open and therefore already counted in this total. Last year both areas were used as escalation wards from December with a phased opening to support flow going into the post Christmas period. Both wards were closed at the end of March but unfortunately the increase in non elective demand necessitated the opening of both areas during the summer and they remain fully occupied at the present time. Therefore the only additional in-patient beds which could be used for winter escalation are 18 beds on the old AMU at MH.

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

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

10. Safer Better Sooner Programme

What is the problem we are trying to solve?



Non-standardised and poor processes

- Linear working not parallel
- Different models for handover, board round, discharge lounge process
- Bed availability late in day



Opportunities to improve patient care

- Patient may be in wrong place in system to enable best care
- Patient Delays
- Silo working impacting on ability to deliver best care



Low levels of staff engagement





- Staff energy levels low, leading to poor engagement
- Relentless daily impact on staff to crisis manage
- High reliance on bank/ agency staffing & shift fill rate challenged



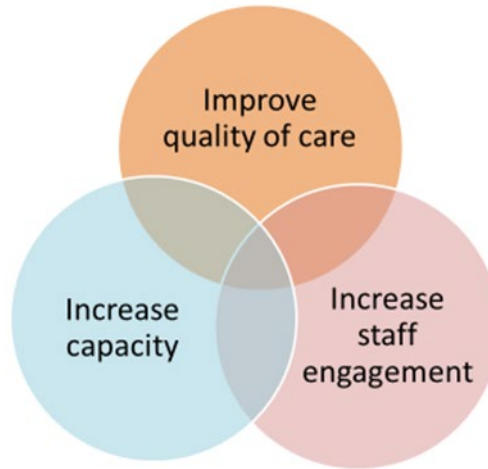
High demand for care

- Increased non elective demand & backlog of elective patients
- Lack of capacity in system to support
- Complex, older patients

Where do we want to be?

-  **Standardised processes**
 - Effective board rounds on medical wards incl. Day before Actions/ EDD
 - Real time Teletracking on board rounds
 - SDEC model developed to increase throughput with additional resource/ space
 - Discharge Lounge to pull patients from wards
-  **Outstanding patient care /no patient delays**
 - 50% patients discharged by midday
 - Reduction in patient delay in ED to reduce mortality (against ED Clinical Review of Standards)
 - Meet LOS goal in top 3 medical/ surgical diagnoses
 - Increased patient experience through Friends and Family
-  **Improved staff engagement**
 - Staff working at top of skill set
 - Appropriate skill mix and shift fill
 - Engagement sessions for specific cohorts, i.e. B6/7
-  **Right patient, right place, right time**
 - Confirmed discharges to leave within 2 hours
 - ITU patients transferred out within 4 hours of being fit
 - Increased number of day rates for elective patients
 - Elective work to fit within agreed bed base

What do we want to do?



How do we achieve this?



Inpatient wards – implementation of SAFER BETTER SOONER programme

A new programme is being developed called SAFER BETTER SOONER encompassing the following streams of work. This will incorporate the Teletracking implementation team, the Discharge team and further programme work. It will sit under the Director of Nursing and Quality, MEC, Sally Foy. The work will report into the Acute and Urgent Care corporate workstream with the COO as Executive Sponsor.

- Early discharges – KPI to discharge 40% of patients by midday
 - Effective, well attended board rounds with top 5 questions monitored through development of Board round audit tool
 - Teletracking updated in real time monitored through site meetings
 - Mop up board rounds in place
 - Board round solution for Surgical wards if required
 - Additional admin support for wards after 4pm
 - Criteria Led discharge
 - Flow Coordinators – standardise roles and provide further training if required
- Discharge Lounge – KPI to increase number of patients from x to y
 - Expand operational hours
 - Development of resource within DL, i.e. trolleys, beds, staff, TTO cupboard if required
 - Pull patients from wards
 - Review transport policy
 - Reduce internal wait within DL
- Staff engagement to support improved flow
 - Key cohorts for engagement
 - Flow Coordinators
 - B5/6
 - Registrars
 - Use of Dragons Den or similar to implement small improvements
 - Comms plan - develop branding and animated film for staff
- Corporate services
 - Medium to long term plans are being developed with the Director of Ops for Diagnostics and Clinical Support services
 - This will encompass the support services in their role for flow

11. Live Data Systems

Smarties

- Real time view of all ED Metrics to support capacity management and flow.
- Real time view of CUR tools to identify delays in the patient pathway
- Key managers provided access through mobile app and web browser can be used both on and off site
- Displayed on Ops Centre and reviewed by managers during the day and whilst on call to understand the site pressure. All metrics RAG rated for easy view

What is SHREWD Resilience

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

Power BI

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

Live Data Systems (cont.)

TeleTracking

- Real time reporting available to key managers via mobile app and web browser
- Transitioning to a Care Coordination Centre (CCC) model to facilitate bed placement for both acute trust sites from one central place, facilitating a reduction in idle bed time and improved patient placement leading to improved patient experience and care
- Work continues with KCHFT to gain real time visibility of Community Bed availability allowing for improved discharge planning and reduced LoS in the Acute hospital

12. Full Hospital Capacity Protocol

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

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

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

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



MTW Full Capacity
Protocol 1.8 (3).docx

13. Operations Control Centre (OCC)

Purpose:

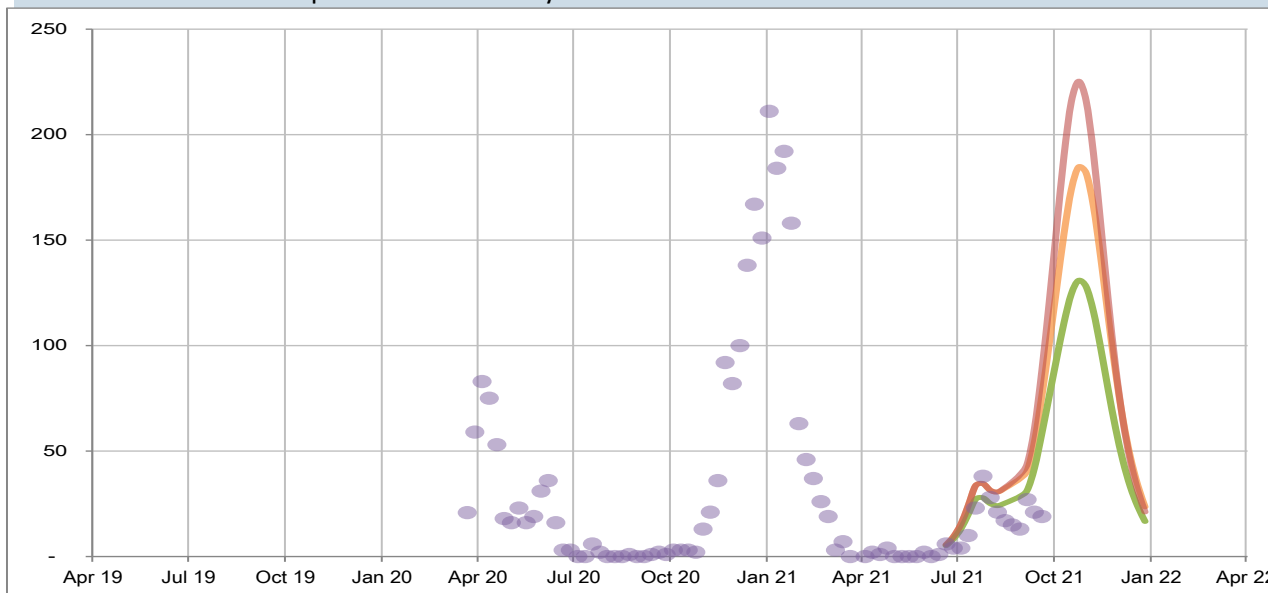
- Last year, as a result of the Covid-19 pandemic the Trust established an Incident Control Centre. After a review, the function was felt to be beneficial to the Clinical Operations function and a decision made to transform the ICC into an Operations Control Centre (OCC) which will occur continue over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

14. COVID-19

The graph below has been modelled using the Covid data released in mid-September.

The previous release in July assumed that as lock down eased, public behaviour would revert to normal levels causing a spike of Covid infections in the unvaccinated population over the summer. However, this has not happened in reality. The general public has not gone back to completely normal behaviour and as a result, infection numbers over the summer have been substantially lower than expected, meaning that we are hitting the Autumn with a much larger pool of unprotected people than anticipated. This pool could potentially increase as the protection from the vaccine or prior infection starts to wane.

The current model projects a peak in late October / early November, and for MTW, the forecast occupancy is in the 140-210 range – around half to two thirds what was experienced in January 2021.



15. Influenza and Covid Vaccination

This winter, there is a risk that Influenza may circulate in the community.

For the winter season of 2021/22 MTW will be running a combined influenza and COVID-Booster vaccination service.

All staff have been invited to book an appointment to have (ideally) both their flu and COVID-booster jab at the same time. Staff have the option to opt for just one or other vaccine, but the recommendation to most effectively protect yourself, colleagues, your family and patients is to have both vaccines.

Both vaccinations will be recorded on NIVS (National Immunisation and Vaccination System). This will provide not only the individual with an electronic “passport” of the vaccines, but also national reporting.

Where staff are vaccinated elsewhere (be that GP, a pharmacy or other centre) our Business Intelligence team have access to NIMS (NHS Immunisation Management Service). We are able to extract vaccinations that our staff may have had elsewhere, and thus combine with our own reporting to collate a full picture of the entire Workforce.

The combined COVID-Booster / Flu vaccination clinics are scheduled (as at 30/09/21);

TWH site;

Clinic dates are available between 5th October – 15th October. 1,512 appointments currently available

MGH site;

Clinic dates are available between 19th October – 5th November. 3,780 appointments currently available

The project plan is to open up initial clinics and as they fill up, open the additional clinic times / days. Overall the plan is to provide capacity for 8,000 appointments if needed.

There is a bias towards the MGH site for vaccination appointments. This is due to the constraints of accommodation on the TWH site from within which to run the vaccination service.

It is projected that by the 5th November over 85% of our workforce will have received the flu vaccine and COVID-Booster vaccine.

16. Severe Weather

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

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

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

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

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

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

17. Workforce

Row Labels	Cancer Services	Corporate and Support	Diagnostic + Clinical Support	Estates and Facilities	Medical + Emergency Care	Surgery	Women, Children and Sexual Health
Registered nursing, midwifery and health visiting staff	13.39	30.46	8.13	0.00	170.88	105.57	50.25
Allied Health Professionals	0.00	0.00	0.00	0.00	0.00	0.00	1.06
Health Care Scientists	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Other Scientific, Therapeutic and Technical Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.00
NHS Infrastructure Support	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Support to clinical staff	12.29	-2.95	69.10	-0.70	64.03	66.46	21.22
#N/A	0.00	8.00	-1.00	0.00	0.00	0.00	0.00
Medics - Career/Staff Grade	1.20	2.00	0.10	0.00	37.30	13.44	-0.82
Medics - Consultant	5.95	2.98	5.11	0.00	10.82	16.51	1.01
Medics - Training Grade	5.50	1.00	1.10	0.00	12.02	2.60	-5.50
Total NHS infrastructure support	8.30	34.32	13.17	47.79	0.20	2.53	2.84
Any other staff	0.00	-9.00	0.00	0.00	0.00	0.00	0.00
Registered Scientific, therapeutic and technical staff	19.14	0.80	68.42	1.00	17.16	13.20	4.75
Registered ambulance service staff	0.00	0.00	0.00	0.00	-2.33	1.24	0.00
Grand Total	65.75	67.60	164.13	48.09	310.07	221.55	74.82

Nursing gaps, particularly in Medicine & Emergency Care, is a concern as we approach winter. The opening of escalation wards, the impact of securing Covid-19 safe pathways and obvious challenges with the continued overseas recruitment this year, has exacerbated the vacancy rate.

The senior nursing teams continue to work with the recruitment lead to ascertain current vacancy levels and predict month by month WTE turnover. HRBPs and the senior Workforce team will continue to collaborate with nursing colleagues to ensure that the plan is “live” and responds to changing needs and demands. Staffing is reviewed weekly at the Forward Planning meeting to ensure decision making around staff allocation is planned and responds safely to the demands faced.

18. Out of Hospital Capacity

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

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



Hospital_Discharge_
Policy.pdf

Discharge to Assess pathway model:

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

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

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

Pathway 3: 1% of people – require ongoing 24-hour nursing care, often in a bedded setting. Long-term care is likely to be required for these individuals
For MTW, commercial care home beds are used across a number of settings to provide ongoing care and assessment. These beds are funded via the CCG but managed by the MTW Discharge Manager.

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

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

Out of Hospital Capacity (cont.)

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

Out of Hospital Capacity (cont.)

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

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

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

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

19. Festive Period Plans

Christmas and New Year Targeted planning:

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

20. Risk Register

Embedded below is the full Risk Register for Winter 2021/2022

21. Finance

Appendix 1: Divisional Winter Action Plans

To review a Strategic Outline Case (SOC) for cardiology**Chief Operating Officer**

The enclosed report provides information on the status of the proposed inpatient and cardiac catheter lab reconfiguration. It does not assume any changes to outpatient clinics or outpatient diagnostic services. The report and supporting Strategic Outline Case (SOC) include:

- An update and overview of the formal public engagement process as deemed appropriate by the Health Overview and Scrutiny Committee (HOSC) which commenced on 20th October 2021. This is a 12-week period in which the three priority audiences detailed in the report will be given the engagement plan on which to comment and the opportunity to attend a range of listening events and focus groups to gain further understanding of the benefits of the proposed changes and the impact on the quality of cardiology care at the Trust. The engagement process has been carefully constructed to give staff, patients and members of the public the opportunity to voice any concerns or issues they have with the proposals and for the Trust to respond and give reassurance regarding the impact and improvements the proposed change will bring.
- The SOC outlines the rationale for change focussing on:
 1. The need to improve clinical services and outcomes in line with national Getting It Right First Time (GIRFT) recommendations relating to the centralisation of specialty beds, 7-day access to cardiac catheter lab for procedures and 24/7 on call access for all disciplines.
 2. Improve recruitment and retention of staff by developing a specialist service
 3. Delivery of the Trust strategy to expand cardiology services in the future and become a local cardiology centre of excellence
 4. Added to this the development of the service will future proof cardiology at the Trust as the local cardiology network develops and will align with other clinical strategies and plans including the development of stroke services.
- The four options are to make no changes (option 1), centralise the service on the Maidstone site (options 2 and 4) or centralise the service on the Tunbridge Wells Hospital site (option 3). These options are scored using criteria relating to availability of space, the timescale for delivery, the capital cost of such a development and clinical acceptability. The current engagement process will give the Trust another element to support the decision making regarding the future of the cardiology inpatient beds and cardiac catheter lab service.

N.B. The embedded documents are available upon request from the Trust Secretary's Office

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 19/10/21

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

- Information regarding the 12-week engagement process and assurance regarding the thoroughness of the same
- Information and discussion on the requirements for inpatient and cardiac catheter lab reconfiguration
- Support for the development of a full business case once the engagement period is complete in January 2022 with a view to progressing the development of the cardiology service in line with GIRFT and strategic objectives during 2022

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

1. Introduction:

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

The report outlines progress and includes the Strategic Outline Case for consideration and confirmation for the way forward with this programme of work. The report will include the following:

- Communication Update
- SOC update
- Recommendations to the Board

2. Communications

Whilst the preferred option for the reconfiguration of the reconfigured cardiology service is centralisation on the Maidstone site (see Trust Clinical Strategy) at this stage this is an aspiration until the 12-week engagement period recommended by HOSC is complete. The public engagement period will commence on 22nd October 2021 and will be completed on 14th January 2022. Thereafter a decision will be taken as to the preferred option for the development of the service going forward.

In terms of the communications the communications team are working with Hood & Woolf on the staff, stakeholder, and public engagements.

The communication groups have been split into 3 priority groups as detailed below and communications throughout the 12-week engagement period will vary depending on the audience. Those groupings are detailed in the table below: -

Group/organisation
Priority 1 audiences - internal
<ul style="list-style-type: none">• MTW Board• MTW senior leadership team• Directorate/division/service leads• All cardiology clinical and non-clinical staff• Staff side/unions
Priority 1 audiences - external
<ul style="list-style-type: none">• Local MPs• Kent HOSC Chair and members• East Sussex HOSC Chair and members• NHSEI regional lead• NHSEI regional director – Ann Eden• NSHEI regional communications leads - Stuart Green/Gayle Carrington• Head of South East Clinical Senate - Emily Steward• Care Quality Commission regional lead• KMCCG/ICS accountable officer – Wilf Williams, KMCCG Clinical Chair – Dr Navin Kumta, Executive Director of Strategy and Population Health – Rachel Jones, and Director of Communications – Tom Stevenson• KMCCG governing body members• Healthwatch Kent – Robbie Goatham• Healthwatch East Sussex – John Routledge• Media (via media release)

Priority 2 audiences
<ul style="list-style-type: none"> • All MTW staff • MTW patient/stakeholder groups • CCG (Kent) member practices, PCNs and local area teams • KMCCG staff • KM ICS Board/system partnership board • ES ICS Board/system partnership board • West Kent ICP • East Sussex ICP • K&M provider collaborative communications leads • Neighbouring K&M and East Sussex acute provider CEOs and MDs (if not covered above): <ul style="list-style-type: none"> ○ Dartford and Gravesham NHS Trust – Louise Ashley, Dr Steve Fenlon ○ Medway NHS Foundation Trust – Dr George Findlay, Dr David Sulch ○ East Sussex Healthcare NHS Trust – Joe Chadwick Bell, Dr David Walker ○ East Kent Hospitals University NHS Foundation Trust – Susan Acott, Dr Rebecca Martin • CEOs of KCHFT (Paul Bentley) and KMPT (Helen Greatorex) • Leader of KCC – Roger Gough, Corporate Director KCC – David Cockburn
Priority 3 audiences
<ul style="list-style-type: none"> • Royal Colleges and professional organisations • Local health partners – LMCs, HWB, patient groups, voluntary organisations • District/borough councils • Patients, carers and public – via websites, social media, traditional media and other existing communications channels (e.g. bulletins and newsletters)

In terms of the start date for the plan it is imperative that staff have communication before the public engagement process commences. On that basis the decision has been taken to run the staff engagement plan immediately after the cardiology GIRFT visit on 18th October.

The timings are detailed in the table below: -

Date	Group	Communications
15 th October	Priority Group 1	Update regarding cardiology in CEO Bulletin
18 th October	Staff	Cardiology GIRFT virtual visit
19 th October	Staff	Cardiology Governance Meeting
20 th October	Priority Group 1	Email from clinical lead, Laurence Nunn, confirming the engagement process will start on 22 October 2021
22 nd October	Priority Group 1	Email from CEO, Miles Scott
22 nd October	Priority Groups 2 & 3	Official launch of engagement process – email from Miles Scott
23 rd October – 11 th January 2022	All	Active dedicated email address Dedicated telephone number and address Pop up information in local shopping centres Focus groups for staff and public Listening events for staff and public

The events from 23rd October to 11th January 2022 are being confirmed with appropriate timings to allow maximum attendance particularly from staff. The full details will be confirmed with events likely to start the third week after the launch to give people in each of the priority groups the opportunity to review the engagement pack. Communication via post, email (dedicated email address set up) and telephone will be handled real time.

Details of the communications plan to date are in **appendix 1**.

3. Strategic Outline Case

3.1 Background

The SOC builds on the work previously done in 2020 and earlier in 2021 regarding the development of a managed equipment and consumables service for cardiac catheter lab equipment and a potential mobile cardiac catheter lab on the Maidstone site. The drivers for the development focussed on developing the estate to support the Trust aspiration of becoming a second PPCI provider in Kent and securing an operating lease within 2021/22 within the current financial rules (IFR4 and IAS17) which would manage the lease arrangement of equipment as revenue. New financial rules coming into force on 1st April 2022 (IFRS16) will mean any operating lease including equipment will result in that equipment being recorded on the Trust balance sheet as capital. Under the new financial rules, the total managed service would need to be in place and fully operational by 31st March 2022 including the provision of new equipment.

In April 2021 a presentation to the executive team outlined a tight timeline for delivering the total managed service including equipment by 31st March 2022. Also, of note was the fact the mobile cardiac catheter lab was considered clinically unacceptable to the consultant cardiologists due to the potential temporary nature of such a facility.

The publication of the GIRFT recommendations and the assessment of the Trust's performance against these recommendations in March 2021 added another dimension to the development of a cardiology service which would be considered viable to support clinical developments such as PPCI in the future. An MTW specific GIRFT meeting was held on 18th October 2021, these having been suspended for site specific visits during the worst of the COVID pandemic. The meeting was very positive, particularly about our future direction of travel. GIRFT were categorical that to be a credible dedicated cardiology service MTW has to deliver both inpatients and cardiac catheter lab services on one site to provide a dedicated bed base with seven days a week access to procedures for patients admitted with a heart attack or heart rhythm problem, to pool the staff and skills needed to run 24/7 emergency on call rotas and develop the service for the benefit of all patients in the region. GIRFT did mention the potential increase in travel for some patients but this would be more than compensated by the improvements in the service delivery. Without the centralisation their view is that MTW will be seen as two services neither of which would be able to fully deliver the GIRFT standards and would not have the ability to develop services as the cardiology network develops.

This changed the emphasis in the development of the SOC which has resulted in a much further reaching and detailed evaluation of the current service and the proposal to develop that service in the future.

3.2 SOC

3.2.1 Principles

The attached document has been prepared to give the executive directors and the Trust Board a view of the vision and aspiration of the service and describe the journey required to deliver both. The SOC directly supports the service and Trust aspirations for:

- Transforming the way the cardiology department delivers services to ensure the needs of patients are met now and, in the future
- Deliver and develop services that are clinically viable and financially sustainable.
- Deliver services in line with recognised NICE and GIRFT recommendations and embrace the delivery of the Trust strategy to develop the service.

The principles supporting an improved cardiology service at MTW focus on delivering the GIRFT recommendations to improve the quality of care and increase the service provision; centralisation of

the inpatient cardiology service and the cardiac catheter laboratories onto one of the Trust hospital sites; delivering a 7-day service which is appropriately resourced with the required skilled staff to deliver improved quality of care, service efficiencies, minimised waits and enhanced patient experience. All of which will place the cardiology service in the market for future growth including the potential provision of PPCI.

3.2.2 Staffing

The SOC details the requirement of an appropriately trained and competent workforce including medical, nursing and physiology teams. The recruitment market is challenging in the NHS particularly in specialist disciplines like electrophysiology and cardiac radiography. The aim of the development and resourcing of the service would be to make the service more attractive and thereby improve recruitment. Whilst the investment required is considerable with an annual cost of £3.4m for 59.4 wte staff it would result in a flexible multidisciplinary workforce, focussed on development, teaching and training to aid retention and ultimately develop modern and effective workflows to maximise efficiency and productivity. In reality recruiting to this number of staff would be a challenge and the aim would be to split recruitment across more than one financial year to align with the other site and service developments for the cardiology service. This will require an incremental approach to the delivery of the optimum service.

3.2.3 Estates Development

There are four options for delivery of the service to meet the drivers for change being considered as follows:

Option 1: Do nothing. This would not allow the Trust to meet the future clinical strategy, the NICE guidelines or improve service efficiency and quality as it assumes the GIRFT recommendations will not be met. To deliver these across two sites would be the subject of another case that looked at increasing staffing more substantially to run a compliant rota and 7/7 service on both sites. This would not represent value for money and result in unnecessary duplication. It is unlikely that recruitment to a further increase in staffing would be deliverable. This option will not deliver the Trust clinical strategy.

Option 2: Internal reconfiguration to centralise on the Maidstone site by redeveloping current estate for the cardiac catheter lab. This would use and redevelop current clinical space but would rely on a surgical service being successfully displaced. To deliver this, the surgical services operating out of the Short Stay Surgical Unit would move to a purpose build facility which is the subject of a separate but co-dependent business case. The ward configuration would result in the development of Culpepper and Cornwallis wards to create a specialist unit and 12 bedded CCU. The estimated estates cost is £5m. In terms of site development this would be the quickest option to implement.

Option 3: Internal reconfiguration to centralise on the Tunbridge Wells site. This would require redevelopment of floor space surrounding the current catheter lab including the current CCU. It would also rely on successful displacement of some ward areas to accommodate a specialist ward and 12 bedded CCU and this is not factored in the plan, although it is likely to be cost neutral it will potentially displace ward areas on the busiest emergency site. The timescale for delivery would be longer than the other options due to the PFI legal requirements. Estates costs are estimated to be £13.64m

Option 4: Part new build / part internal reconfiguration to centralise on the Maidstone site. This would require a new build adjacent to the back of the current cardiac catheter lab to create a new second lab and recovery area and the same internal ward reconfiguration as option 2. The capital cost is circa £8m and would require a planning period of 3 months on top of the build timescale.

3.2.4 Equipment

Up to date equipment and facilities are required to support efficiency in throughput, productivity and clinical outcomes. Cardiology has an ageing stock of medical equipment and £1.5m of the estimated £4.5m equipment is now past its lifetime. This is reflected in breakdowns and increased down time

of the equipment in the Maidstone site cath lab. The absence of an adequate replacement strategy means there is a risk to improving the efficiency of the service and improving patient outcomes.

The cardiology service is dependent on other equipment provided and managed by other services. This is being reviewed.

The equipment and consumables replacement/management options are as follows:

Lease cardiology equipment

This option would result in the development of an operating lease for a total managed service which would include equipment and consumables management which would encompass equipment maintenance and replacement. The current consumables spend is £2.5m per annum. This is likely to decrease with efficiencies gained from an equipment deal which will benefit the Trust. The £2.5m would be included in the contractual arrangement with a supplier and be off set against current budgets.

In this scenario the equipment will be capital on the balance sheet as it is unlikely there is time to deliver the service within 2021/22. In year 1 this would mean a £1.5m commitment to capital in the balance sheet to replace expired equipment.

Purchase replacement cardiology equipment

This option is a continuation of the current arrangements where equipment is/should be replaced at the end of its life cycle. The equipment replacement programme is not robust and a commitment would be required to include this in the service development.

Separate Business Case for a Total Managed Equipment Service

Another option is to consider a total managed equipment and consumables service as a separate business case. Expressions of interest have been received from Medtronic and InHealth and a procurement specification is being developed, to go out to the market in late October. Once this process is complete a review of the options will be undertaken to recommend a way forward either as part of the whole case or on a separate basis.

3.2.5 Summary of Costs

The cheapest option is 'do nothing' but this will not deliver the clinical strategy or GIRFT requirement which will both lead to improved quality of service, including improvements in patient experience, and in efficiency and future service development and associated income. The most cost-effective option is internal reconfiguration on the Maidstone site which is in line with the clinical strategy but does not take account of the impact of the public engagement process. More financial detail will be developed once an option for progression is confirmed and the procurement process is completed.

3.2.6 Constraints and Dependencies and Risks

The proposal is not without challenges and the key constraints, dependencies and risks are detailed below: -

Key constraints include:

- Availability of capital, and capital prioritisation
- Revenue cost increase
- Timescale to deliver maximum benefit before the accounting rules change
- The need to maintain service provision at both sites whilst carrying out development work.

Key dependencies include:

- Ability of the trust to relocate other services for the development of a centralised cardiology model
- Ability to recruit and appropriately train staff to support all cardiology services.

- GIM ability to cover basic core service at 'cold' site, with support from cardiology to support cardiology patients managed on the cold site.

Key Risks

- Capital availability makes the build costs unaffordable
- Recruitment and retention of clinical staff adversely effected by change
- Inability to meet any financially viable arrangements prior to April 2022 thereby putting more pressure on the capital allocation
- Inability to make changes which impacts on delivery of the GIRFT recommendations in full and will impact on the Trusts ability to deliver the Clinical Strategy
- Risk of clinical dissatisfaction and staff leaving the Trust
- Risk of losing the cardiology specialist service if no reconfiguration is planned
- Risk of not delivering the Trust Strategy relating to PPCI

The SOC presents options for the proposed solution and mitigating actions to reduce the risks outlined here.

4.0 Recommendations

The Board are asked to consider the recommendations as follows: -

1. Note the report and the contents
2. Note the engagement activities and timeline – a 12-week public engagement period as agreed with Kent Health Overview and Scrutiny Committee
3. Recognise the proposed cardiology reconfiguration as critical to the delivery of the Trust strategy
4. Confirm action relating to the Total Managed Service for equipment and consumables as part of the SOC or a separate arrangement
5. Support the development of a full business case once the engagement period is complete

5.0 Appendices:

Appendix 1 - Cardiology Service 12-week communications and engagement plan (Oct 21 – Jan 22)

Introduction:

As part of MTW's Clinical Strategy the Trust has been looking at ways to improve the quality of cardiology care. Our vision is to create a cardiology service that is fit for the future, provides the very best care, strengthens the service and meets GIRFT requirements. Communication and engagement activities will enable internal and external stakeholders to share their thoughts on the service. The activities will also enable us to respond to questions and use feedback to agree the next steps for the service. Staff communications and engagement will run alongside external work but our staff will hear information from the trust before it is shared more widely.

Background:

The Trust recently presented the need for change to the local Health Overview and Scrutiny Committee (HOSC) and while HOSC considered the change being proposed as not a substantial variation of service the Trust and HOSC agreed to a three-month public engagement process which will run from 22 October 2021 to 14 January 2022.

Public pre-engagement has already been carried out and included:

- Face to face discussions with current inpatients at both hospitals
- Interviews with people who use cardiology outpatients
- Focus groups to capture public/patient experience
- An on-line survey to reach a wider audience

In total the pre-engagement work received feedback from 220 people. On the whole, experiences were positive but with a few key themes emerging. These included rushed appointments, waits for procedures and moving between sites. This feedback, as well as the responses we've had from our staff, have been used to support the development of the 12-week engagement process which will start on 22 October.

Objectives:

The three objectives for our communications and engagement work are:

- Staff and the public feel involved in the development of the cardiology service
- Staff and the public understand how the proposals for cardiology services were developed and the evidence they are based on
- Staff and the public are able to share their views on the proposed options

Current cardiology service:

Cardiology at MTW is currently provided at MH and TWH. There is a cardiac catheter laboratory at both sites and a six bedded coronary care unit at each hospital site. If patients require an angioplasty intervention they are be transferred to TWH. If they require cardiac pacing or electrophysiological intervention they are transferred to MH. Outpatients and other diagnostics (ECG, echocardiography) are provided on both sites.

Going forward the Trust is looking at options to develop Cardiology as part of the Trust Clinical Strategy as there are a number of weaknesses with the current service:

- Two small units compared to neighbouring hospitals
- Minimum procedure volume on coronary angioplasty are not met
- Delays in patient transfers between each site for procedures

- Difficulty in recruiting and retaining staff
- Cannot meet seven-day standards as recommended by GIRFT
- The Trust is not in a position to deliver the aspirations of the clinical strategy of delivering primary PCI

Options:

The trust believes the best model of care is to consolidate some specialist care at one hospital while continuing to provide more day to day and routine services and care at other hospital locations.

As well as a 'do nothing' option, three options have been developed and evaluated.

1. Consolidate specialist services at Maidstone Hospital by reconfiguring existing space
2. Consolidate specialist services at Tunbridge Wells Hospital by reconfiguring existing space
3. Consolidate specialist services at Maidstone Hospital by building a new space and reconfiguring existing space

Draft narrative:

At Maidstone and Tunbridge Wells NHS Trust (MTW) we have been looking at ways to improve the quality of our cardiology care [*include for public audiences*- care for people with heart problems]. At the moment our cardiology services, especially those for people with heart conditions needing an inpatient stay and/or a specialist procedure, for example to treat heart attacks, heart failure or life-threatening heart rhythm problems, are split across our two main hospital sites. Some specialist cardiology services are delivered from Maidstone Hospital, others from Tunbridge Wells Hospital. This often leads to patients being transferred from one site to another during an inpatient stay. It also means our specialist cardiology teams are thinly stretched across two sites and we can't consistently provide a seven-day service at either site. Nor can we care for all heart patients on a dedicated, specialist cardiology ward (some currently are admitted to a general medical ward). Despite the hard work of our fantastic staff we are struggling to meet national best practice standards in some areas because of how our cardiology services are organised.

After careful consideration, our cardiology team has identified three potential ways we could improve our care. This would mean making changes to how services are organised and delivered, including a proposal to bring our very specialist inpatient cardiology services together on one site.

It is important to state that these proposed changes will *not* change how or where we deliver cardiology outpatient clinics and outpatient cardiology diagnostic services.

We are holding a 12-week engagement period, running from Friday 22 October 2021 until midnight on Friday 14 January 2022 to understand what patients, the public, staff and stakeholders think about these proposals.

You can find out more about our proposals and provide feedback on our website at mtw.nhs.uk/cardiology-engagement. Information can also be requested in hard copy by calling 01622 225771 or emailing mtw-tr.cardioreconfig@nhs.net.

There are several opportunities for patients, the public, staff and stakeholders to get involved over the next 12-weeks, including some virtual public listening events. Further details of how to get involved can be found on our website. In addition, we are also carrying out some telephone polling and targeted focus group discussions to ensure a wide range of views are captured.

After the engagement period ends, an independent agency will compile and review the feedback. This will be presented to MTW's board to inform our decision making. The final decision about the proposals is expected in early 2022.

Our audience and communications cascade list:

The cascade list sets the order in which communications are shared with stakeholder groups.

Group/organisation
Priority 1 audiences - internal
<ul style="list-style-type: none">• MTW Board• MTW senior leadership team• Directorate/division/service leads• All cardiology clinical and non-clinical staff• Staff side/unions
Priority 1 audiences - external
<ul style="list-style-type: none">• Local MPs• Kent HOSC Chair and members• East Sussex HOSC Chair and members• NHSEI regional lead• NHSEI regional director – Ann Eden• NSHEI regional communications leads - Stuart Green/Gayle Carrington• Head of South East Clinical Senate - Emily Steward• Care Quality Commission regional lead• KMCCG/ICS accountable officer – Wilf Williams, KMCCG Clinical Chair – Dr Navin Kumta, Executive Director of Strategy and Population Health – Rachel Jones, and Director of Communications – Tom Stevenson• KMCCG governing body members• Healthwatch Kent – Robbie Goatham• Healthwatch East Sussex – John Routledge• Media (via media release – see separate sequencing timing and ensure NHSEI sign-off as required)
Priority 2 audiences
<ul style="list-style-type: none">• All MTW staff• MTW patient/stakeholder groups• CCG (Kent) member practices, PCNs and local area teams• KMCCG staff• KM ICS Board/system partnership board• ES ICS Board/system partnership board• West Kent ICP• East Sussex ICP• K&M provider collaborative communications leads• Neighbouring K&M and East Sussex acute provider CEOs and MDs (if not covered above):<ul style="list-style-type: none">○ Dartford and Gravesham NHS Trust – Louise Ashley, Dr Steve Fenlon○ Medway NHS Foundation Trust – Dr George Findlay, Dr David Sulch○ East Sussex Healthcare NHS Trust – Joe Chadwick Bell, Dr David Walker○ East Kent Hospitals University NHS Foundation Trust – Susan Acott, Dr Rebecca Martin• CEOs of KCHFT (Paul Bentley) and KMPT (Helen Greatorex)• Leader of KCC – Roger Gough, Corporate Director KCC – David Cockburn
Priority 3 audiences
<ul style="list-style-type: none">• Royal Colleges and professional organisations• Local health partners – LMCs, HWB, patient groups, voluntary organisations• District/borough councils• Patients, carers and public – via websites, social media, traditional media and other existing communications channels (e.g. bulletins and newsletters)

Channels:

The communication cascade with audiences will begin on 22 October and use a range of channels over the 12 weeks to reach a broad audience across our geography.

Channel of Communication	Audience
Face 2 face and on-line listening events	Staff and public
MTW existing internal channels	Staff
Staff specific briefing	Cardiology staff and all staff
Stakeholder update	Key partners
Website	External audiences
Intranet	Internal audiences
Pop up stand events	Public
Engagement document	Public and staff
Engagement video	Public and staff
Online and telephone survey	Public and staff
Newspaper adverts	Public
Social media	Public

Media:

Media release (currently draft) to be issued under embargo until 22 Oct:

MTW seeks views on proposals to improve cardiology care

Maidstone and Tunbridge Wells NHS Trust is seeking views on its proposals to improve cardiology (heart) care.

At the moment, its cardiology services, for people with heart conditions needing an inpatient stay and/or a specialist procedure, are split across the two main hospital sites. Some specialist heart services are delivered from Maidstone Hospital, others from Tunbridge Wells Hospital. This often leads to patients being transferred from one site to another during a hospital stay. It also means the specialist heart doctors and nurses are thinly stretched across two sites and can't consistently provide a seven-day service at either site. Nor can all heart patients currently be cared for on a dedicated, specialist cardiology ward. Some may be cared for by specialist heart doctors but on a general ward. Despite the hard work of fantastic staff, it is a struggle to meet national best practice standards in some areas because of how heart services are currently organised.

It is important to state that these proposed changes will not change how or where we deliver cardiology outpatient clinics and outpatient cardiology diagnostic services

After careful consideration, Maidstone and Tunbridge Wells NHS Trust's heart specialists have put forward four potential ways to improve care. This would mean making changes to how services are organised and delivered, including a proposal to bring our very specialist inpatient cardiology services together on one site. The Trust is seeking views on the proposals over a 12-week period running from today (22 October 2021) until midnight on 14 January 2022.

Dr Laurence Nunn, Consultant Cardiologist at the Trust, said: "We are determined to provide the very best care for our heart patients. These proposals will allow us to do this. I would like to encourage people from Maidstone and Tunbridge Wells and surrounding areas to tell us what they think of our proposals, which will help us to shape our plans."

After the engagement period ends, an independent agency will compile and review the feedback. This will be presented to the hospital Trust's board to inform its decision making. The final decision about the proposals is expected later in 2022.

ENDS

Evaluation:

The communications team will compile an engagement log detailing date, activity, location, engagement lead, audience, key message/discussion content, reach/numbers and locations.

This will be used to both evidence the success of the communications and engagement campaign and update messages and channels if needed.

Strategic Outline Case (SOC)
Cardiology Clinical Strategy
Reconfiguration of Cardiology Services

Issue date/Version number	1.27 14/10/21
Division	Emergency and Medical Services
Directorate	Medical Specialities
Department/Site	Cardiology
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1.0 Purpose of this document

1.1 The purpose of this document:

This Strategic Outline Case (SOC) provides the strategic context behind the proposal to reconfigure Cardiology services; makes a robust case for change; and provides stakeholders and customers with an early indication of the proposed way forward. It scopes out options for investment in the centralisation of the inpatient cardiology services of Maidstone and Tunbridge Wells NHS Trust in order to meet GIRFT requirements.

The SOC has been drafted in accordance with the 5 Case Model recommended by HM Treasury and includes:

- the Strategic Case – completed in full but may be revised later;
- the Economic Case – completed to the long-list of alternative options stage, with a recommended way forward and an initially recommended shortlist for further examination at OBC stage;
- the Commercial Case – addresses the fundamentals of any potential Procurement and Deal;
- the Financial Case – discusses the likely affordability of the proposed Scheme; and,
- the Management Case – outlines how the project will be set up and managed,

The SOC seeks approval to take forward detailed planning for the centralisation of inpatient cardiology services at MTW NHS Trust and develop a fully costed Outline Business Case (OBC). The investment will be used to centralise inpatient and interventional catheter laboratory procedures onto one site to enable a more efficient and integrated approach to patient care. This will deliver quality sustainable services while aiming to reduce emergency length of stay (LoS) by improving the current 7-day in-patient services in line with the medical division's long-term vision and GIRFT recommendations. It aligns with the South East Clinical senate's clinical co-dependencies and provides MTW with an opportunity to be a key player in the development of regional Cardiology services for the people of Kent. A centralised service will place the Trust in a position to become the second Primary PCI centre for Kent and Medway in the future and provide capacity to increase catheter lab volumes in line with NICE guidance.

1.2 Structure and content of the document.

The case has been prepared using the agreed standards and format for Business Cases from NHS/E.

2.0 Executive Summary

2.1 Strategic context

This SOC directly supports the core strategic objectives of the Trust, in particular the aspirations for:

- Transforming the way, the cardiology department delivers services to ensure the needs of patients are met
- Delivering services that are clinically viable and financially sustainable.
- Delivery services in line with recognised NICE and GIRFT recommendations.

The principles supporting an improved service model for cardiology services at MTW:

A centralised cardiology service is important in ensuring a 7-day service can be offered which to create efficiencies and contribute to minimising any delays to patient treatments. The aim is to reduce length of stay, by extending current 7-day ward round commitments with Cath Lab procedures and diagnostic services to facilitate earlier treatment and discharges, which in turn will enhance patient experience. Centralisation is also fundamental to the Trust's clinical strategy and service's future aspirations of becoming the second PPCI centre in Kent.

Quality service provision

- Focus on patient treatment and reduced waiting times for required treatment.
- Effective pathways of care that is compliant with national guidance.
- Effective 7-day cover in line with division's vision.
- Improved elective and emergency pathways.
- Improved patient experience

Staffing

- Appropriately trained and competent staff to support all cardiology services, inclusive of medical, nursing and physiology teams.
- A flexible multidisciplinary workforce.
- Focus on recruitment, retention, teaching, training and development.
- Modern and effective workflows to maximise workforce efficiency and productivity.

Building & Equipment

- Provides a safe, secure and healthy environment for patients and staff with appropriate provision of clinical and non-clinical space.
- Will reflect privacy, dignity and equality requirements.
- Will be equipped with the best and appropriate medical equipment and technology infrastructure.
- Provide contemporary facilities for teaching and training

2.2 Value for money

Given challenges with capital and revenue funding in NHS post COVID and the future potential changes to the financial rules regarding operational and financial leases (IFRS16), it is essential that any option considered provides value for money by:

- Reducing capital requirement of the scheme
- Working with colleagues in the independent sector on a plan with leasing options prior to April 2022 to maximise revenue opportunities

2.3 Constraints and dependencies

Key constraints include:

- The need to maintain service provision at both sites whilst carrying out development work.
- Availability of capital, and capital prioritisation
- Revenue cost increase
- Timescale to deliver maximum benefit before the accounting rules change

Key dependencies include:

- Ability to recruit and appropriately train staff to support all cardiology services.
- GIM ability to cover basic core service at 'cold' site, with support from cardiology to support cardiology patients managed on the cold site.
- Ability of the trust to relocate other services for the development of a centralised cardiology model.

2.4 Options for consideration

There are four options for delivery of the service to meet the drivers for change being considered as follows:

Option 1: Do nothing.

This option will continue to see cardiology inpatient and cardiac catheter lab facilities over 2 sites. Delivery of GIRFT recommendations across two sites does not fit the objectives of the reconfiguration as it will not release efficiency, will be costly with unnecessary duplication; will not be attractive in terms of recruitment and is unlikely to support the Trust strategy aspiration.

Option 2: Internal reconfiguration to centralise on the Maidstone site by redeveloping current estate for the cardiac catheter lab.

This would use and redevelop current clinical space but would rely on a surgical service being successfully displaced. The aim is for the surgical services operating out of the Short Stay Surgical Unit will move to a purpose build facility which is the subject of a separate but co-dependent business case. The ward configuration would result in the development of Culpepper and Cornwallis wards to create a specialist unit and 12 bedded CCU.

Option 3: Internal reconfiguration to centralise on the Tunbridge Wells site

This would require considerable redevelopment of floor space surrounding the current catheter lab including the current CCU. It would also rely on successful displacement of some of ward areas to accommodate a specialist ward and 12 bedded CCU.

Option 4: Part new build / part internal reconfiguration to centralise on the Maidstone site

This would require a newbuild adjacent to the back of the current cardiac catheter lab to create a new second lab and recovery area the same internal reconfiguration of the ward areas would be required.

A fifth option, to undertake a new build on the TWH site, was considered but was discounted after discussion with the estates team due to physical space constraints on the site.

A considerable amount of the cardiology equipment is past expiry dates so each of the above would need an option for the ongoing management of equipment assets as outlined below. There are 2 possible options:

2.5 Equipment Management

Option: Lease cardiology equipment

This option would result in the development of an operating lease for a managed service which would include equipment and consumables management which would encompass equipment maintenance and replacement.

Option: Purchase replacement cardiology equipment

This option is a continuation of the current arrangements where equipment is/should be replaced at the end of its life cycle.

2.6 Financial evaluation

The financial evaluation will take account of the following issues:

1. Capital costs
2. GIRFT revenue costs
3. Revenue costs of managed equipment service in 21/22
4. Possible financial management of capital and revenue under IFRS16
5. Movement of resource within the division to support centralisation

Key Risks

- Level of build costs becomes unaffordable
- Recruitment and retention of clinical staff adversely effected by change
- Inability to meet any financially viable arrangements prior to April 2022

Action requested

The project team ask for recommendation from the approving bodies (TME /Trust Board) to either:

- Support the development of the case
- Identify most strategically viable option to progress
- Confirm the strategy regarding equipment replacement and management going forward

3.0 Strategic Case

3.1 Outline of current Cardiology service

The cardiology service serves the population of Maidstone, Tonbridge, Tunbridge Wells, Crowborough, Sevenoaks and Paddock Wood, as well as patients from the East Sussex border.

The inpatient cardiology service at MTW is currently provided at both the Maidstone (MH) and Tunbridge Wells (TWH) hospital sites. Both sites have a 6 bedded Coronary Care Units (CCU), and patients' inpatient stays outside of CCU are managed in the general medical wards on both sites. Nominally 6 beds are allocated on the MH site on Culpepper ward which is shared with endocrine medicine and 8 beds on ward 12 on the TWH site which is shared with general medicine. These beds do flex depending on specialty demand and cardiology regularly take up more than the allocated beds or patients are managed on other wards due to lack of specialty allocated beds. There is one cardiac catheter laboratory on each site. No one laboratory provides the full range of cardiac procedures, with the Tunbridge Wells site providing diagnostic angiography & angioplasty intervention and simple pacing procedures, and the Maidstone site providing diagnostic angiography, simple & complex cardiac pacing and electrophysiological intervention. Patients at Maidstone hospital requiring an angioplasty intervention will be transferred to Tunbridge Wells Hospital. Patients at Tunbridge Wells Hospital require complex cardiac pacing or electrophysiological intervention will be transferred to Maidstone Hospital. Both sites also have outpatient services, including clinic and non-invasive diagnostic services (ECG, echocardiography, 24-hour monitoring). Out-patient services are also provided at Crowborough and Sevenoaks hospitals

The average number of patients accessing the cardiology service each year, based on 2017-2019 data is summarised in the **figures 1, 2 and 3** below. The centralisation will affect the inpatient stays and catheter lab activity only, as outpatient activity and diagnostic services will remain in their current sites.

Figure 1: Average number of patients seen per year, based on data collected between 2017-2019

	Average no. of patients per year
Inpatient stays	3731
Outpatient appointments	19883
Cath Lab activity	2484
Diagnostic services	3738

The inpatient length of stay averaged 3.9 days giving a total bed day usage of 14551 which equates to 40 beds used for cardiology coded patients. Of these 12 are CCU beds with the remaining 28 for inpatient stays for cardiology coded patients. The result is the 14 allocated beds are insufficient for demand and a percentage of patients are not managed within cardiology dedicated beds or necessarily by cardiologists.

Figure 2: Inpatient/bed activity (by ICD10 code) breakdown (3-year average) excluding cath lab

Site	Day Case	Elective	Non-Elective	TOTAL
Maidstone	549	84	1125	1773
Tunbridge Wells	625	139	1186	1958
TOTAL	1174	224	2311	3731

Figure 3: Total Cardiac Catheter Lab Activity by Procedure (3-year average)

Procedure	3-year average
Angio (diagnostic)	1050
PCI (incl PW and IVUS)	299
Cardiac Implanted Electronic Devices (PPM, CRT, ICD)	516
Loop recorder	162
TOE	115
Cardioversion	300
EP Procedures	31*
RF Ablation	126*

*1 year data only

3.2 Patient Access

All speciality patients access services from the post codes highlighted in the map below, which also highlights the home proximity of service users to each hospital. Maidstone hospital is situated in ME16 and Tunbridge Wells hospital in TN2. With the exception of TN6 and TN19 patients, all patients are residents of the surrounding areas of the hospital, or fall within the catchment area in between Maidstone and Tunbridge Wells sites.

Inpatient data collected between 2017 – 2019 shows that 87% of inpatient admissions to Maidstone Hospital come from the top 20 local post codes and 88% of inpatient admissions come from the top 20 post codes to Tunbridge Wells Hospital.

The change in distance to travel from each postcode to each site, highlighted in **figures 4 and 5** show the cardiology referral patterns across the catchment area. The red crosses show Maidstone and Tunbridge Wells Hospitals and also Crowborough and Sevenoaks hospitals where cardiology outpatient clinics are held.

Figure 6 and 7 indicate the change in distance and travel time depending on the centralised inpatient site and shows that patients in ME14, ME10, ME9 and ME20 would have considerably further to travel if the centralised service was on the TWH site and patients from TN6 and TN3 the same if the service was to be centralised on the Maidstone site. In terms of travel times public transport for patients from ME14, ME10, ME1 and ME9 would take considerably longer if the site was centralised on the TWH site, and patients from TN8, TN14 and TN16 would have the same issue if the service was centralised on the MH site. More detail is in **appendix 1**

Figure 4: Map of current patient population using cardiology services

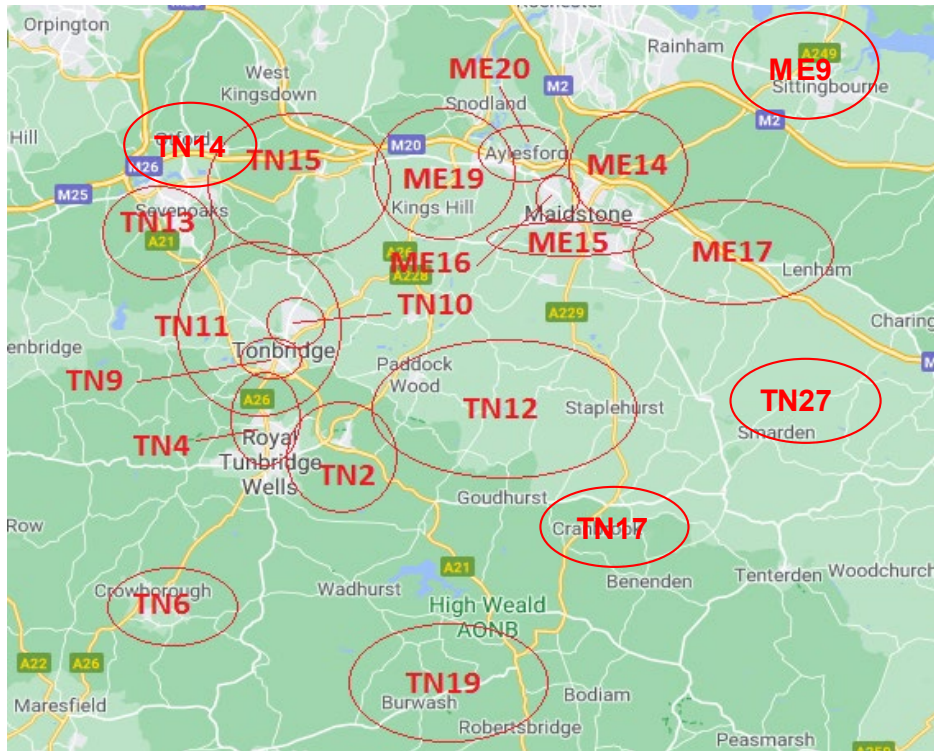


Figure 5: Distribution of Patient Activity

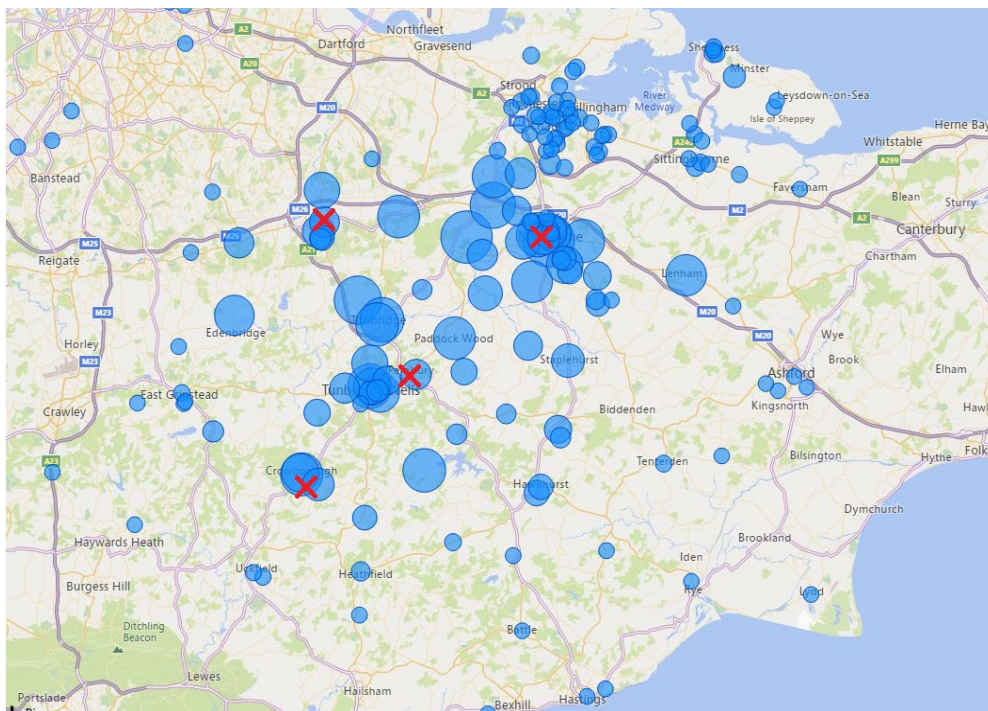


Figure 6: Travel times for both sites from top 20 postcodes for Maidstone hospital inpatients based on 2017-2019 activity

Postcode	% inpatient attendance from this post code	Distance to MH (ME16 9QQ)	Distance to TW (TN2 4QJ)	+ / - to TW	Time to Maidstone by car	Time to Maidstone by public transport	Time to TWH by car	Time to TWH by public transport
ME15	15.75%	3.2	14.6	-11.4	14 min	1 hr 8 min	42 min	1 hr 57
ME14	10.77%	6.5	22.6	-16.1	12 min	1 hr 13 min	36 min	2hr 4 min
ME16	10.60%	1.3	15.7	-14.4	3 min	16 min	30 min	52 min
ME17	9.69%	9.1	20.5	-11.4	17 min	1 hr 3 min	41 min	1 hr 42 min
ME20	7.86%	3.6	22	-18.4	10 min	1 hr	35 min	1 hr 12 min
ME19	6.92%	5.1	13.9	-8.8	15 min	29 min	26 min	1 hr 22 min
TN12	4.29%	10.9	6.7	4.2	25 min	1 hr and 2 min	13 min	36 min
TN15	3.37%	14.2	12.8	1.4	23 min	57 min	24 min	1 hr 6min
ME6	3.34%	6.7	17.5	-10.8	15 min	45 mins	34 min	1 hr 2 min
ME18	2.92%	4.4	12	-7.6	12 min	27 min	22 min	38 min
TN4	1.29%	3.3	15.8	-12.5	35 min	1 hr 2 min	11 min	39 min
TN27	1.26%	15.7	20.7	-5	35 min	48 min	38 min	1 hr and 25 min
TN10	1.23%	6.8	12	-5.2	24 min	1 hr 9 min	14 min	30 min
ME10	1.23%	15.4	31.7	-16.3	25 min	1 hr 30 min	48 min	2 hr 15 min
TN11	1.17%	13.9	7.1	6.8	28 min	1 hr 5 min	17 min	46 min
TN2	1.09%	13.9	0.7	13.2	26min	43 min	4 min	8 min
ME1	1.09%	9.5	22.1	-12.6	23 min	1 hr 44 min	41 min	2hr 28min
TN14	1.09%	19.8	14	5.8	36 min	1 hr 32 min	20 min	1 hr 14 min
TN17	1.06%	17.1	16	1.1	38 min	2 hr 17 min	35 min	1 hr 11 min
ME9	1.06%	13.9	30.2	-16.3	22 min	1 hr 47 min	45 min	2 hr 19 min

Figure 7: Travel times to both site from top 20 postcodes of Tunbridge Wells hospital inpatients based on 2017-2019 activity

Postcode	% admissions from this postcode	Distance to MH	Distance to TWH	+ / - to MH	Time to TWH by car	Time to TWH by public transport	Time to MH by car	Time to MH by public transport
		(ME16 9QQ)	(TN2 4QJ)					
TN2	10.04%	13.9	0.7	-13.2	4 min	8 min	26 min	43 min
TN6	9.47%	25.9	10.7	-15.2	26 min	1 hr 36 min	48 min	2 hr 5 min
TN4	8.83%	15.8	3.3	-12.5	11 min	31 min	35 min	1 hr 2 min
TN12	7.98%	10.9	6.7	-4.2	13 min	36 min	25 min	1 hr and 2 min
TN10	6.68%	6.8	12	5.2	14 min	30 min	24 min	1 hr 9 min
TN13	5.01%	18.8	12.8	-6	20 min	46 min	34 min	1 hr 28 min
TN11	4.93%	13.9	7.1	-6.8	17 min	46 min	28 min	1 hr 5 min
TN9	4.93%	13.3	4.6	-8.7	10 min	19 min	27 min	1 hr 13 min
TN3	4.29%	23.5	7.4	-16.1	21 min	27 min	44 min	1 hr 33 min
TN8	4.11%	26.3	16	-10.3	32 min	55 min	49 min	2 hr 9min
TN5	3.67%	21.3	11.3	-10	28 min	1 hr 6min	42 min	1hr 47 min
TN15	3.59%	14.2	12.8	-1.4	24 min	1 hr 6min	23 min	57 min
TN14	2.90%	19.8	14	-5.8	20 min	1 hr 14 min	36 min	1 hr 32 min
TN17	2.90%	17.1	16	-1.1	35 min	1 hr 11 min	38 min	2 hr 17 min
TN1	2.21%	15.6	2.5	-13.1	8 min	25 min	31 min	1 hr 20 min
TN18	1.67%	19.8	14.3	-5.5	33 min	1hr 19min	41 min	1 hr 38 min
TN16	1.44%	22.7	17.6	-5.1	25 min	1hr 36min	42 min	2 hr 22 min
TN20	1.41%	24.6	11.8	-12.8	26 min	54 min	48 min	1hr 46 min
ME15	1.05%	3.2	14.6	11.4	42 min	1 hr 57	14 min	1 hr 8 min
ME18	0.92%	4.4	12	7.6	22 min	38 min	12 min	27 min

3.3 Current staffing and service provision

The cardiology services are consultant led and all consultants currently participate in a 24/7 Consultant of the week (COTW) rota on each site, which involves daily ward rounds and emergency out of hours advice and treatment. Due to inpatient services being present on both sites this results in 2 COTW rotas having to be in place. This equates to a 1 in 4 rota at Maidstone and 1 in 5 at TWH. The medical team are supported by specialist nurses, cardiac physiologists, radiographers, ward nurses and physiology support staff. The breakdown of current staffing is detailed below in **figure 8**.

Figure 8: Breakdown of staff within current service

Consultants	10 WTE
Associate Specialists	1.0 WTE
Specialist nurses	8.97 WTE
Ward nurses (Inc. CCU)	50.10 WTE
Cath Lab nurses	17.67 WTE
Radiographers	4.0 WTE
Cardiac Physiologists	11.68 WTE
Cardiac Physiology support staff	10.64 WTE
Ward Clerk	2.0 WTE
Admin – Cath lab & Cardiac Physiology	3.0 WTE

There is currently no provision for out of hours catheter lab nurses, catheter lab radiographers or cardiac physiologists. This means out of hours emergency cardiac procedures are currently performed in the emergency theatres at both sites and not the catheter labs. Emergency theatre staff are unfamiliar with these procedures and cases have to be fit around other emergency surgical work which can result in delays. There is no provision for out of hours interrogation or programming of implanted devices (such as pacemakers and defibrillators) which can result in an increased length of stay. The consultant on call rotas are understaffed and weekend in-patient review is limited to CCU patients and urgent referrals, rather than a full ward round of cardiology patients. Echocardiography cover is limited to emergency cases only and is provided by the consultants.

3.4 Case for change

This case for change relates to the provision of inpatient and cardiac catheter laboratory services only. Currently cardiology outpatient services, rapid access clinics and heart failure clinics are provided on both the Maidstone and Tunbridge Wells Hospital sites. In addition, general cardiology clinics are provided at Crowborough and Sevenoaks Hospitals. Specialist arrhythmia clinics are held on the Maidstone site. Non-invasive investigations such as ECG and echocardiography are provided on both Hospital site. The case for change will not impact on the outpatient or non-invasive diagnostic services. The only change will be to provide arrhythmia clinics on both hospital site going forward.

The case for change for the inpatient and cardiac catheter lab services has been driven by the following factors:

- To meet the Getting It Right First Time (GIRFT) recommendations, particularly related to dedicated specialist facilities, COTW cover and access to rapid intervention
- To reduce catheter laboratory treatment delays for inpatients, by eliminating the site transfers
- To reduce the dilution of services due to necessary duplication across two sites
- The ability to deliver the Trust clinical strategy
- To improve efficiency and increase capacity
- To support flow, it the organisation
- To improve recruitment and retention, particularly within Cardiac Physiology

A cardiology GIRFT report published in February 2021 recommended 25 standards for services to meet. MTW are non-compliant with 9 of these recommendations (detailed in **figure 9** below), 7 of which relate to inpatient management, and are partially compliant with 4.

Figure 9: Non-compliant MTW GIRFT requirements

	GIRFT Recommendation
1	All hospitals must deliver cardiology services as part of a defined and agreed network model.
2	All hospitals receiving acute medical admissions must have a consultant cardiologist on-call 24/7 who is able to return to the hospital as required. There should be a consultant job planned specifically to review newly admitted and acutely unwell inpatients 7/7 and a consultant job planned (note this may be the same consultant) to deliver 7/7 review of other inpatients, ensuring continuity of care. This requires a minimum 1 in 6 consultant rota
4	All members of the wider heart team should be supported to work in extended roles and trusts should ensure that appropriate staff (including ACPs, specialist nurses and cardiac physiologists) are trained, accredited and authorised to prescribe medications relevant to their role.
5	Each network must ensure that there are clearly defined patient pathways covering all acute hospitals for the provision of 24/7 emergency temporary pacing and 7/7 permanent pacing.
7	Networks should ensure that stable chest pain pathways are consistent with the recommendations of NICE CG95. Invasive angiography should, as a default, be performed as 'proceed' and must be performed in PCI-enabled Cath lab by a PCI-trained operator.
8	Networks must ensure that all hospitals performing PCI have a 24/7 on-site rota for urgent return to the Cath lab.
10	For the acute chest pain pathway, all networks should provide 7/7 ACS lists, accessible to all hospitals in the network. Coronary angiography 'proceed' should be performed within 72 hours for patients without high risk features, within 24 hours for high risk patients and within 2 hours for the highest risk patients. Where cardiac surgery is required, this should by default be undertaken within seven days of coronary angiography.
11	In each hospital there should be a specialist consultant lead for HF, supported by a multidisciplinary HF team. Secondary care services should be integrated with community teams, with regular joint multidisciplinary meetings (MDMs). (<i>this will be resolved when a new consultant joins the team in December 2021</i>)
15	Networks should ensure that all hospitals admitting acute cardiology patients have 24/7 access to emergency echo including the facility for immediate remote expert review as required. Elective/urgent echo should be routinely undertaken 7/7. Urgent TOE should be available 7/7 and delivered on a network basis).

See **appendix 2** for full breakdown of all GIRFT recommendations along with MTW's action plan for each.

Aligned to this, GIRFT outline the essential base level services required at each hospital admitting acute cardiology patients as follows:

- Coronary care unit (CCU) or equivalent high dependency unit (HDU)
- Dedicated (ring-fenced) inpatient beds
- 24/7 consultant on-call (at a minimum 1 in 6 frequency)
- 7/7 cardiology consultant ward review for all cardiology inpatients

- 24/7 emergency echocardiogram provision and review (including virtual review) and 7/7 elective/urgent echocardiography

The current service provides a limited 7-day service which would need extending to deliver the GIRFT standard. There is a CCU on each site but cardiology patients are managed in a medical bed base where beds are nominally but not exclusively designated for subspecialty patients.

The importance of cardiac patients being admitted to cardiology wards and benefitting from optimum cardiac monitoring and access to highly trained cardiac nursing staff has been highlighted in both the MINAP audit data and NCEPOD Failure to function report. European Society of Cardiology Guidelines advise that patients with NSTEMI should be admitted to a monitored unit – coronary care, intensive care or intermediate care depending on risk – and managed by personnel adequately trained to manage life-threatening arrhythmias. Whilst no national standard has been set for admission to a cardiac ward following a NSTEMI, MINAP has recommended a target of 80%. The proportion of NSTEMI patients admitted to a cardiac ward at Maidstone was 28% and 66% at Tunbridge Wells (before the TW CCU ward was moved to a smaller bed base).

In line with GIRFT requirements, there is a need to extend the current service to a 7-day service provided specifically for cardiology to improve quality and efficiency of the service but not impact on ease of access for patients. The 7-day service will include the provision of diagnostic and treatment (Catheter Lab) services being available when required to ensure the patient flow is maintained. There is currently a 1 in 4 COTW rota in place. In order to meet the GIRFT recommendation of a minimum 1 in 6 COTW would be required.

There is a delay within the current service for inpatients requiring Cath Lab interventions due to site transfer required for EP, complex pacing and coronary intervention procedures. To improve efficiency there needs to be a decrease in the site transfer dependency and the availability of specialist beds to support effective patient pathway to reduce fragmented care and less than optimum patient experience. The Myocardial Infarction National Audit Project (MINAP) confirms that Maidstone & Tunbridge Wells does not currently meet the NICE quality standard (QS68) providing coronary angiography within 72hours of admission for patients admitted with a NSTEMI heart attack (non-ST elevation myocardial infarction).

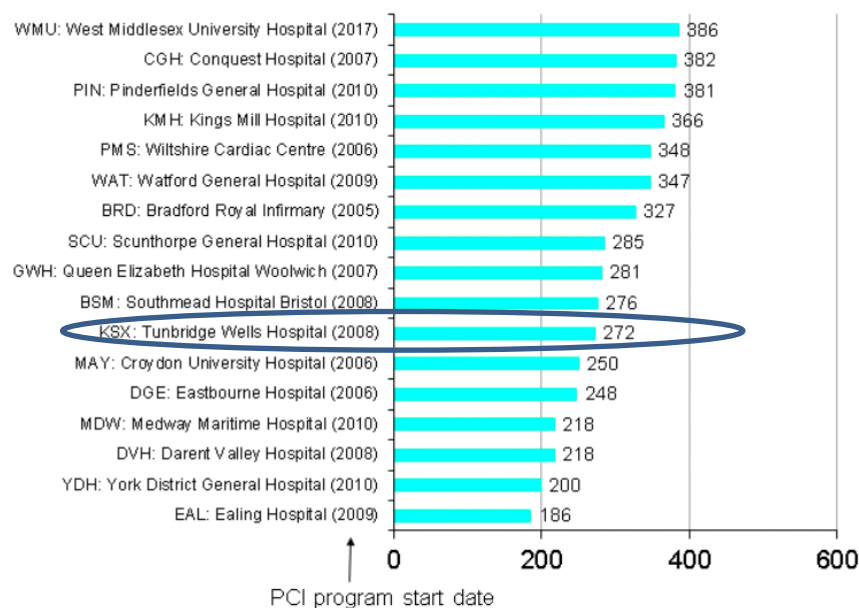
The Cath Labs are also impacted by busy periods during the year, such as winter escalation, when the catheter lab recovery beds are used as escalation beds due to being adjacent to the medical ward, resulting in the cancellation of elective catheter lab cases. At Maidstone during 2019, escalation resulted in the cancellation at short notice of the majority or entire elective lists on 5% of normal working days.

In addition, in 2019 at Maidstone, a further 21 elective lab sessions per year were reduced or cancelled due to COTW commitments, with the on-call consultant covering the lab for inpatient work and emergencies instead. GIRFT has explicitly stated that on call consultants need to be freed from all other duties to provide effective on call cover. Expansion of the consultant staff and pooling to one site would permit better cover for lab sessions by non-COTW consultants, resulting in a reduction in cancellation of elective cases.

The current service also has implications for national standards. Current recommendations from the British Cardiovascular Intervention Society (BCIS) are that centres should perform more than 400 coronary angioplasty (PCI) cases a year. In the 2019 summary from NICOR (National Institute for Cardiovascular Outcomes Research), summarised below in **figure 10**, it shows that MTW currently sits 101st out of 108 centres (2017/2018 data) and the three West Kent hospitals performing PCI (Darent Valley, Medway and Tunbridge Wells) all sit in the lowest performing seven. Any future national review of PCI services would likely highlight West Kent as an area that requires rationalisation and in our current configuration we would

potentially be vulnerable to this and risk losing services. A reconfigured service would be more robust to such a review.

Figure 10: NHS Centres performing <400 coronary angioplasty cases per year (Lifted from 2019 NICOR summary)



In 2016 the recovery area at TWH was significantly reduced, following a move from a recovery ward with 14 trolley spaces, to the radial lounge with 4 recovery chairs available. The loss of recovery beds impacted the throughput of the lab, particularly those requiring longer recovery times such as angiograms. This, added to the downtime on the MH site due to winter escalation has seen the cath lab activity fluctuate during the year and lead to procedure cancellations.

Recruitment & retention has been issue, particularly for the cardiac physiology team. There is a national shortage of cardiac physiologists as outlined in the strategic review of cardiac physiology services in England. This makes it extremely difficult to recruit qualified & accredited staff. Such high demand had led to cardiac physiologists being able to secure high paid locum placements, which has made permanent contracts with NHS organisations less attractive financially. During 2019 there were several attempts to recruit with minimal success.

MTW applied a recruitment and retention premia (RRP) for all band 6 and above cardiac physiologists to attract and retain staff to the trust in December 2020. This has improved the recruitment, however there continues to be vacancies and retention issues. A more dynamic service, improved service provision and a development strategy would make the MTW service more attractive and improve recruitment.

The Trust clinical strategy, **appendix 3**, aims to focus the cardiology services on to one site, with future aspirations of becoming the second primary PCI centre in Kent. The clinical strategy currently states Maidstone as the centralised site, however options for both sites are being considered as part of the staff and public engagement process.

3.5 Activity Growth

Kent County Council estimates a 16.5% increase in population over the next decade. Current 20% of resident are over 65 and KCC project a 39% increase in this age group over the next 10 years. Population growth and growth in the over 65 age group will increase demand on cardiology services.

Figure 11 below outlines the potential growth in the cath lab activity projected to 2025. 2020 is missing from the table due to the distorting effect of COVID.

Figure 11: Cardiac Cath Lab Expected Activity to 2025

Procedure	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
CIED	379	313	572	468	508		550	568	587	607	627
ILR (M)			116	101	104		107	108	109	110	111
ILR (TW)			59	64	42		55	56	57	58	59
EP	74	90	157	80*	84*		200	224	252	283	317
Angiography (M)	484	419	486	449	367		434	438	443	447	452
Angiography (TW)	559	564	648	640	556		615	621	627	633	640
Angioplasty (TW)	249	254	267	266	283		272	275	277	280	283

* Note cardiac physiologist staff shortage and equipment breakage negatively impacted procedure numbers in 2018/2019 and this is not a true reflection of activity

CIED (cardiac implanted electronic devices) procedures are overwhelmingly performed on people over 65 and the expected growth in figure 11 reflects the predicated population change. National demand for EP procedures (RF Ablation) is increasing by 4% per annum. In 2021 MTW started complex ablation procedures and repatriated 50 complex ablation patients from the current waiting list usually sent to St. Thomas' Hospital. Medway started referring a proportion of simple EP procedures to MTW in 2019 rather than sending them to London and the growth in EP in **Figure 11** represents a realistic estimate of growth based upon demographic changes, and in line with procedure numbers per capita rate compared to similar DGHs. This does not include the potential growth if Darent Valley or Medway repatriated a proportion of their complex cases to us from London which would give another opportunity for growth. Growth in angiography is based upon demographic growth and does not include the potential for additional growth based upon providing angiography at weekends for in-patients at Medway/Darent. The biggest growth potential with the largest financial impact would be the provision of PPCI.

Echocardiology activity for both in and outpatients has been circa 11,000 a year as an average over 3 years. This did decrease by 20% during COVID but is anticipated to increase from 2020 to 2021 by 40% to 14,000 echos per annum. The echo waiting list is currently 2255 and is anticipated to increase as indicated with growth for 2021 and beyond if the trend continues. Without extra capacity the reconfiguration will facilitate there will be an impact on waiting times for 2-week wait pathways, inability to deliver the heart failure 6-week target, delay to cardiology diagnoses and risk to patient outcomes.

Other growth is likely to come from population growth non-elective increases in activity which will be delivered through efficiency gains from 7 day working. This will also create capacity to manage the flow of any changes in referral patterns, and potentially provide weekend working for West Kent patients at centres that do not provide 7-day cover.

Activity increase will also come from the future aspiration of PPCI. Single site working with the commensurate support services as outlined by GIRFT would be required to deliver this.

3.6 Proposed service changes

Considering the drivers for change, the proposed changes are as follows:

- A **'hot'** site for acute cardiology patients, consisting of:
 - 22 bedded dedicated cardiology specialist ward
 - 12 bedded CCU
 - Acute cardiology assessment unit of 4 trolleys open from Monday to Friday 08.00 – 20.00 (ACAU) to support management of flow and reduce demand on ED
 - 2 collocated cardiac catheter labs (one specialising in intervention procedures and 1 for EP and complex devices), for both elective and emergency procedures
 - Recovery ward with 12 trolleys, remote from ward areas

- A **'cold'** site for patients with less complex cardiac conditions, consisting of:
 - Monday – Friday morning ward rounds by a designated consultant for ward referrals
 - 24/7 on-call telephone service provided by one COTW, based on 'hot' site for acute advice.
 - OP clinics, physician and nurse led, and non-invasive diagnostic tests will continue to run on both sites and other locations

The main changes to the service will affect patients who require procedures within the catheter lab and those who require an inpatient stay, where there is already an element of travel dependant on the condition being admitted for. Mitigations are in place to ensure all patients are managed in the most effective way, causing the least disruption. These include outpatient clinics to remain on both 'hot' and 'cold' sites, as well as outreach sites such as Sevenoaks and Crowborough. In addition, there are robust transport links to, and between, both hospital sites, with ample visitor parking.

ACAU will be a nurse led service, adjacent to the ward, in order to help flow from ED. This will ensure all patients are seen and treated by the most appropriate clinician, in the most effective, timely way.

The changes will ensure skills and facilities are consolidated on to one site to ensure the most effective clinical pathways for the most complex cardiology conditions. There will also be a robust transfer protocol, agreed by clinicians and external parties involved (e.g. SECAMB), to ensure patients on the 'cold' site are managed safely, quickly and appropriately for their condition.

3.5.1 Activity and Bed Modelling

The beds required for a specialist unit, has been calculated using an average of three years data from 2017 – 2019. 2020 was excluded as this was distorted as a result of the COVID pandemic. ICD10 codes were used to identify the circulatory diseases admissions. A clinical exercise was undertaken to determine confirm the patient requiring specialist cardiology care. Based on the activity data and assuming the same AvLoS this would require 40 beds on the 'hot' site including CCU. This assumes a 100% occupancy. with a 12 bed CCU and 28 bed split. Adding a 1-day AvLoS efficiency reduction would reduce the overall number to 30 beds which includes 12 CCU beds. The remaining 18 ward beds assumes a 100% occupancy. Reducing this to 85% requires 22 beds. This is outlined in **figure 12**.

Figure 12: Cardiology Coded Admissions Data – Bed Numbers Required for a Cardiology Specialist Unit.

DESCRIPTION	TOTAL	MH	TWH
Total annual activity	3731	1773	1958
Activity per day	10.3	4.9	5.4
Average length of stay (AvLoS)	3.9	4.1	3.7
Bed days used	14551		
Beds currently used	40		
<i>of which CCU</i>	12		
<i>ward beds usage</i>	28		
AvLoS if efficiency reduction of 1 day	2.9		
Efficiency bed days required	10820		
Beds required	30		
<i>CCU beds</i>	12		
<i>ward beds required (assumes 100% occupancy)</i>	18		
<i>ward beds required (at 85% occupancy)</i>	22		

3.7 Staff and Public Engagement

The Trust recently presented the need for change to the local Health Overview and Scrutiny Committee (HOSC). The divers for change were outlined and the need for changes supported by HOSC in line with the Kent and Medway Joint Strategic Needs Assessment (JSNA) and the Health and Wellbeing Strategy (HWBS) both of which recognise the need for specialist provision in facilities with the best expertise to manage care which may mean an increase in journey time for some. The HOSC considered the change being proposed as not a substantial variation of service and a three-month public engagement process will run from 18th October 2021 to 11th January 2022.

Pre-engagement work with staff and public has highlighted common themes around concerns and potential improvements to the cardiology service.

A staff survey was responded to by 129 people, 63% of which work directly with cardiac patients. A summary of staff responses is in **figure 13**.

Figure 13: Themes from staff pre-engagement survey

Thoughts on current service:	Suggestions for development
Disjointed service	Addition of relative & staff break out rooms
TWH CCU not fit for purpose	Centralised service to be 'centre of excellence'
TWH Cath Lab recovery not fit for purpose	Additional staff recruitment
Access to services on each site limited (EP and stents in particular)	Dedicated cardiology beds
Site transfer for patients cause delays to treatment	Future development for PPCI service
Concerns for staffing levels	Protected recovery beds harder to escalate to
Equipment available for services	Increase cath lab activity and utilisation
Service currently provided not full 24/7	Development of 24/7 service

Cath lab utilisation	
Limited number of dedicated Cardiology beds	

Public pre-engagement was undertaken on behalf of the Trust by EK360 who used a number of methodologies to reach out to the local population as follows: -

- Face to face discussions with current inpatients at both hospitals (31 patients)
- Interviewing people who use cardiology outpatients (25 telephone interviews)
- Listening to people within small focus group settings about their experience (13 people)
- Offering an on-line survey to capture a wider view (151 responses)

In total the pre-engagement work captured feedback from 220 people. On the whole experiences were positive but a few key themes emerged regarding hospital treatment: -

- Rushed appointments
- Poor explanations and dismissing patient and family concerns
- Lack of information about what is going on and timescales for treatment
- Not feeling reassured or listened to
- Post discharge follow up issues regarding advice about communication, advice, GP correspondence, delays in getting a follow up
- Poor psychological support – would like a Macmillan cancer model to support patients in the community
- No information and access to medical staff over a weekend
- Waits for procedures
- Moving between sites
- Difficulty traveling to and between sites due to poor public transport and poor parking
- Difficulty travelling further if the service should move.

See **appendix 4** for the full report.

Both sets of feedback will support the development of the public engagement process which is being supported by Hood Woolf specialists in public engagement and communication who will work closely with the Trust communications team.

4.0 Economic Case

There are 4 options being considered, taking in to account both hospital sites, revenue and capital financing options. The revenue increases for staff are driven by the GIRFT standards and seek to provide a sufficient level of service with the dedicated expertise to improve quality to the recommended GIRFT standards. The equipment options seek to improve the equipment provision and streamline consumables to deliver increased value for money and increased service efficiency; the revenue and capital impact of each equipment options will be determined via the current procurement process. The estates capital costs seek to deliver GIRFT standards and improved efficiency.

4.1 Summary of options:

1. Option 1: Do nothing
2. Option 2: Internal reconfiguration at MH
3. Option 3: Internal reconfiguration at TWH
4. Option 4: Part new build / part internal reconfiguration at MH

An option proposing an element of new build on the TWH site was considered. The programme has been advised by the estates team that this is not viable as there is no space

to expand out of the current TWH footprint to build a new cardiac catheter lab. On this basis this option has been discounted.

4.1.1 Criteria for options evaluation

Options will be assessed against the following Critical Success Factors:

- I. Meet non-compliant GIRFT recommendations in full
- II. Provide more efficient and integrated approach to patient care
- III. Improve patient flow and patient experience.
- IV. Deliver value for money
- V. Create capacity to support the Trust clinical strategy aspiration.
- VI. Travel for patients within catchment area to be accepted by public.
- VII. Clinical acceptability – must be accepted by the clinical team as a reasonable and safe adjustment to the service
- VIII. Sustainability
- IX. Achievability

A high-level review of the options against the criteria is summarised in **figure 14**. The scoring assumes 1 is not compliant and 5 is compliant with the evaluation criteria. The scoring assumes equal weighting of each of the criteria at this stage.

Figure 14: Overview of options

Options	GIRFT recommendations	Efficient and integrated care	Patient flow and patient experience	Value for money	Support clinical strategy aspirations	Travel acceptability	Clinical acceptability	Sustainability	Achievability (Inc. timescale)	TOTAL
1. Do Nothing	2	2	2	2	1	5	2	1	4	21
2. Internal Reconfiguration at Maidstone Hospital	5	5	5	4	5	3	4	4	3	38
3. Internal Reconfiguration at Tunbridge Wells Hospital	4	4	4	1	5	3	4	3	1	29
4. Part new build/part internal reconfiguration at MH	5	5	5	2	5	3	4	4	2	35

5.0 Financial Case

The service costs £12.98m per annum which includes £2.6m fixed overheads with these costs covered by the block arrangement with the CCG. Whilst the need to increase staffing and provide the cardiology facilities to deliver the GIRFT requirements will have a cost, the efficiencies gained from new facilities and new ways of working will provide opportunities for increasing capacity and therefore activity and income which will require negotiating within the contractual arena.

5.1 Revenue Costs

The main impact on revenue will be increased staffing to meet the GIRFT requirements, as detailed in **figure 15** below. The bed assumptions should reflect no increase in ward staffing however the ability to pull costs out of the baseline budget for the division will need consideration to determine whether the centralisation of the cardiology inpatient beds could be cost neutral. The staff required to deliver the GIRFT standards include cardiac physiologists, radiographers, consultant cardiologists, catheter lab nursing staff and increased CCU nursing to national levels to meet the minimum GIRFT standards for provision of a 7-day service and a dedicated specialist ward. The 7-day service will be provided 8am – 6pm Monday – Friday and 9am – 5pm Saturday and Sunday, with 24/7 emergency catheter lab access on an on-call basis for all staff groups. Added to this there is likely to be a small increase in non-pay for IT equipment and maintenance, and consumables usage in line with any increase in activity.

Figure 15: Additional staff requirements

Staff Group	Grade	Current	Proposal	Difference
		WTE	WTE	WTE
Medical Staff	Consultant	10.00	14.00	4.00
	Specialty Dr	1.00	2.00	1.00
	Medical Secs		2.50	2.50
Cardiac Physiologist	Cardio-Resp	28.29	38.29	10.00
Nursing	Ward and CCU	50.1	71.60	21.5
	Cath Lab and recovery	17.67	25.10	7.43
	ACAU	0	4.97	4.97
	CNS	11.03	11.03	0.00
Radiographer	Radiology	4.00	12.00	8.00

The cost implications of the changes are details in **figure 16** and represent:

- The GIRFT costs of a 7-day cath lab service (12 hours per day), out of hours on call services to give 24/7 cover and cover for complex pacing and intervention procedures. This includes medical staffing, cardiac catheter lab nursing, physiologists and radiographers in order to ensure there is adequate staffing to open cath labs routinely at the weekend and out of hours on call for emergencies. This will contribute to reduction in the wait for urgent procedures and commensurate length of stay reduction for emergency patients as the increased service provision will increase turnover. It will also improve the consultant rota from the current 1 in 4 to the minimum recommendation of 1 in 6. The increase will enable all other disciplines to deliver the extended service outlined by GIRFT. The additional physiologists will also ensure there is a 7-day echo service for all inpatients.
- The increase in nursing costs for the cardiac catheter lab extended hours

- The ward staffing implications for a specialist unit of 22 beds. These beds are in use within the medical bed base currently so could be considered already in use. The mechanism for pulling out funding to support the centralised site would need to be confirmed. The increase in CCU nurse staffing to a ratio of 1:3.
- Staffing of a 4 trolley Acute Cardiology Assessment Unit to allow faster access for patients from ED at the hot site and direct admission to the ACAU for patients being transferred from the cold site. This will support flow and is in line with the direction of developments in both stroke and frailty in the Trust
- Appropriate skill mixes for each discipline (electrophysiologists, radiographers, nursing)

Figure 16: Summary of additional staffing costs

Ward staffing	Staff Impact (wte)	Financial Impact (£000s)
22 ward beds	21.50	836
12 CCU beds		
1 cardiology acute assess unit (ACAU) - 4 trolleys (8-8 Monday to Friday)	4.97	247
Total Ward Staffing	26.47	1,083
7/7 Rota Staffing	Staff Impact (wte)	Financial Impact (£000s)
Consultants	4.00	513
Specialty doctor	1.00	88
Cath lab and recovery nursing	7.43	399
Medical Secretaries	2.50	74
Physiologists	10.00	757
Radiographers	8.00	473
Total 7/7 Rota Staffing	32.93	2,304
GRAND TOTAL	59.40	3,387

The costs would be partially mitigated by delivering benefits in efficiency as follows: -

- A minimum length of stay reduction of circa 1 day to 2.9 days
- Funding the CCU increase, the ACAU development and bed requirements from escalation funding within the division as the reconfiguration will release and condense capacity
- Faster turnaround of procedures to create capacity for increased activity to reduce waiting lists and develop services in the future and increased activity and income to be negotiated in contractual arrangements
Capacity created to manage a more complex case load and thereby create the ability to increase income

- Improved recruitment and retention will reduce expensive agency costs, whilst physiologists and specialist radiographers are very difficult to recruit, without a robust and attractive service all recruitment to the services is likely to be challenging.

5.2 Equipment and Consumables Management

Up to date equipment and facilities are required to support efficiency in throughput, productivity and clinical outcomes. Cardiology has an ageing stock of medical equipment a significant element of the equipment is now outdated. Technology improvements improve patient outcomes through improved efficiency and improved performance. The absence of an adequate replacement strategy means that the service risks the efficiency of the service and impact on patient outcomes. Increased use to deliver a 7/7 service will put more pressure on ageing equipment. The equipment assets are estimated in the tables below. **Figure 17** details the total assets and **figure 18** the expired assets in each department.

Currently the asset register's value is estimated at £4.2 million, with £1.5 million stock having expired its recommended life span. More work is underway to confirm the total cardiology assets for a potential equipment service in the future.

Figure 17: Overview of total assets

Total items on asset register	468
Total value of asset register	£4,225,965.72
Expired equipment	175
Value of expired equipment	£1,503,682.76
Expired stock over £5k	40 *
Value of stock over £5k	£1,359,194.98

* See figure 18 for breakdown of site / department of expired equipment

Figure 18: Overview of expired assets over £5k

Department	Total cost	No of items
Cardio respiratory MGH	£57,308.80	4
Cardio respiratory TWH	£254,097.00	5
Cath Lab (MAI)	£820,696.80	12
Cath Lab (TWH)	£118,272.12	9
CCU (MAI)	£76,947.06	6
CCU (TWH)	£24,088.40	3
Culpepper Ward (MAI)	£7,784.80	1

As part of the reconfiguration the case will include equipment procurement, support and provision of consumables, consumables management, equipment management and maintenance, and identification of savings schemes. The aims are to: -

- provide quality seamless, efficient and responsive service to clinicians
- enable high quality patient care
- provide significant financial benefits
- facilitate the most effective use of cardiac catheter laboratory, cardio respiratory services, and supporting CCU and cardiology beds in the delivery of healthcare pathways
- optimise rationalisation and associated savings on consumables and equipment replacement costs
- deliver IT infrastructure improvements to increase efficiency, workflow and audit

The options for this provision are: -

1. To continue with the current process where the Trust manages equipment via the asset register, updates equipment as required or as affordable and manages maintenance and consumables contracts separately within the service revenue budgets.
2. To work with private provider to establish a cardiology and cardiac catheter laboratory equipment and consumables managed service agreement with a third-party provider to support cardiology services.

Option 1 will require the Trust to continue with current management and practice relating to equipment and consumables management via the current capital and revenue routes. This is a risk due to the lack of available capital and the age of the current stock of equipment.

Option 2 requires the procurement of a total managed service which also allows optimisation and rationalisation to deliver associated savings on consumables and equipment replacement costs.

The commercial case (section 6) outlines the Trusts approach and the aim is to work with providers to deliver this service by 31st March 2022 as an operating lease under the current financial rules. Work is ongoing to determine the costs and benefits which will include circa £350k on VAT savings however the timescale is tight for delivery of a new service by the deadline.

A consideration regarding equipment is the pending financial accounting rules change relating to the financial management of managed services as revenue. Currently the rules (IFR4 and IAS17) allow for this. From April 2022 the accounting rules change (IFRS16) and require all managed services whether operational or financial to be classed as capital on balance sheet. Given the timescale it is unlikely that the expired equipment to be replaced will be in place by 31st March 2022. This sum will therefore be allocated to capital.

The current consumable revenue costs are circa £2.5m per annum. If included in a total managed service these would impact on the total value of the business case overall but the costs of consumables do not increase and is likely to reap savings.

5.3 Capital costs of estate enhancement

Three of the four options will have a capital impact and vary according to the site and scale of the scheme as follows: -

Figure 19: Estimated capital build costs:

Options	Capital build requirements	Capital Costs	Impact
Do Nothing	0	0	Inability to meet all the GIRFT requirements without larger staff costs and inefficiency. inability to deliver the Trust clinical strategy
Internal Reconfiguration at Maidstone Hospital	Development of SSSU into 2 cath labs, with recovery, a procedure room and pre-assessment facilities. The development of the Cornwallis into a 12 bedded CCU and Cornwallis into a specialist ward. The development of cardio respiratory service and supporting offices in the current cath lab space	£5m (estimated)	Would support deliver of the Trust objectives and GIRFT objectives. Cath lab and ward areas are split. Could be delivered within 6 months dependent on other site developments
Internal Reconfiguration at Tunbridge Wells Hospital	Create a second cath lab and 12 recovery spaces using space adjacent to the current cath lab and the current CCU area.	£13.64m (actual)	Would give sufficient cath lab and recovery space but a ward and CCU base would have to be found from the current bed base. Timescale for delivery would be prolonged due to planning consent and legal processes for the PFI. This cost does not include the conversion of a clinical area to CCU. Costs include £7.5m construction, £3m PFI costs, £2.93m life cycle costs.
Part new build/part internal reconfiguration at MH	New cath lab and recovery at the back of the current cath lab. Current cath lab remains. Cardiorespiratory area could be developed but would result in no office space. The ward area and CCU as per option 2.	£8m (estimated)	Would deliver the Trust and GIRFT objectives and all services collocated. Would lose all office space. Planning permission would be required which would elongate the timescale for delivery

5.4 Summary of financial impact of options

An overview financial impact of each of the four options are detailed below in **figure 20** which highlights the one financial difference in all cases relating to capital build requirements:

Figure 20: Financial Options Appraisal

Options	Pay increase £000s	Total Managed Service (revenue p.a. and total over 7 years) £000s (offset against current budget)	Total Managed Service (capital year 1 est.) £000s	Capital building (est.) £000s	Interdependencies/ impact
Do Nothing	0	0	1,500	n/a	Commitment to equipment replacement of £1.5m in 2022 would be required
Internal Reconfig at Maidstone Hospital	3,387	2,500 (17,500)	1,500	Circa 5,000	Barn theatre development to vacate SSSU Confirm site flow arrangement for escalation as Cornwallis will not be available Move of endocrine inpatients to Pye Oliver ward enabled by the DDU moves
Internal Reconfig at Tunbridge Wells Hospital	3,387	2,500 (17,500)	1,500	13,640	Reconfigure the TWH bed base to develop co-located CCU and 22 bedded specialist ward. Clarity impact on flow on the busiest ED site
Part new build/part internal reconfiguration at MH	3,387	2,500 (17,500)	1,500	Circa 8,000	Confirm site flow arrangement for escalation as Cornwallis will not be available Move of endocrine inpatients to Pye Oliver ward enabled by the DDU moves

In building the financial case the following items have been considered:

1. No option can be fully progressed until the 3-month public engagement process has been completed in January 2022

2. Estates costs for two of the options at this stage are estimates as the estates team are working with a Quantity Surveyor to confirm costings for the proposed changes including planning consent and associated legal costs and fees. These will be confirmed in the OBC
3. Equipment replacement is central to the plan but could be progressed in parallel as a separate case
4. The £2.5m consumables budget is currently in the divisional budget
5. Consideration is being given to an operating lease for the provision of the cardiology equipment and consumables to be delivered before April 2022. This would mean part of the case could be managed as revenue and thereby not be required to call on the NHS capital resource. As outlined above to deliver an operating lease as revenue would require the Trust to enter into this arrangement in the 2021/22 financial year
6. No capital building could be allocated to revenue in either year, with the only possible exception being the use of a mobile cardiac catheter lab which is clinically unacceptable to the cardiologists
7. Co dependencies and need to move other services to facilitate any of the options.
8. If the total cost of the case regardless of which estates options is determined is over the £14m threshold NHSE/I approval will be required

6.0 Commercial case

The model the Trust is going out for is a Total Managed service which incorporates all equipment, consumables, maintenance, business development and lean consultancy. Whilst it could include build costs but given the change in accounting rules on 01/04/22 this is undesirable and any estates work will remain out of scope. This will not include staff.

This contract will be let via the SBS framework for Managed Clinical Services – Lot 1.

We have issued a Capability Assessment to all suppliers on the framework from which we intend to shortlist down to a maximum of 3 to be invited to tender.

There are also currently VAT implications if the deal is structured correctly in that it can all be claimed as a service rather than purchasing of equipment and consumables, which means we can claim the VAT back on those elements (worth approximately £350k per annum).

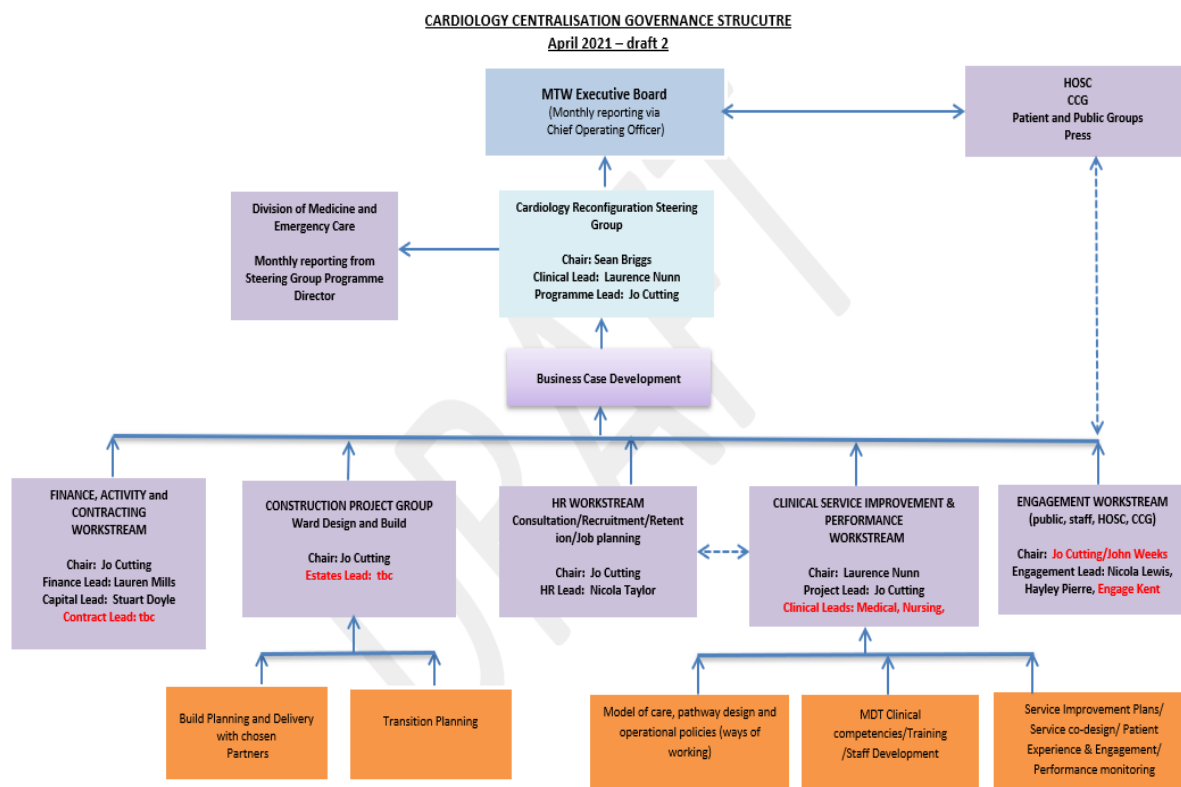
7.0 The Management Case

7.1 Programme structure

Figure 19 below illustrates the governance structure with regard to the delivery of this project. The reconfiguration of Cardiology services will be clinically driven via the Cardiology Reconfiguration Steering Group chaired by and report to the MTW Executive Board through the Chief Operating Officer. The Steering Group will provide overarching governance and assurance and will support the following sub groups (outlined in the governance chart below. All groups have memberships and terms of reference.

- Communications Workstream including internal and external consultation
- Finance and Activity Workstream
- Estates Workstream
- HR Workstream
- Clinical Service Improvement Workstream (to include clinical pathway development)

Figure 21: Cardiology Reconfiguration Governance Structure



7.2 Project management arrangements

Steering Group – Roles & Responsibilities

The cardiology reconfiguration steering group is responsible for the governance of the Cardiology Reconfiguration Programme to deliver a single site cardiology service in line with GIRFT recommendations to include:

- a second cardiac catheter lab on the chosen site
- dedicated and ringfenced cardiology and CCU beds on the chosen site
- a robust pathway for both ambulance and walk-in patients to ensure stable transfers to the preferred site
- a chosen site with robust facilities for the range of diagnostic service required to support the inpatient service

The purpose of the steering group is to:

- Identify and manage risks and ensure appropriate mitigation plans are in place.
- Implement the governance structure, terms of reference and membership of the workstreams and consider progress reports and updates from the workstreams.
- Ensure appropriate monitoring arrangements are in place to quickly identify problems or concerns within the programme and ensure rapid remedial action
- Direct, monitor and review the programme delivery plans for each of the workstreams listed above

- Ensure that the project is delivered within the timeline identified
- Deliver appropriate and accurate communication with all internal and external stakeholders throughout the programme
- Oversee the necessary service changes and developments to ensure the service best fits the needs of the patient group.

7.4 Outline project plan and timetable

The overall project plan will be worked up in more detail in the Outline Business Case and will be dependent on the options evaluation after the public engagement phase of the programme.

7.6 Business assurance and benefits realisation arrangements

The benefits identified within the Strategic Outline Case will be monitored throughout the development of the scheme, via project evaluation reviews (PER) and post implementation reviews (PIR), to maximise the opportunities for them to be realised.

7.7 Risk management and contingency plans

The project uses a standard MTW risk matrix scoring to develop a project risk register. The risk register will be developed as part of the OBC.

7.8 Arrangements for post project evaluation

Post Project Evaluation (PPE) will be undertaken to improve future project briefing, project management, and implementation for future projects. It will also be used to measure the performance of the completed facility against the benefits identified within this Business Case.

8.0 Appendices

Appendix 1 – Travel Time Analysis



Appendix 1
Cardiology service c

Appendix 2 – GIRFT Report



Appendix 2 - GIRFT
recommendations, N

Appendix 3 – Clinical Strategy



Appendix 3 - MTW
Clinical Strategy.jpe

Appendix 4 – Public Pre-Engagement Feedback



Appendix 4
Cardiology Pre-cons

To approve the Outline Business Cases (OBCs) for the new Picture Archiving and Communication System (PACS) and Radiology Information System (RIS)	Director of IT; and Radiology Transformation Programme Manager
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Please find enclosed the Outline Business Cases (OBCs) for the new Picture Archiving and Communication System (PACS) and Radiology Information System (RIS). The Trust Board is required to approve the OBCs, so the Finance and Performance Committee will therefore be asked, at its meeting on 26/10/21, to consider the OBCs and recommend that the Trust Board gives its approval. The outcome of the review by the Finance and Performance Committee will be reported to the Trust Board after the Committee's meeting.

The OBCs for the Kent and Medway Imaging consortium will take forward the project to replace the Picture Archiving Communication System (PACS) and renew the contract for the existing Radiology Information Service (RIS).

The current GE contract for the KMMIC (Kent and Medway Medical Imaging Consortium) PACS and RIS is due for renewal in June 2023.

Over a 10 year contract the investment is expected to be around £30 Million split between the KMMIC Trusts, the split will be calculated on the size of the population and the number of images and storage required per trust.

Picture Archiving & Communications System' (or PACS) is the term used to describe an IT system used to acquire, store and retrieve digital images. It is most often, but not exclusively, used to manage digital X-Rays, CT's and MRI's and, in conjunction with a Radiology Information System (or RIS), to schedule, report on and share images either within an organisation or across a wider clinical network.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 05/10/21
- Finance and Performance Committee, 22/10/21

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

1. To approve the enclosed Outline Business Cases and full tender process
2. To inform the Trust Board that the Full Business Case will be circulated for approval in February/March 2022.

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



**Transforming
health and social care**
in Kent and Medway

KMMIC PACS and RIS Replacement

Outline Business Case MTW

Strategic Outline Case

- Current GE contract ends in June 2023. A chance to use improved technology and AI capability
- Sharing images image and Radiology documents with Dartford and Gravesham NHS Foundation Trust as we are all part of the Imaging Network (KMIN) Allowing seamless transfer of images across the whole of Kent. Great news for the patient.
- Includes connectivity for Community Diagnostic Centres as well as the GP sites to allow patients to be scanned in the community
- To align with workforce planning for allowing home reporting, good news for retention and work/life balance.
- Sharing of the patient record and image will allow radiologists to report not only from home but form anywhere hospital (again providing efficiencies in future workforce planning) and ensuring the patient is not imaged twice.
- Improving patient care by including dose monitoring solution ensuring correct radiation levels for the patient.



Strategic Outline Case

- Replacement required 1 year in advance of GE contract end to allow for data migration
- Migrate Soliton RIS to new PACS supplier contract with minimal business disruption
- Include PACS based reporting so as to cater for different RIS's across the Imaging Network, and provide efficiencies for the Radiologists.
- Improving MDM performance across Trust boundaries, which will benefit Cancer patients
- Include provision of other departments images in a Vendor Neutral Archive, cardiology, Endoscopy etc.
- Improve efficiencies with of use of AI integration and imbedded AI technology as well as automation



Strategic Outline Case

Strategic Local and National Drivers

Current GE contract ending

Image sharing and document sharing across the entire Kent and Medway Imaging network

Fast access to images, reduced mouse clicks and improved technology.

Workforce planning to allow for home reporting

Sharing of the patient record and image and allow radiologists to report from anywhere

One Radiology patient record to across Kent and Medway

Ensuring patient is not imaged twice as previous images will be available across Kent

Dose monitoring software to allow monitoring of patient radiation

Improving MDM performance across Trust boundaries

PACS or RIS reporting to provide efficiencies with home working

Improve efficiencies with use of AI integration and imbedded AI technology

Connectivity for Community Diagnostic Hubs to upload images to PACS

Connectivity from primary care sites to upload Ultrasounds

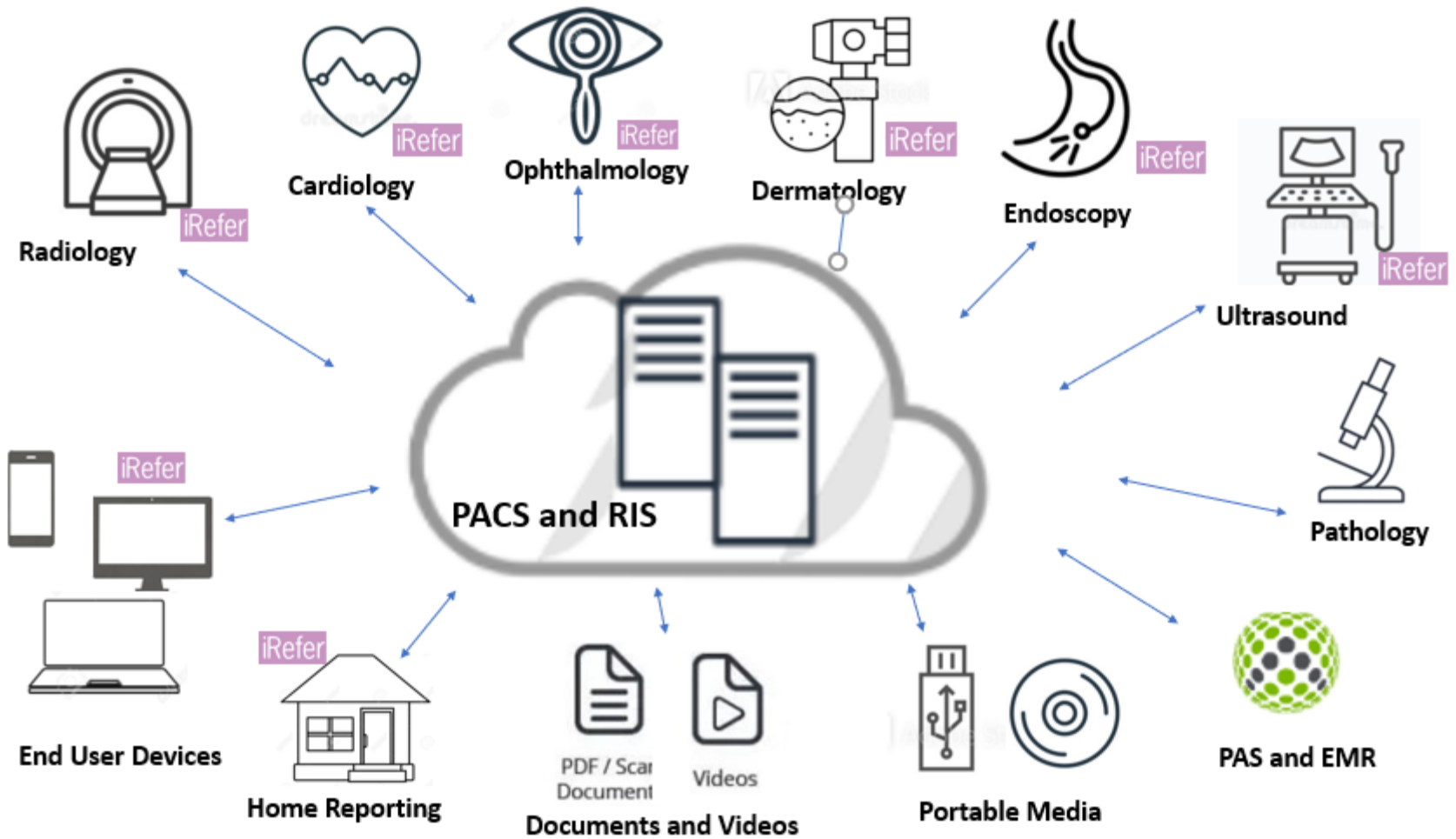
Access to the PACS application from primary sites to view images and reports

Include provision of other departments images in a Vendor Neutral Archive

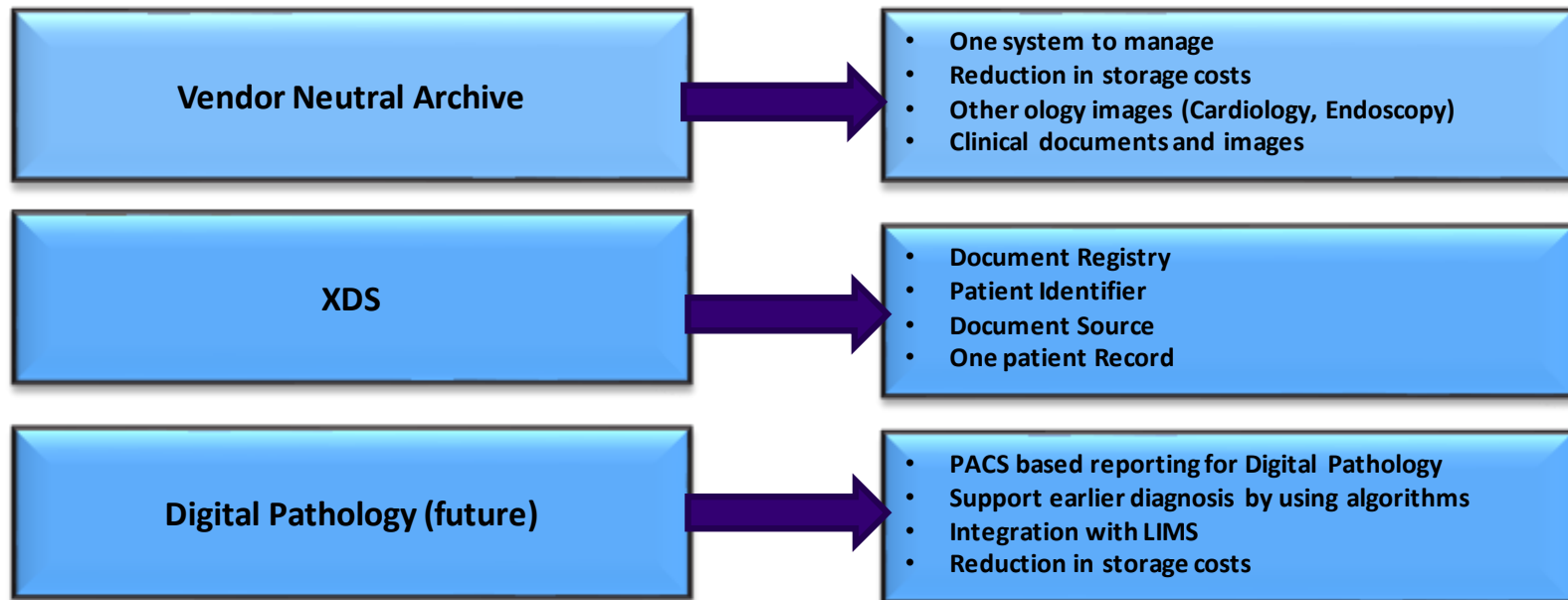
Capability to use the solution for Digital Pathology In the future



K&M IT Strategy



Case for Change



Options Appraisal

A list of options that have been or will be considered will be found In the OBC. Market testing for costs have provide the following options. Option 3 is the preferred option.

Option Ref.	Option	Strategic Fit	Investment Objectives	Value for money	feasibility	Potential affordability	Organisational Achievability	Comments / conclusions
A1	Do minimum. Continue as is with current systems	✓	✓	✓	✓	✓✓✓	✓✓✓	This is not really an option as the GE contract is ending on June 2023 and so the incumbent supplier would need to complete the completion process Conclusion: Discounted
A2	A Public Cloud PACS solution (such as Azure or AWS)	✓✓	✓✓	✓	✓	✓	✓✓	Though this would satisfy the image sharing side of the solution, though it is felt that the transfer of images from a cloud supplier would not produce the efficiencies in the speed of reporting as images may take longer to download. No Business continuity on site so it is a risk to the service if connectivity fails. Conclusion: Discounted
A3	A Private Cloud PACS solution, with hardware on site for business continuity at each Trust holding more recent images	✓✓✓	✓✓✓	✓✓	✓✓	✓✓✓	✓✓	Would enable image sharing via image standards as well as providing sharing due to central archive. Ensures speed of images as local storage for recent images and pre-fetching for appointment Conclusion: Carried forward
A4	A federated PACS solution with image sharing capability	✓✓✓	✓✓✓	✓✓	✓✓✓	✓✓	✓✓	Would enable image sharing via image standards, would allow for efficient image reporting as all images are on site, would include resilience for business continuity as hardware would be spread across multiple data centres. Conclusion: Carried forward
A5	A centrally hosted PACS solution within one Trust	✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓	✓✓	Would enable image sharing via image standards as well as providing sharing due to central archive. May not produce the efficiencies in the speed of reporting as images may take longer to transfer between network over HSCN Conclusion: Carried Forward

Economic Case

Market testing to seek costs of a new solution have been completed for a shared PACS as well as a federated PACS. This has provided a wide range of costs from the major PACS providers.

Option 1 – Do Minimum - Discounted

Option 1 has been discounted due to GE being at the end of contract term. However 'Market Testing' which has been completed via the QE framework has included GE, who have provided costs for a new contract. The GE contract has had many problems over the last 8 years with long periods of downtime and contract damages awarded to the Trusts.

Option 2 - Replacement with a Public Cloud solution - Discounted

Option 2 has been discounted due to this not yet being a trusted solution with the PACS providers. Though this would satisfy the sharing element, the speed of image transfer may be slow, and the cost of image downloads may be prohibitive.



Economic Case

Option 3 – A Private Cloud Solution - Carried Forward

Option 3 would enable image sharing via image standards as well as providing sharing due to central archive. The solution would ensure speed of images with dedicated connectivity from each Trust. Business continuity storage will be required at each Trust to ensure service if connectivity fails. Local storage could be included for recent images and pre-fetching for appointment.

Option 4 - Replacement with Federated PACS Solution – Carried Forward

Option 4 would enable image sharing via image standards and would allow for efficient image reporting as all images are hosted locally at each Trust. The solution would already include resilience for business continuity as hardware would be spread across multiple data centres per Trust.

Option 5 – Replacement with a Hosted Solution at One Trust. – Carried Forward

Option 5 would enable image sharing via image standards as well as providing sharing due to central archive. May not produce the efficiencies in the speed of reporting as images may take longer to transfer between network over HSCN. Options for dedicated connectivity could be explored. Business Continuity storage would be required locally at each Trust.



Benefits realisation

	Indicator	Current Measure	Target Measure	Target Change	Benefits Realisation Measure
Sharing of images to improve patient safety	Sharing of images in one system improved radiation to patients so they are not scanned twice.	Not directly available, though can be seen by logging into each other's PACS	See all PACS images, with one patient number being a master	See all images so that patients are not radiated at 2 sites.	See all PACS images in all KMMIC Trusts
Shared images	Images seen in all KMMIC Trusts	Not directly available, though can be seen by logging into each other's PACS	See all PACS images, with one patient number being a master.	See all PACS images, report from any hospital, see historical images alongside for better diagnosis	See all PACS images in all KMMIC Trusts
Shared documents	Store non DICOM images and scanned documents	Not available, as was not delivered as part of the GE contract	Ability to store all patients' images / documents	Store non DICOM images / Documents such as reports or other diagnostic information	Ability to store all patients' images / documents if Trust requirement
Dose monitoring	Dose monitoring in Radiology for patient safety	Only available in Nuclear medicine or manually entered into RIS by radiologists.	Automatically gather, store and analyses information on patients' radiation exposure	Automatic transfer of dose amount to PACS/RIS	Reduction of population radiation exposure.



Commercial Case

PROCUREMENT AND EVALUATION PROCESS

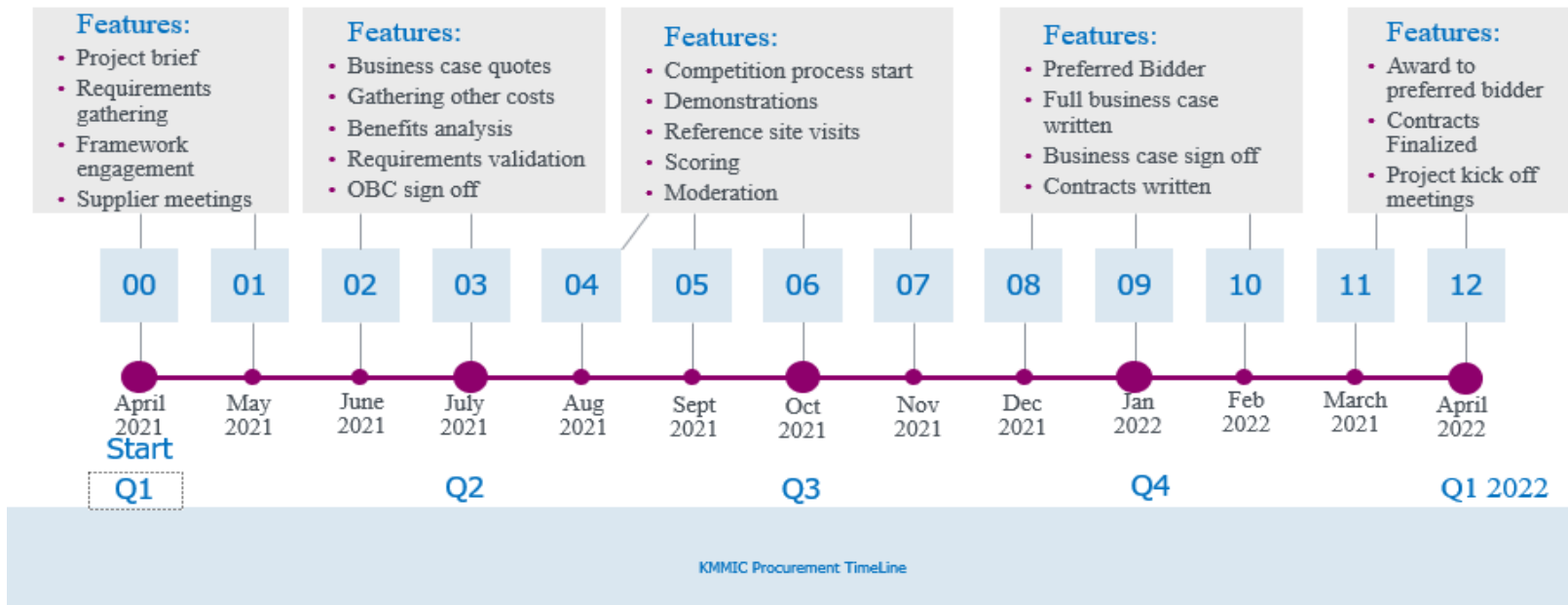
- The current contract for the PACS and RIS solution is held by EKHUFT on behalf of the KMMIC consortium. EKHUFT procurement with the help of NHS Business Services.
- The procurement process will be competition/tender via the QE Procurement framework
- The procurement is expected to be weighted 55% Technical 32% cost to 10% social Value and 3% contractual mark up. To allow for an improved solution.
- Evaluation team made up of; Clinical Leads (Radiologists and Reporting Radiographers), Heads of Service, IT Director, PACS Managers, IT Technical Teams, IG Medical Physics and Cardiology.
- The evaluation process will include, supplier questionnaire, product demos, evaluation, reference site visits, scoring ratification, etc.



Procurement Roadmap

PACS Procurement Roadmap

2021/2022



Key Contractual Arrangements

- The contract for PACS/RIS and associated products is expected to be 10 years from the commencement of the service with opportunities to extend for further years based on performance and delivering continued value for money.
- The contract for EKHUFT Viewpoint will be determined by the Obstetrics lead, prior to the commencement from the competition.
- The contract will cater for change control.
- The contract will contain clauses for dispute resolution and cover contractual obligations by the supplier.
- The contract will have exit arrangements including data migration.
- The framework includes standard Radiology contract terms and conditions.



Financial Case

Replacement with Federated PACS solution – MTW Costs

Costs - MTW Top End	10 year totals
Workstations/Monitors	£363,004.80
RIS Transfer Costs	£50,000.00
RIS Revenue	£1,474,200.00
PACS GE Exit costs	£38,556.00
PACS Capital	£4,247,976.01
PACS Revenue	£4,264,157.62
Programme Manager	£53,458.44
Senior Project Manager	£42,204.63
PACS Managers backfill	£53,403.41
Enovation Costs for RIS move	£5,100.00
Modality suppliers engineering @£700 each	£92,400.00
Radiologists backfill for procurment	£77,083.03
Total	£10,761,543.95

Costs - MTW Bottom End	10 year totals
Workstations/Monitors	£363,004.80
RIS Transfer Costs	£50,000.00
RIS Revenue	£1,474,200.00
PACS GE Exit costs	£38,556.00
PACS Capital	
PACS Revenue	£3,694,755.55
Programme Manager	£53,458.44
Senior Project Manager	£42,204.63
PACS Managers backfill	£53,403.41
Enovation Costs for RIS move	£5,100.00
Modality suppliers engineering @£700 each	£92,400.00
Radiologists backfill for procurment	£77,083.03
	£0.00
Total	£5,944,165.86



Financial Case

Current Annual Costs MTW

Existing	New System Lower estimate	New System Higher Estimate
£540,780.	£594,416.	£1,076,154.



NHS Bids for Funding

National funds are available for the Kent and Medway Imaging Network, which may be available to provide some funding to assist in any costs for the contract change over period; as well as provide some revenue assistance with the first two years of the contract.

<u>Bids for National Funding</u>	<u>Revenue 21/22</u>	Capital 21/23	Capital 22/23	Revenue 22/23	Revenue 23/24
Workstations/Monitors		£1,694,376.26			
PACS replacement			£2,050,609.08	£2,050,609.08	£2,050,609.08
RIS replacement				£486,154.00	£486,154.00
Programme Manager		£64,076.16		£76,598.40	
Project Manager				£74,401.20	£37,200.00



Training & Governance

The following training aspects have been considered:

- A separate training system will be included in the procurement.
- The PACS contract will provide training to new starters for the life of the contract.
- Training for new modules and upgrades in the product will be provided for the life of the contract.
- Super user training will be provided for implementation.

The following governance meetings are in place:

- IT Digitisation & Connectivity Work Programme.
- Monthly Heads of Service Meetings.
- Monthly Contract Management meeting.
- Weekly or ad-hoc meeting PACS Technical.



Summary

- We are tendering for a new improved PACS solution which will allow much better integration across Kent and Medway.
- Creating better efficiencies for the department and the workforce
- Improving patient care for the next 10 -15 years with continued realisations of benefits
- Full costs of solution and Full Business Case sign off will be February 2022





**Transforming
health and social care**
in Kent and Medway



Questions?


Approval?

BUSINESS CASE

Title: The re-procurement of the Picture Archiving Communication System, Radiology Information Service and Image Archive Systems Contract for the Kent and Medway Medical Imaging Consortium (KMMIC).

Issue date/Version number	21/07/2021/ V0.3
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Directorate	Imaging (Radiology)
Department/Site	Radiology/Cross site MTW
Author	Sue Lang (sue.lang@nhs.net)
Clinical lead/Project Manager	Antony Gough-Palmer/ Sue Lang

Approved by	Name	Signature	Date
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Division Board	Ritchie Chalmers		
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**KENT & MEDWAY MEDICAL IMAGING CONSORTIUM
PACS AND RIS DIGITAL TRANSFORMATION PLAN**

**Outline Business Case
(OBC)**

The re-procurement of the Picture Archiving Communication System, Radiology Information Service and Image Archive Systems Contract for the Kent and Medway Medical Imaging Consortium (KMMIC).

Senior Responsible Officer:

Andrew Barker, Chair, Director of Health Informatics, EKHUFT

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PACS Managers	Various		

Approval

Name	Title	Date of issue	Version	Signature

This document is only valid on the day it was published, please contact the author to confirm this is the most recent version.

Glossary

The following table presents a glossary of specific terms used in this business case that are in many cases important with regard to precise definitions of the content of the business case.

Abbreviation	Definition
KMMIC	Kent and Medway Imaging Consortium
EKHUFT	East Kent Hospitals University Foundation Trust
MTW	Maidstone and Tunbridge Wells NHS Trust
Medway	Medway NHS Foundation Trust
CRB	Cash Releasing Benefits
DNA	Did Not Attend
FBC	Full Business Case
NCRB	Non-Cash Releasing Benefits
PAS	Patient Administration System
PACS	Picture Archiving and communication System
eMPI	Electronic Master Patient Index
RIS	Radiology Information System
SRO	Senior Responsible Owner
UAT	User Acceptance Testing
VNA	Vendor Neutral Archive
XDS/XDSi	Cross enterprise document sharing (imaging)
MS	Managed Service
AD	Active Directory
CDH	Community Diagnostic Hub
GIRFT	Getting it Right First Time Report
K&MIN	Kent and Medway Imaging Network
PID	Project initiation document

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EXECUTIVE SUMMARY

1. PURPOSE OF THIS DOCUMENT

This document sets out the Outline Business Case (OBC) for the Kent and Medway Imaging consortium to take forward the project to replace the Picture Archiving Communication System (PACS) and re contract for the existing Radiology Information Service (RIS).

Over a 10 year contract the investment is expected to be £30 Million split between the KMMIC Trusts, the split will be calculated on the size of the population and the number of images and storage required per trust.

Picture Archiving & Communications System' (or PACS) is the term used to describe an IT system used to acquire, store and retrieve digital images. It is most often, but not exclusively, used to manage digital X-Rays and, in conjunction with a Radiology Information System (or RIS), to schedule, report on and share images either within an organisation or across a wider clinical network.

Today, patients and their families have an expectation of seamless, integrated care between organisations providing their healthcare. Sharing patient data between primary, acute and community care is practically impossible to manage consistently without technology support. Patients have an expectation that their images and patient record can be viewed at any location, we need to ensure that we use this opportunity to provide the sharing of images and patient information to meet the expectation of the patient.

This outline business case demonstrates how a shared PACS and RIS solution can contribute to the overall efficiency of the KMMIC organisations, helping to drive down costs, provide greater efficiency with workforce as well as providing better connectivity for current and future imaging centres across Kent

This document is in line with the five-case model recommended by HM Treasury and provides decision makers and stakeholders with a proven framework for structured 'thinking' and assurance that the project:

- The Strategic Case section – explains why the investment is needed and the nature of the investment objectives.
- The Economic Case section – confirms the value for money of the solution based on the specific costs, benefits and risks of the preferred bidder.
- The Commercial Case section – explains commercial aspects of the solution.
- The Financial Case section – confirms funding arrangements, affordability and the effect on the balance sheet of the organisation;
- The Management Case section - demonstrates that the scheme is achievable and can be successfully delivered in accordance with accepted best practice.

2. STRATEGIC OUTLINE CASE

This strategic case identifies the national, regional, and local drivers for change and defines the investment objectives for a new PACS and RIS

The current GE contract for the KMMIC (Kent and Medway Medical Imaging Consortium) PACS and RIS is due for renewal in June 2023. The original KMMIC Trusts contained East Kent Hospitals

University Foundation Trust (EKHUFT); Maidstone and Tunbridge Wells NHS Foundation Trust (MTW); Medway Foundation Trust (MFT) and Dartford and Gravesham NHS Trust (DGT). In 2013 there was a joint procurement for a PACS and RIS solution for all of the KMMIC Trusts, this led to the award of the GE PACS and RIS solution with a contract period of 7 years and an option to extend at the end of this time period, for a further 3 years. The contract has been extended and is now nearing its end and needs to be re-procured.

The GE contract has not been without issue, there have been prolonged periods of downtime (weeks) and failing KPI's, which have led to coverage about patient delays and issues in the national press. As well as these issues, parts of the procured solution that were originally contracted to be delivered have not been deployed, including the document sharing solution which was a key part of the previously procurement. In 2017 the Trusts sought damages from GE and were awarded compensation for GE failing to meet some of their contracted obligations.

Due to these issues, Dartford (DGT) decided to leave the contract and procure a separate PACS (Sectra) and RIS (CRIS) outside of KMMIC in 2018.

The three remaining KMMIC Trusts have recently undertaken a transfer of their radiology reporting solution (RIS) to a new Soliton RIS application. The soliton RIS is currently contracted via GE. Any new contract for PACS must also transfer the Soliton RIS into the new contract, there is no desire to change the RIS application at the commencement of a new contract, as a full selection and evaluation process was completed in 2019 and the Soliton RIS has only recently been implemented across all three Trust, with MTW only going live with the new RIS in March 2021.

2.1 LOCAL AND NATIONAL POLICY DRIVERS

Part of the NHS Long term plan is to provide Digitally Enabled Care. Section 5 of the long-term plan covers Improving clinical efficiency and safety. the bullet points below are taken from the long-term Plan:

- By 2023, diagnostic imaging networks will enable the rapid transfer of clinical images from care settings close to the patient to the relevant specialist clinician to interpret. This open standards-based infrastructure will enable both the rapid adoption of new assistive technologies to support improved and timely image reporting, as well as the development of large clinical data banks to fuel research and innovation.
- Decision support and artificial intelligence are developing all the time. These technologies need to be embraced by the NHS, but also subjected to the same scrutiny that we would apply to any other medical technology. In the coming years AI will make it possible for many tasks to be automated, quality to increase and staff to focus on the complexity of human interactions that technology will never master.

Over the last five years, the use of radiology has grown more than 16%, with more than 42 million examinations carried out on NHS patients in England

Many clinical specialties rely heavily on radiology to function. With technological advances and an ageing population, this demand is likely to continue to increase year-on-year

Radiology is also a key enabler to other government health delivery plans including cancer services. The reporting of results and findings, for the radiology services across Kent, provide expert advice and interpretation of often complex and highly-specialist results, contributing hugely to the quality

of care provided to patients. To enable this vital role to be performed, the radiology service requires the tools and digital infrastructure to be available and adequate to match the ever-changing clinical context. The backbone of any Radiology services is the PACS and RIS

Recently there has been a national review of radiology services and a paper written by Sir Mike Richards. This has led to a new national imaging strategy being included in the NHS long-term plan and the creation of diagnostic imaging networks at a regional level. The Kent and Medway Imaging Network has been created, which includes all of the Kent trusts which make up the Kent Integrated Care Partnerships (ICP).

Key requirements from the Richards review are the sharing of images across the Kent and Medway Imaging Network, this will involve PACS connectivity to Dartford and Gravesham NHS Trust to enable the sharing of images and to report; the ability for the Radiologist to report from any site or from home and the creation of community diagnostic hub as well as the use of AI.

A list of the local and strategic drivers is below:

Strategic Local and National Drivers
Current GE contract ending
Image sharing and document sharing across the entire Kent and Medway Imaging network
Fast access to images, reduced mouse clicks and improved technology.
Workforce planning to allow for home reporting
Sharing of the patient record and image and allow radiologists to report from anywhere
One Radiology patient record to across Kent and Medway
Ensuring patient is not imaged twice as previous images will be available across Kent
Dose monitoring software to allow monitoring of patient radiation
Improving MDM performance across Trust boundaries
PACS or RIS reporting to provide efficiencies with home working
Improve efficiencies with of use of AI integration and imbedded AI technology
Connectivity for Community Diagnostic Hubs to upload images to PACS
Connectivity from primary care sites to upload Ultrasounds
Access to the PACS application from primary sites to view images and reports
Include provision of other departments images in a Vendor Neutral Archive
Capability to use the solution for Digital Pathology In the future

2.2 NATIONAL FUNDING

There is national funding available for the Kent and Medway imaging network, which may provide financial support to assist with any costs for the contract change over period and provide some revenue assistance with the first two years of the contract. This is to allow the Trusts to work towards the Richards review requirements, as well as assisting in streamlining diagnostic services at an ICS level (Integrated Care System). However, there is no guarantee that we will receive this funding for the bids that have been requested and the outcome of this will not be known until the next financial year.

Whether or not we receive funds to assist the procurement, our systems still need to be replaced and we rapidly need to complete the procurement process to enable all of the KMMIC trusts to have migrated away from the current solution by the contract end date.

3 THE CASE FOR CHANGE

Ongoing Radiology programmes are under way across the ICS, this will improve the diagnostic services across the acute, community trusts and GP systems, this programme is not achievable with current system, yet it is essential in providing the best possible care for patients across Kent.

The do minimum option would not provide an IT solution that meets the significant requirements of service redesign required by the Imaging Network Board across Kent. Refresh of existing technology will have significant cost but will not facilitate rapid universal access to imaging across KMMIC and will have negative impact on other Radiology service projects. This will not be in the best interests of patients across Kent.

Current radiology services are beyond breaking point and single click access to the KMMIC imaging is required regardless of location. This will allow rapid access to the right radiologist at the right time and reverse the increasing reliance on premium cost and variable quality outsourcing

The case for change could be made purely on the basis that the current PACS and RIS systems have reached 'end of contract' and a refresh / renewal is required. However due to the findings of the Richards review, and the programs happening across the ICS for imaging, the project has to consider the scope and scale of new requirements and must be an enabler for the projects listed below.

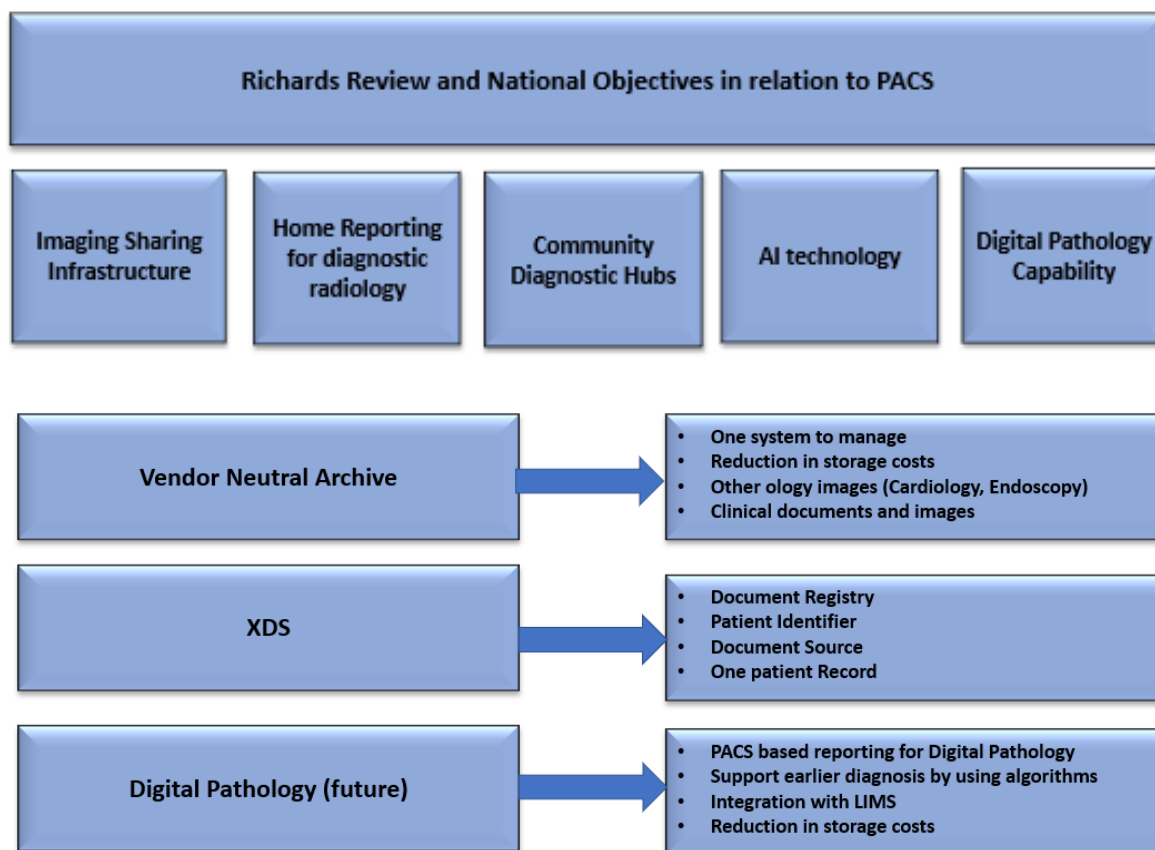
The programs being undertaken by the Kent and Medway imaging network are:

- PACS and RIS replacement for KMMIC – this project
- Radiology iRefer - A decision support software
- Home reporting - Enabling Radiologists to report from home
- Radiology Order Comms - To enable GP ordering directly
- Radiology X-Air - Imaging in Community settings
- Radiology AI - Artificial Intelligence for reporting Lung Screening Chest Images
- Community Diagnostic Hubs - Creating locations for diagnostics in the community
- Workforce planning - Changes in workforce to report from anywhere and increase reporting

Though PACS is one of these projects, it is also an enabler for all of the other projects listed.

KMMIC acknowledges that the current applications do not provide the functionality required to meet the needs of national drivers and regional drivers.

The change needs to support formation of the new imaging networks, as well as the continuing future changes in radiology, AI and technical changes in PACS systems, which allow for better connectivity for PACS to PACS connectivity. PACS based reporting could provide improvements for Home reporting as well as allowing KMMIC and Dartford to be able to share reports without requiring the same RIS. PACS technology has moved forward in the last 10 years, we need to take advantages of these changes in technology.



3.1 STABILITY OF CURRENT SYSTEM

As mentioned previously, the stability of the current solution has been a problem throughout the life of the current contract. This has not only caused outages of the PACS and RIS, but has also provided reputational problems with the Radiology service as well as delays to the patient pathway. The reputation and patient pathway cannot be accessed in terms of monetary value; but should be considered as detrimental to the service to the patient and could delay diagnosis.

The prolonged periods of downtime will have a monetary value, this will be made up of staff costs to complete tasks such as (but not limited to) the list below:

- Managing a priority one incident within the Trust (Management staff)
- Key Radiology staff attending meetings with the supplier
- IT staff attending meetings with the supplier
- IT staff assisting the supplier in resolving their issues.
- Key Radiology staff managing the business continuity process
- Radiologist completing reports on paper and dealing with the patient manually
- Radiographers entering details directly on the modality which is prone to human error
- PACS managers managing administration of hundreds of unspecified images once the system is restored
- Admin staff having to rebook appointments

Each separate incident of down time will have a varying degree of the staff required to manage the above list. This equates to a large financial sum which is hard to quantify over the lifetime of the contract but which will equate to a significant financial figure.

It is noted that a stable and reliable system will not require the effort that is currently needed to manage an unreliable solution.

3.2 SPECIALITY WORKFLOWS

Some of the basic functional constraints of the current solution include the inability to fully support advanced 3D visualisation software, Tomosynthesis, MDT workflows, and integrated PACS reporting and VR functionality.

The ability to support a wider range of specialty workflows from a single PACS which could enable consolidation of workstations and licenses would be a particularly beneficial way of reducing costs of imaging.

3.3 EDUCATION, AUDIT, ANALYTICS AND RESEARCH

The KMMIC Trusts find the current PACS system to be insufficient in its ability to support their education and training agenda. For example, there is a common requirement across the Trusts to easily anonymise and store images for training purposes and identify images as a personal 'interesting case' which can be shared with others. Users require the ability to tag images with key words for searching across a central KMMIC wide repository. They also wish to share material with health care professionals and students alike to ensure high quality and standardisation of learning across Kent

Auditing is currently a labour-intensive manual process. The replacement PACS system will be required to better support the audit process as well as double reads and peer review, or peer learning.

Better auditing capabilities are also required to support IG audits. These are currently limited in scope and rely on the supplier to provide the data. It is envisaged that IG auditing will become more crucial within a KMMIC-wide environment.

The replacement PACS system must also support the anonymization and storage of images for the purposes of clinical trials, modelling and research.

3.4 IMPROVED VALUE FOR MONEY AND POTENTIAL COST SAVINGS.

The current contracts were procured in the mid-2000's. Repeated extensions would not provide value for money (and would not resolve the image sharing problems described above in the business case for change) as there would be no competitive pressure to reduce pricing.

MDT preparation time for any new solution is expected to be more efficient and streamlines as cross Trusts

The new solution should provide a cost saving for the outsourced Telemedicine suppliers and allow workforce changes that will allow on call staff to be provided across all Trusts from one location and will allow of all Trust to report on each other's images. This will allow staff efficiency and cover for sickness and holidays between the trusts, rather than employing locums and telemedicine suppliers to provide cover.

PACS administrators spend many hours transferring images between Trusts or burning disks and uploading images to solicitors. The need to transfer images via the IEP to the other Kent Trust will no

longer exist. It is also expected that the new PACS solution will provide a portal to allow access to solicitors to be able to review the images directly.

3.5 ARTIFICIAL INTELLIGENCE

Artificial Intelligence and machine learning within Radiology is probably the biggest fundamental change in imaging diagnostics for decades. Though machine learning is generally included in core PACS offerings with use of automated measurements and efficiencies around hanging protocols, AI itself is often provided by specialist companies or is charged as optional extra's from the PACS suppliers. The aim of the procurement, when considering AI, is to ensure integration with our current and future third-party AI offerings with the core PACS, as well as to seek any AI enhancements from the PACS suppliers without making the procurement affordable.

3.6 BREAST SCREENING IMAGES

The connectivity between the Breast screening Sectra PACS and the GE PACS has many issues. The two solutions do not integrate well and this caused many administration problems.

If a patient that has been screened using the Sectra PACS then becomes symptomatic. The images have to be transferred by the PACS administrators to the GE system using the one of the PACS administrator workstations. It is expected that a new PACS solution would provide improved interoperability between the Breast and the Core PACS solutions, thus saving time on administration tasks.

3.7 WORKSTATIONS AND HOME REPORTING

Workstations which have historically been part of the supplied PACS solution, are expected to no longer be part of any new contract; these are more economically and efficiently managed by each individual Trust. Historically they have not been managed well by the current supplier and so have posed a security risk when the management of security updates and upgrades to outdated operating systems have not been completed in a timely manner.

Due to the Covid 19 pandemic, home working has now become the norm for many staff, including some Radiologists. NHS Improvement are keen that Radiologist take advantage of the push for home working as there are already established remote working practices for Radiologists working for Teleradiology companies. Funding is available from NHSI to support home working and provide equipment to enable Radiologist to work from home. The Royal College of Radiologists have issues guidance to support the rapid deployment of home reporting.

Any new PACS/RIS contract should take account of this and allow a seamless solution for Radiologists based at home. This will include the possibility of PACS based reporting, rather than writing radiologist reports in another system, which could also reduce the need for separate monitors in the future.

3.8 COMMUNITY DIAGNOSTIC HUBS (CDH'S)

As a result of the Richards Review, and subsequent funding, CDH's will rapidly grow in numbers. The direct knock on effect of this will be an increase in the number of images being uploaded to the PACS and VNA, suitable planning is needed to cater for this increase as CHD's come onboard.

Some funding is available for the initial creation of these Community Diagnostic Hubs (CDH's) and West Kent ICP have put in a proposal to become an early adopter. EKHUFT (at ICP level) are also in

the process of completing a business case for a CDH and over the coming years it is recommended that there is one site per 300,000 of population.

Recommendation from the Richards review included the creation of community diagnostic hubs:

Recommendation 4: Community diagnostic hubs should be rapidly established to provide Covid-19 minimal, highly productive elective diagnostic Centre's for cancer, cardiac, respiratory and other conditions. For patients with suspected cancer, these should incorporate the rapid diagnostic Centre service model.
Community diagnostic hubs should be established away from acute hospital sites and kept as clear of Covid-19 as possible.
Diagnostic services should be organized so that as far as possible patients only have to attend once and, where appropriate, they should be tested for Covid-19 before diagnostic tests are undertaken. 1 NHS England. 2019. The NHS Long Term Plan 6 Diagnostics: Recovery and Renewal
Community phlebotomy services should be improved, so that all patients can have blood samples taken close to their homes, at least six days a week, without needing to come to acute hospitals.

3.9 OBSTETRICS APPLICATION (EKHUFT ONLY)

The Viewpoint obstetrics application is in use across all KMMIC Trusts, however East Kent have the application primed though the GE contract. The Viewpoint application was being hosted on an out of date operating system on the GE PACS infrastructure, this was posing a cyber security risk to the Trust, due to security updates being unavailable to the aged operating system. GE were unable to upgrade due to inadequate space requirements on their infrastructure, therefore it was decided that the Viewpoint application would be migrated to East Kent infrastructure and this project was completed in early 2021. The Viewpoint application requires a major upgrade as the software version is at the end of life in December 2021. It is GE's responsibility to upgrade the software as although the application is on East Kent's infrastructure, it is still managed by GE.

Because the software is no longer hosted on the GE infrastructure. There is no reason for the software to be primed by another supplier following the GE contract end date; when priming software suppliers charge a priming fee on top of the cost of the software, it is expected that any additional VAT that can no longer be saved from this being a managed service contract, will be saved on the priming fee paid. A new contract will need to be completed by East Kent and HCN in June 2023

3.10 LESSONS LEARNED

Many lessons can be learned from the previous procurement process, one of the main lessons is that the GE bid was significantly cheaper than the all of the other suppliers; nowadays this would have been probably considered as an abnormally low tender and could well be excluded from progressing further with the competition.

Other issues were around the offering itself and the elements of the bid that GE could not provide during the implementation. Some of the elements that made up the tender were eventually purchased by GE from other suppliers and provided to us at a later date (such as dose monitoring, obstetrics and orthopedic templating). Other elements have gone end of life and GE have delayed in purchasing updated software (EMPI). At least one element has still not been implemented (XDS).

This new procurement needs to be robust in asking the bidders to demonstrate all elements of the requested product, both during the initial demonstration and also during the site visit stage. The

suppliers will need to be open and honest about providing software from third parties and work with KMMIC to provide the best solution whilst still remaining cost effective.

4 THE ECONOMIC CASE

This Economic Case identifies the preferred option for delivery of the programme.

This section of the OBC documents the range of options that have been considered in response to the potential scope identified within the strategic case

The current PACS and RIS contract will be due for replacement in June 2023. To allow continuity of service for this patient critical system, all migration needs to take place prior to the end of the contract, all images from the PACS, for all 3 KMMIC Trusts, will need to be migrated to a new solution. The RIS will need to be migrated as is; to a new supplier or hosted directly by Soliton by June 2023. This means that realistically a new contract needs to be in place by June 2022 to allow for the transfer of data.

The new contract will need to include a combined approach to image archiving, via a Vendor Neutral Archive (VNA), allowing the 3 KMMIC trusts as well as Dartford to be able to view or share images. It will also require the sharing of patient documents, via a cross document storage platform (XDS). The solution will also need to host Cardiology images at the end of the current cardiology archive contracts for at least Cath Lab images at each Trust, as well as becoming a host for Digital Pathology images in the future. The VNA should also allow the storage of other departments images such as Endoscopy and Ophthalmology.

Not only should the investment allow for a continuation of the current sharing between the KMMIC Trusts (and Dartford) but it should also allow for a wider scope to include some of our ICS partners to allow upload of locally captured images and provide access to view images if possible. This will provide a single view of patients, promoting efficiencies in working processes and improving clinical outcomes.

The PACS and RIS should also be scalable to cater for the increased demand as a result of new Community Diagnostic Hubs which will be being commissioned across Kent over the next couple of years. The hubs are expected to increase the amount of imaging captured and so the new solution will need to cater for this uplift.

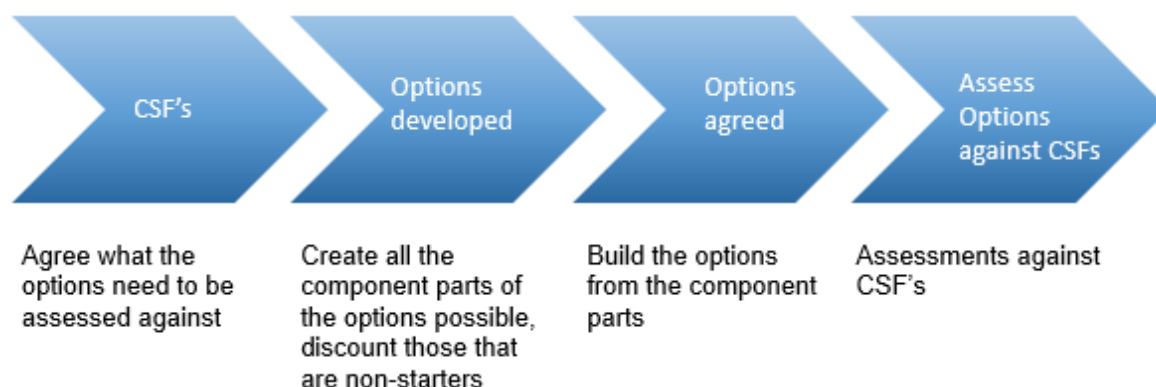
With the changes in digital pathology, the PACS is also expected to become the future target for pathology microbiology slides images. Having one system to perform integrated image analysis for the patient, will assist diagnosis, particularly for cancers.

4.1 APPROACH TO INVESTMENT APPRAISAL

In accordance with the Department of Health '5-case' guidelines for IM&T business cases, the process adopted was as follows:

- Step 1: generate a list of critical success factors (CSFs) against which the options will be appraised;
- Step 2: identify and evaluate against the CSFs a 'long list' of potential options for satisfying the investment objectives;
- Step 3: create a shortlist by forming composite options from the individual options that emerged from each category in the previous step;

- Step 4: undertake a full value for money appraisal of these shortlisted options to identify a preferred option that forms the basis of the remainder of the business case.



4.2 IDENTIFICATION OF CRITICAL SUCCESS FACTORS

The following is the set of critical success factors that have been applied to appraise the options, and have been generated through reference to the Treasury IM&T guidelines:

Critical Success Factors	Evaluation Method
Strategic fit	Degree to which the options: <ul style="list-style-type: none"> • meet business and clinical requirements and the PACS investment objectives; • support any wider KMMIC strategies including local, regional, and national technology requirements within the constraints identified in the Strategic Case; • meet the Imaging Network policy targets • are compatible or enable other corporate Imaging Board initiatives; • integrate with other diagnostic developments; • providing a resilient service to patients and staff; and • meet any legal/statutory requirements.
Investment objectives	<ul style="list-style-type: none"> • Degree to which proposed options meet objectives.
Value for money	Degree to which: <ul style="list-style-type: none"> • the likely costs balanced against risk and benefit opportunities; • the return of investment (ROI) is optimised in terms of economy, efficiency, and effectiveness; • the options deliver high quality, safer care to patients and improved outcomes • the options minimising associated risks and non-delivery of benefits.
Supplier feasibility	Capability of supplier to:

Critical Success Factors	Evaluation Method
	<ul style="list-style-type: none"> undertake and deliver the programme; supply services within the agreed timescales.
Potential affordability	<ul style="list-style-type: none"> Ability of the KMMIC Trusts to meet the required total capital and revenue costs, including any anticipated cash releasing benefits and new financial contributions.
Organisational achievability	<p>Capacity and capability of:</p> <ul style="list-style-type: none"> KMMIC Trusts Informatics programme and project management to deliver the required services, within planned timescales; the service users to assimilate, adapt and respond to the required changes enabled by the preferred solution, within the planned timescales; KMMIC Trusts staff to support the new service after implementation.

4.3 ASSUMPTIONS

The following assumptions and bases have been used to calculate the economic and financial impact of the proposed investment scheme:

- Contract duration and anticipated system life is 10 years based on historic rate of system development. Within this period a hardware refresh at year 5 is expected to be required and has been included within the costs.
- A 5- year extension to the contract will be included so as the contract can be extended if the solution has found to be satisfactory
- Effect of inflation has been excluded.
- The Managed Service Contract term of 10 years is assumed to commence from the date of the start of the migration for the first Trust . There may be a cash impact caused by any payments to the supplier during the implementation stage but these have not been modelled. These will be identified during the tender.
- Anticipated cash-releasing benefits within the wider Radiology Programme will be achieved through staff efficiency savings resulting in part from the implementation of a more technically superior solution.
- Specific procurement related costs have been included within the implementation team costs however work undertaken by Trust-based procurement services are absorbed within business as usual costs of the Trust and therefore not included within the OBC costs
- Imaging activity at KMMIC will increase year on year by 5% for studies and 10% for storage
- The Soliton RIS will be migrate to the new contract for the PACS supplier and a new RIS will not be procured
- Workstation will be removed from the contract and will be managed by the Trusts IT departments
- The migration period from the current contract to a new supplier will take at least one year.
- Dartford and Gravesham NHS Trust will allow equipment to be installed to allow transfer of images.

4.4 PROGRAMME OBJECTIVES

The investment objectives are aligned with the ICS Kent and Medway Imaging board Strategy Good objectives should be:

- SMART: Specific, Measurable, Achievable, Relevant, and Time-constrained – to facilitate options appraisal and post evaluation;
- Customer-focused and distinguishable from the means of provision, so focus is on what needs to be achieved rather than the potential solution;
- Not be so narrowly defined as to preclude important options, nor so broadly defined as to cause unrealistic options to be considered at the options appraisal stage;
- Focused on the vital outcomes, since a single or large number of objectives can undermine the clarity and focus of the project.

The following overarching investment objectives for the PACS and RIS replacement Programme have been identified:

- **Improve patient experience:** by imaging patients once and monitoring their radiation Dose, Demonstrating a shared understanding of a patient's history, diagnosis, and outcomes.
- **Improve working with care partners:** by adhering to common data standards and sharing patient data across the health economy to support holistic, integrated care delivery across multiple providers;
- **Improve, performance and efficiencies:** Ensure all recommendations by the Royal College of Radiologist are met when procuring the new PACS solution. Any new solution must meet IHE standards.
- **Ensure IT systems are highly performant, resilient and cyber-secure:** by providing state-of-the-art technology and security. All systems should achieve 99.95% availability and have a maximum 5 second screen refresh. Workstations managed by Trust IT;
- **Meet the strategic National and Local Drivers :** set out in section 2.1

The detailed objectives for the PACS and RIS replacement programme are below

Objective	Objective
Objective 1:	Replacement of end of life contract
Objective 2:	Meeting the National and Local Drivers
Objective 3:	Delivery of a high-quality diagnostic service for patients, hospital and general practitioners that meets their current and future needs.
Objective 4:	Providing a solution which is more technically advanced and provides better functionality
Objective 5:	Includes imaging standards for cross platform working
Objective 6:	Allows expected increase in the demand for services
Objective 7:	Better technology which will increase efficiencies in the reporting process
Objective 8:	Allows for 'In-sourcing' of Radiologists in future (due to home working)
Objective 9:	Allows PACS Managers more control over the application, saving time on calls logged
Objective 10:	Removal of current licence limits, allowing more access to PACS from other trusts services and Primary Care
Objective 11:	Automatic Dose Monitoring in the same solution (increasing productivity and saving money on secondary systems as well as less patient radiation)
Objective 12:	Provide true sharing of images and patient record, saving time and money on imaging the patient twice
Objective 13:	Cyber security improvements to guard against downtime, with Trust managed workstations.
Objective 14:	Smooth transition from one system to another with minimal disruption or downtime
Objective 15:	Transfer of the Soliton RIS to the new contract
Objective 16:	Transfer of the TraumaCAD software to the new contract
Objective 17:	Improve the transfer of images to the London hospitals and Other Radiology networks outside of Kent

4.5 IDENTIFY AND EVALUATE OPTIONS

With such an investment appraisal, there are several approaches to identifying and evaluating the options available. Options could vary according to the scope, funding, solution, and implementation approach/timescale.

In developing the review, which considers these various options, the approaches have been sub-divided into the following categories and a long list of options considered within the framework set out below, which is consistent with the Treasury Green Book and NHS Guidance:

- **Service Solution Scope options:** considering the various levels of technical and functional solution that could be adopted.
- **Service Scale options:** considering how the system requirements could be scaled.
- **Service Delivery options:** considering the options for delivery of the solution within the NHS.
- **Implementation options:** considering the options for different timescales and incremental approaches to implementation of the solution.
- **Procurement options:** considering the possible procurement routes.
- **Funding options:** considering the available methods of finance.

For each category, the options within each category and their assessment against the CSFs where:

- '✓' indicates a poor match against the critical success factor.
- '✓✓' indicates a medium match against the critical success factor.
- '✓✓✓' indicates a good match against the critical success factor.

For the development of the Outline Business Case the following options were evaluated in a series of meetings and were either discounted or carried forward.

Option Ref.	Option	Strategic Fit	Investment Objectives	Value for money	feasibility	Potential affordability	Organisational Achievability	Comments / conclusions
A1	Do minimum. Continue as is with current systems	✓	✓	✓	✓	✓✓✓	✓✓✓	This is not really an option as the GE contract is ending on June 2023 and so the incumbent supplier would need to complete the completion process Conclusion: Discounted
A2	A Public Cloud PACS solution (such as Azure or AWS)	✓✓	✓✓	✓	✓	✓	✓✓	Though this would satisfy the image sharing side of the solution, though it is felt that the transfer of images from a cloud supplier would not produce the efficiencies in the speed of reporting as images may take longer to download. No Business continuity on site so it is a risk to the service if connectivity fails. Conclusion: Discounted
A3	A Private Cloud PACS solution, with hardware on site for business continuity at each Trust holding more recent images	✓✓✓	✓✓✓	✓✓	✓✓	✓✓✓	✓✓	Would enable image sharing via image standards as well as providing sharing due to central archive. Ensures speed of images as local storage for recent images and pre-fetching for appointment Conclusion: Carried forward
A4	A federated PACS solution with image sharing capability	✓✓✓	✓✓✓	✓✓	✓✓✓	✓✓	✓✓	Would enable image sharing via image standards, would allow for efficient image reporting as all images are on site, would include resilience for business continuity as hardware would be spread across multiple data centres. Conclusion: Carried forward
A5	A centrally hosted PACS solution within one Trust	✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓	✓✓	Would enable image sharing via image standards as well as providing sharing due to central archive. May not produce the efficiencies in the speed of reporting as images may take longer to transfer between network over HSCN Conclusion: Carried Forward

For business case planning and the creation of the OBC, the market testing exercise concentrated on 2 main options.

1. A federated system which could share images across all Trusts but which had hardware on site
2. A centrally hosted system which would be hosted on one Trust site or in a private cloud.

The federated costs were added to the business case, as this is the most likely option that will be chosen for the full completion, due to speed of accessing images.

4.6 OPTIONS RISK ANALYSIS

The risk appraisal has been carried out in line with HM Treasury Green book. Each of the options have been ranked on the perceived risk at this stage.

Option		Risk Rank
A1 - Do Minimum	Not really an option as end of contract	5
A2 - Public Cloud	Hosted in AWS or Azure	4
A3 – Private Cloud	Hosted at a PACS suppliers chosen data centre	2
A4 – Federated	Hosted at each Trust site	1
A5 – Central Trust Hosted	Hosted at one Trust	3

Option 1: Do Minimum:

The ‘Do Minimum’ option for PACS is to extend the current GE contract, however as the contract has already been extended to allow for time to complete the procurement competition, the ‘Do Minimum’ option isn’t really possible and GE would still need to complete the competition process.

There have been many issues faced over the lifetime of the GE contract, where there have been significant contract failings, as well as damages paid back to the Trusts for downtime and failure to deliver on the items promised in the current contract. There has been press coverage of the outages and it has caused issues with patient care. GE also don’t seem to have kept pace with the technologies, and the product does not have a good reputation amongst clinical teams in the KMMIC Trusts. A fresh competitive process will provide the ability to look at newer PACS technologies alongside a new review of the technology roadmap of the GE PACS.

Thought the current GE contract had promised the delivery of a Vendor Neutral Archive and the ability to share via an XDS solution, the reality has never materialized, and compensation has been paid to the trusts for some of these contract failings.

The same isn’t true for the RIS however, as due to the failing GE contract, the RIS has recently been migrated from the GE Centricity RIS to the Soliton product radiology+. Due to this recent large project and the KMMIC Trusts being happy with the new Soliton RIS, there will be either migration of the RIS as is to the new PACS supplier’s hardware or to a private cloud data center hosted by soliton.

Option 2: Public Cloud:

Public Cloud hosting has become common place for various IT solutions in the last few years, however this is not yet common place for PACS suppliers. Public Hosted solutions are generally charged on server, storage and data transfer; it is therefore perceived that the costs of viewing

images for reporting may equate to a high charging cost. Public cloud hosting will also rely on heavily on leased lines, therefore the speed of viewing or downloading images is not known. Business continuity may be an issue as there will be no images stored on site. This is seen as a perceived high risk.

Option 3: Private Cloud:

Private cloud hosting is more common place with PACS suppliers than public cloud.

Though this also relies on heavily on leased lines, there is generally local storage on each Trust site with a number of months or years of images held locally, with pre-fetching algorithms available to enable the download images for upcoming patient appointments. This local storage would also cater for the business continuity element if a leased line was to be lost. Due to the business continuity element of this the solution is seen as a low risk.

The patient's historical images and vendor neutral archive would be stored in the private cloud data Centre allowing easy access from any site that has connectivity. This method may be advantageous to our primary care colleagues, as some images from primary care may be stored in the PACS in future. It will also allow direct connectivity from the new Community Diagnostic Hubs

Data is generally spread across two data centre's to act as failover, due to this failover and the business continuity the solution is seen as a low risk.

Option 4: Federated:

A federated PACS solution allows for storage on each Trust site, whilst using technology to share data between Trusts using standard protocols. This allows for a high speed of image retrieval at each location as the image is stored in the Trust, the solution also allows for patient identifier cross referencing (PIX) and one master patient record, and the ability to view the images associated with this record at any of the Trusts. As the storage is local any business continuity issue with leased lines is negated. The solution generally has the storage split over 2 local data centre's to allow for business continuity.

The need to view and exchange images is a major factor in the PACS and RIS procurement, the review by Sir Mike Richards has mandated the use of image sharing technologies and has stated that image sharing technology with home reporting is essential. The Royal College of radiologist are also advising that sharing of images and expertise, across hospital sites, could help to reduce the backlog and provide the technology for the efficient use of workforce to reduce the large costs to teleradiology suppliers. Having a federated PACS and RIS, not only means that images can be accessed quickly on site, they can also be moved around the Trust sites with ease and allow the ability to utilize workforce at other sites, as well as providing the technology for the radiologist to report from home.

A patient's historical images are often stored in different hospitals. Federation allows you to share data between Trusts and view patient images, regardless of where and when they were created. It will allow Trusts and the new Community Diagnostic Hubs to combine their individual data to create a comprehensive medical experience for the patient. The result for a clinician using the system will be a patient timeline that shows local studies in addition to studies created in other KMMIC Trusts.

The ability to also store other images via federated Vendor Neutral Archives also means that this model may be able to be used for other departments such as Endoscopy and Ophthalmology in the future.

Option 5: Central Trust hosting:

Trust central hosting would be similar to a Private Cloud solution with storage at one Trust

This would rely on additional leased lines being installed from each Trust to the hosting site.

Costs which were sought for this solution did not include the business continuity element, which may be able to be added. Therefore this is perceived as a medium risk, for the purposes of the OBC due to lack of business continuity

4.7 BENEFITS

Benefits management is described as ‘The identification, definition, tracking, realization and optimization of expected benefits through to their realization’ value management and benefits management are mutually supportive disciplines, where value management is summarized as ‘value is the extent to which benefits (financial and non-financial) exceed the resources required to realize them’.

Benefits management seeks therefore to optimize benefits realization. Effective benefits management will only arise from effective change management. The objectives of benefits management are:

- Forecast benefits are realizable and represent value for money ensuring that investment is made in the right initiatives.
- Forecast benefits realize and enable business and behavioral change ensuring that performance of the investment is aligned to the benefit.
- Benefits are realized as early as possible and are sustained.
- The value of emergent and unplanned benefits is captured.

Benefits are based around service improvement as well as several reports that have been published to improve radiology services across the country such as the Richards Review and GIRFT report

The following table contains the benefits that should be achieved following the procurement of a new PACS solution.

	Indicator	Current Measure	Target Measure	Target Change	Benefits Realisation Measure
Shared images	Images seen in all KMMIC Trusts	Not directly available, though can be seen by logging into each other’s PACS	See all PACS images, with one patient number being a master.	See all PACS images, report from any hospital, see historical images alongside for better diagnosis	See all PACS images in all KMMIC Trusts

Shared documents	Store non DICOM images and scanned documents	Not available, as was not delivered as part of the GE contract	Ability to store all patients' images / documents	Store non DICOM images / Documents such as reports or other diagnostic information	Ability to store all patients' images / documents if Trust requirement
Dose monitoring	Dose monitoring in Radiology for patient safety	Only available in Nuclear medicine or manually entered into RIS by radiologists.	Automatically gather, store and analyses information on patients' radiation exposure	Automatic transfer of dose amount to PACS/RIS	Reduction of population radiation exposure.
Sharing of images to improve patient safety	Sharing of images in one system improved radiation to patients so they are not scanned twice.	Not directly available, though can be seen by logging into each other's PACS	See all PACS images, with one patient number being a master	See all images so that patients are not radiated at 2 sites.	See all PACS images in all KMMIC Trusts
Efficiency savings in MDT meeting	MDT meetings cannot be cross boundary with image sharing	Image sharing not directly available, though can be seen by logging into each other's PACS	True cross boundary MDT meetings with seamless sharing of images	Saving time and providing shared access MDT meetings	All images available in MDT meeting to save time and increase education.

Richards Review Recommendation 7	New diagnostic technologies should be rapidly evaluated (Artificial intelligence in imaging)	AI connected to PACS	Ensure new PACS has some built in AI and can integrate with All AI technologies	AI emended in application of can integrate with any new AI technology	Use of AI in Trusts to decrease Radiologists workload.
Richards Review Recommendation 8	CT scanning capacity should be expanded by 100% over the next five years to meet increasing demand and to match other developed countries. In the Covid-19 recovery phase, priority should be given to ensuring each acute site with an A&E has access to a minimum of two CT scanners so that patients known to be Covid-19 negative can be kept separate from those who are Covid-19 uncertain or Covid-19 positive. Other additional scanners should be deployed to community diagnostic hubs	Would require expansion of PACS storage	Ensure new PACS has no limit to storage size for expected uplift in image amounts	Increased image storage in new PACS contract.	Further increases via (CCN) storage addition has no limits
Richards Review Recommendation 9	MRI, PET-CT, plain X-ray equipment (including mobile X-ray equipment) and ultrasound and DEXA scanning equipment should, as a minimum, be expanded in line with growth rates prior to the pandemic and all imaging equipment older than 10 years should be replaced	Would require expansion of PACS storage. Ensure any new modalities can be added seamlessly.	Ensure new PACS has no limit to storage size for expected uplift in image amounts. Ensure PACS admins can add new modalities	Increased image storage in new PACS contract. Administration rights to PACS admins	Further increases via (CCN) storage addition has no limits. Training provided to PACS administrators to add/change modalities.

Richards Review Recommendation 12	<p>Recommendation 12: There should be a major expansion in the imaging workforce – an additional 2,000 radiologists and 4,000 radiographers (including advanced practitioner radiographers, who undertake reporting) as well as other support staff and key ‘navigator’ roles. Additional training places should be provided for radiologists and radiographers and initiatives will be needed to meet demand, as well as expansion in assistant practitioner and support staff roles</p>	<p>Limits on current PACS logins.</p>	<p>Ensure no licence limits in new PACS contract to add new workforce.</p>	<p>Add additional users to be able to report from PACS</p>	<p>As many logins as required to the new PACS to view images for reporting.</p>
Richards Review Recommendation 13	<p>There should be an increase in advanced practitioner radiographer roles, including for reporting of plain X-rays (to a minimum of 50%); and expansion of assistant practitioner roles to take on work currently undertaken by radiographers.</p>	<p>Limits on current PACS logins.</p> <p>No training provided without additional cost</p>	<p>Ensure no licence limits in new PACS contract to add new workforce.</p> <p>Include ongoing training in new contract</p>	<p>Add additional users to be able to report from PACS</p> <p>Training given to new staff without additional costs</p>	<p>As many logins as required to the new PACS to view images for reporting.</p> <p>New reporters can confidently use the PACS for image review.</p>
5.9 Richards Review	<p>full development of imaging networks with the connectivity to enable image sharing and flexible working, i.e. home reporting by radiologists/radiographers</p>	<p>Radiologists can report from home but sometimes with bulky or sub-standard equipment</p>	<p>Ensure new contract has the ability to allow home reporting seamlessly and also PACS based reporting if required.</p>	<p>Equipment provided to Radiology staff to home report. New PACS allows home reporting</p>	<p>PACS based reporting and no image download issues for home reporters.</p>

5.9 Richards Review	introduction of artificial intelligence (AI) to support reporting as soon as it has been properly evaluated in different areas of imaging (e.g. screening mammography), thereby reducing radiologist/radiographer reporting time	Some AI technology (Brainomix is already integrated in PACS	Ideally new PACS will have some built in AI.	Integration with all external AI solutions available, and use of built in AI where possible	Decision support AI available to Radiologists to reduce workload where possible.
6.2 Richards Review	For imaging services, IT connectivity will enable efficient use of radiology staff by allowing the workload of reporting to be shared across a network, and will provide access to specialist opinions when these are not available locally. It will allow home reporting of images and avoid duplication of diagnostic tests as patients move between hospitals. The same need for connectivity applies to cardiorespiratory diagnostics	Connectivity via HSCN at present. True image sharing not directly available, though images can be seen by logging into each other's PACS	Sufficient network speeds to allow sharing of images documents	Ensure sufficient speed of HSCN network or upgrade to allow seamless reporting from any site	Quickly open images from another site
6.4 Richards Review	Community diagnostic hubs will also need to be linked effectively with primary care and with hospitals	Not available as CDH's no yet live	Transfer of images to Trust PACS from CDH Sufficient network speeds to allow sharing of images documents	Ensure sufficient speed of HSCN network or upgrade or install Direct links	Development of integrated symptom-based pathways to diagnosis agreed between primary and secondary care

7.5 Richards Review	One of the key drivers for imaging networks is to facilitate sharing of images between providers. This will avoid duplication of imaging when a patient moves between hospitals and will also allow reporting to be done where there is spare capacity, including home reporting. In addition, complex interventional radiology may best be delivered in a small number of locations within a network.	Connectivity via HSCN at present. True image sharing not directly available, though images can be seen by logging into each other's PACS	Sufficient network speeds to allow sharing of images documents	Ensure sufficient speed of HSCN network or upgrade to allow seamless reporting from any site	Quickly open images from another site
GIRFT Recommendation 2	Imaging should be arranged at a time and place to suit patients and ensure their safety.	Not available as transfer of images from AQP not available everywhere.	Transfer of images to Trust PACS from AQP's	Ensure IEP or HSCN connectivity from Primary Care NOUS locations	Development of integrated symptom-based pathways to diagnosis agreed between primary and secondary care
GIRFT Recommendation 9	All trusts must meet the RCR standards for the use of IT	Workstations meet current specification however 'Who Shares Wins' require seamless image and report sharing	See all PACS images, with one patient number being a master	New PACS must meet the RCR guidance for IT And details from who shares wins document.	A new efficient, collaborative radiology solution. Network wide reporting of unreported studies.

GIRFT Recommendation 18	All trusts should move to a network model of service delivery in line with the NHSE/I strategy.	Connectivity via HSCN at present. True image sharing not directly available, though images can be seen by logging into each other's PACS	Sufficient network speeds to allow sharing of images documents	Ensure sufficient speed of HSCN network or upgrade to allow seamless reporting from any site	Quickly open images from another site
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4.7 BENEFITS - Cash releasing and non-cash releasing benefits

Key: **CRB** – Cash Releasing Benefit, **NCRB** – Non-Cash Releasing Benefit, **SB** – Societal, **Q** – Qualitative

Indicator	Target Measure	Target Change	Benefits Realisation Measure	Type
Workstations purchased by Trust and not within the PACS contract	Workstations managed by IT at each Trust	Cheaper overall cost of workstation	£3,462,683.46	Cost Avoidance NCRB
Traumacad	Software no longer required and available in core functionality	No specialist software required	Unknown as part of the overall GE contract	Cost Avoidance NCRB
Cardiology	Cardiology Archives transferred to PACS	Combined Cardiology and Radiology PACS archive following go live of PACS	Approximately 50-80k per year per Trust (Based on new CCN being required to new PACS supplier and current archive contract's not being renewed)	Cash releasing benefit CRB

Indicator	Target Measure	Target Change	Benefits Realisation Measure	Type
Management of contract	Time taken managing the difficulties with the contract would be significantly less	Hours of time equating to cost per hours of staff Average of £25 per hour	Approximately £9,600 per year	NCRB, Q
Uptime of the system	Stability of system, meaning less delay in patient care, rebooking of appointments and further care costs	99.95% uptime to avoid delays in patient case	Staff cost and on-going care to the patient through delayed diagnosis	NCRB, Q
Clinical efficiency	Less time to report studies, faster image transfer, ability to see all patient records.	Overall clinical efficiency, saving time in the department	Staff can report more studies	NCRB, Q
Pooling of Radiologists	Ability for Radiologist to report other Trusts studies	Saving of on-call costs across Trusts, and pooling of resources.	Future saving of on-call costs	CRB

There are no social benefits or financially quantifiable non-cash-releasing benefits therefore the only economic assessment is on net present costs which considers cash releasing benefits.

5. COMMERCIAL CASE

This Commercial Case identifies an overview of the procurement process.

5.1 PROCUREMENT AND EVALUATION PROCESS

The current contract for the PACS and RIS solution is held by EKHUFT on behalf of the KMMIC consortium, costs are then recharged to MTW and MFT by the EKHUFT Finance team. There is a legally binding memorandum of understanding which will be updated or re-written as part of the procurement project.

The procurement process will be competition/tender via the QE Procurement framework for Clinical Software (and Hardware) Solutions for use in Healthcare (2021/S 001-002154) and will be supported by NHS Business services. IT solutions purchased through this framework are supported by NHS standard contracts tailored to the KMMIC requirements.

The initial stage of the procurement will require prospective suppliers to self-assess against pre-qualifying statements, which will center on the need for suppliers to have proven experience in implementing a shared PACS into a complex, multi-organization network.

There will be several subsequent stages through which the number of suppliers taken forward to the subsequent stage will be reviewed based on their responses and performance during each stage.

We expect the stages to be:

- Market testing (completed)
- Advertising the requirement
- Gateway questions
- Supplier self-assessment
- Supplier questionnaire
- Evaluation of responses
- Demonstrations
- Reference site visits
- Ratification of responses
- Preferred bidder
- Contract award

The weighting of the evaluation document will be as follows:

	Weight	Sub criteria	Sub criteria weight
Quality	55%	Specification	55%
		Demonstration	
Commercial	3%	Contract Mark-up	3%
Social Value	10%	The social value of the contract	10%
Price	32%	Pricing	32%
Total	100%		100%

The evaluation team will be made up of the following people from each Trust

- IT Director (MFT)
- IT Technical Lead (all Trusts)
- Heads of Radiology (all Trusts)
- Clinical Leads (Radiologists and Reporting radiographers) at least 3 per Trust
- PACS Managers (all Trusts)
- Radiology Business Manager (EKHUFT)

5.2 SOCIAL VALUE

From January 2021 Social Value must be considered for all central government contracts and should make up 10% of the weighting in any tender. This will become mandatory for NHS contracts in 2022.

Though the application of this model will be mandatory, the commercial team can remain flexible in deciding which of the outcomes should be applied to a particular procurement.

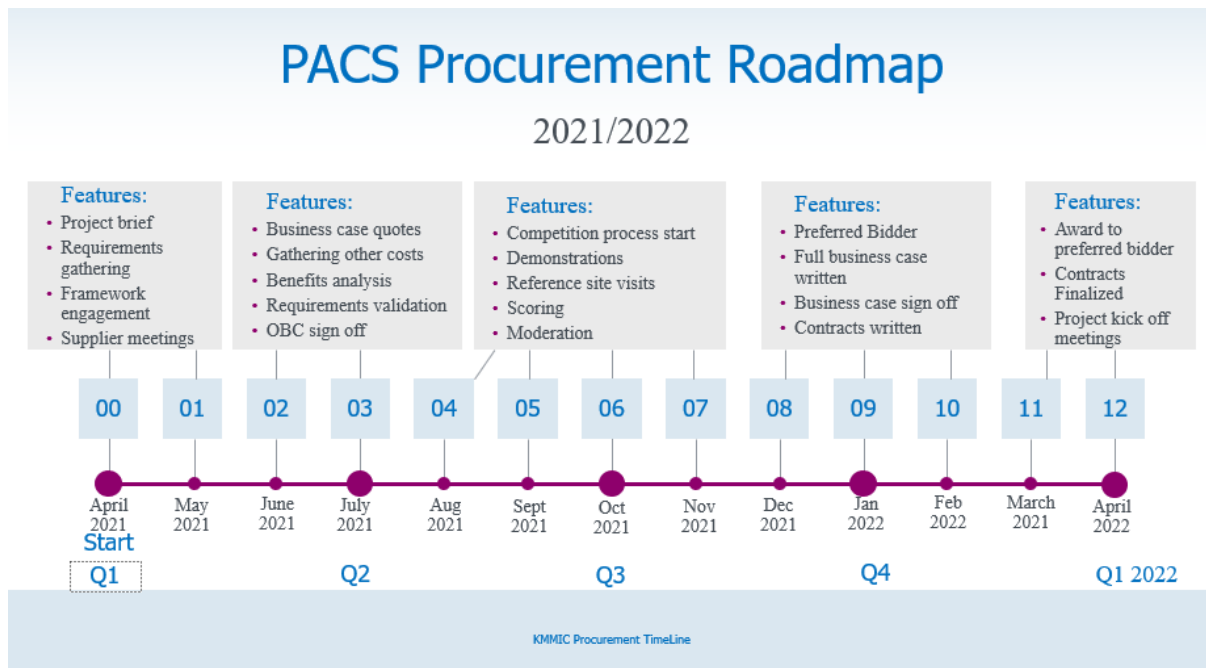
When joining the commercial framework being used for this procurement, the suppliers have had to prove that they comply with the Public Services (Social Value) Act 2012. The Act requires public authorities to have regard to economic, social and environmental well-being in connection with public services contracts.

There will be a scored element within the tender questions will be added to the outline business specification, to enable the scoring of the Social Value portion of the contract.

5.3 PROCUREMENT TIMELINE

It must be noted that the timeline for the procurement process is extremely tight due to the contract end date and migration of data.

See below for the timings of the procurement which must happen this financial year



5.4 MARKET ASSESSMENT

In early May 2021 a Digital Diagnostics Showcase hosted by NHS E&I South East region Stakeholders from all acute Trusts within the Imaging Network attended as well as ICS representatives attended the event, which was staged to showcase recent technological developments affecting Radiology and Pathology services. Market leading suppliers, including the incumbent supplier to KMMIC, accepted the invitation to present their products to the delegates. From this the Network gained and insight to the current market offering.

Following this showcase meeting, QE framework were asked to complete a Market Testing exercise on behalf of KMMIC

The market testing exercise was asked to provide costs for the following options

1. A federated system which could share images across all Trusts but which had hardware on site
2. A centrally hosted system which would be hosted on one Trust site or in a private cloud.

The supplier matrix that was asked to respond to the market testing exercise is shown below

Clinical Software (and hardware) Solutions For Use In Healthcare	Image Management - Radiology
Agfa HealthCare IT UK Ltd	x
Avante IT (UK) LTD T/A 3verest	x
BridgeHead Software Ltd	x
Canon Medical Systems	x
Change Healthcare	x
Fujifilm UK Ltd	x
GE Healthcare	x
Healthcare Software Solutions Ltd	x
Hyland Software UK, Ltd.	x
Insignia Medical Systems Ltd	x
Intelerad	x
Myorb Limited	x
Philips	x
Sectra Limited	x
Siemens Healthineers	x
Soliton IT Limited	x
SynApps Solutions Limited	x
Visbion	x

From the list of suppliers on the QE framework supplier matrix above, the following suppliers responded with costs for both solutions.

Supplier
Agfa
Cannon
Change Healthcare
GE
Insignia
My Orb
Phillips
Sectra
Soliton - RIS Only

5.5 SERVICE REQUIREMENT

Though the contract is a jointly procured KMMIC contract, there are elements that are only in place for one or two of the trust. The RIS is also not expected to change and the contract will be transferred and the software hosted by the new PACS supplier. The table below shows how the different elements of the contract are source and which Trust they relate to

Component	Sourced
Core PACS	Via a Mini Completion process
VNA	Within the Contract for the main Core PACS
XDS	Within the Contract for the main Core PACS
RIS	Transfer of the current contract to new PACS supplier
Trauma Cad	MFT and EKHUFT only. Transfer of the current contract to new PACS supplier
Viewpoint	EKHUFT only direct contract with HNC following GE contract end
Migration of Modalities to new Solution	Procured per modality supplier
Programme and Project Management	Procured by KMMIC (via EKHUFT and recharged)

5.6 CONTRACT AND TERM

An effective contract is one that addresses what is to be delivered, how it is to be delivered (including the division of roles, responsibilities and risks between customer and supplier), when it is to be delivered, how support is to be provided once the PACS system is live, how much it will cost, and what triggers payment.

The contract for PACS/RIS and associated products is expected to be 10 years from the commencement of the service with opportunities to extend for further years based on performance and delivering continued value for money.

The contract will provide the necessary professional services support by the supplier for the implementation phase and the lifetime of the contract. There will be clauses contained within the contract which will cater for dispute resolution either by service credits or refunded costs. The contract will also cater for change control for the lifetime of the contract this will enable additions such as the digital pathology to be added at a later date for an additional charge.

There will be exit clauses written in to the contract which will ensure the supplier assist with the data migration at the end of their contractual term.

The framework includes standard Radiology contract terms and conditions, the contract will also include specifics from the outcome of the competition process.

At the end of the current GE contract a direct contract between the viewpoint supplier (HNC) and EKHUFT will need to be arranged.

6 FINANCE CASE

The economic case puts forward options some of which have been taken forward for Market Testing to get an understanding of the costs involved the finance case now looks at the affordability of this option

The current cost of the contract, excluding the new Soliton element is £120,379 excl. VAT per month. (1,444,548.00 per year) The Soliton element added £1,580,000.00, which due to the staggered go lives is being charged.

6.1 ORIGINAL 7 YEAR CONTRACT COSTS

The original Contract Value including the GE RIS is in the table below. Please **note this is a 7-year** cost and we have now extended the contract by 2 years

Invoice Amounts	DGT	EKHUFT	MTW	MFT	Totals
Seven Year Totals					
PACS Component	835,635	2,016,325	1,029,096	880,648	4,761,704
RIS Component	722,319	1,131,267	789,355	603,898	3,246,839
VNA Component	187,669	340,698	276,333	205,111	1,009,812
	£1,745,624	£3,488,290	£2,094,784	£1,689,657	£9,018,355
Annual Charge					
PACS Component	119,376	288,046	147,014	125,807	680,243
RIS Component	103,188	161,610	112,765	86,271	463,834
VNA Component	26,810	48,671	39,476	29,302	144,259
	£249,375	£498,327	£299,255	£241,380	£1,288,336
Quarterly Charge					
PACS Component	29,844	72,012	36,753	31,452	170,061
RIS Component	25,797	40,402	28,191	21,568	115,959
VNA Component	6,702	12,168	9,869	7,325	36,065
	£62,344	£124,582	£74,814	£60,345	£322,084

6.2 CURRENT MONTHLY CONTRACT COSTS

Feb-21	60000050					18.8%	38.7%	23.6%	18.8%	100.0%
Managed service		£80,521.03	£16,104.21	£96,625.24		£15,150	£31,166	£19,028	£15,176	£80,521.03
Accepted 206 (205 items)		£26,709.45	£5,341.89	£32,051.34		£5,025	£10,338	£6,312	£5,034	£26,709.45
Accepted 206 since April 2019				£0.00		£0	£0	£0	£0	£0.00
5% retainer		-£5,361.52	£0.00	£0.00		£0	£0	£0	£0	£0.00
Servers		£7,179.22	£1,435.84	£8,615.06		£2,132	£2,701	£543	£1,804	£7,179.17
CCN2 Deduction	ALL Nmed	-£1,666.67	-£333.33	-£2,000.00		-£314	-£645	-£394	-£314	-£1,666.67
CCN6	MTW	£2,400.00	£480.00	£2,880.00				£2,400.00		£2,400.00
CCN9	EKH	£600.00	£120.00	£720.00			£600.00			£600.00
CCN10	All	£817.86	£163.57	£981.43		£204.47	£204.47	£204.47	£204.47	£817.86
CCN11	EKH	£832.71	£166.54	£999.25			£832.71			£832.71
CCN12	EKH	£575.31	£115.06	£690.37			£575.31			£575.31
CCN13	D&G	£688.16	£137.63	£825.79		£688.16				£688.16
CCN16	EKH	£486.00	£97.20	£583.20			£486.00			£486.00
CCN17	EKH	£222.36	£44.47	£266.83			£222.36			£222.36
CCN18	D&G	£493.67	£98.73	£592.40		£493.67				£493.67
CCN21	EKH	£557.48	£111.50	£668.98			£557.48			£557.48
CCN22	EKH	£1,190.73	£238.15	£1,428.88			£1,190.73			£1,190.73
CCN23	Medway	£300.17	£60.03	£360.20					£300.17	£300.17
CCN25	D&G	-£10,000	-£2,000.00	-£12,000.00		-£10,000.00				-£10,000.00
CCN26	EKH	£1,342	£268.46	£1,610.77			£1,342			£1,342.31
CCN27	EKH	£880	£176.02	£1,056.14			£880			£880.12
CCN29	EKH	£1,615	£322.95	£1,937.70			£1,615			£1,614.75
CCN30	EKH	£856	£171.16	£1,026.95			£856			£855.79
CCN34	EKH	£1,280	£256.02	£1,536.10			£1,280			£1,280.08
CCN35	EKH	£2,499	£499.76	£2,998.57			£2,499			£2,498.81
Total		£120,379	£24,076	£144,455		£13,380	£56,701	£28,093	£22,205	£120,379

6.3 SOLITON RIS CCN CHANGE COSTS

Additional Cost - KMMC Soliton RIS revised phasing	20/21	21/22	22/23	23/24	Total
EK Go Live 19th Oct 20	£128,345	£280,025	£280,025	£70,006	£758,400
Medway Go Live 19th Feb 21	£19,126	£153,011	£153,011	£38,253	£363,400
MTW Go Live End of March 21		£203,644	£203,644	£50,911	£458,200
Total Additional GE Soliton RIS cost	£147,471	£636,680	£636,680	£159,170	£1,580,000

6.4 WORKSTATION COSTS

The current GE contract included the provision and support of the workstations. The contract charge per workstation equates to £3,600.00 per annum (taken from CCN 09 – 2 Workstations), so over the 10 year's this equates to £36,000.00 per workstation. For the Trusts this equates to the following amount over a 10-year period:

GE 10 Year Costs Workstations	
EKHUFT	£3,348,000.00
MTW	£1,044,000.00
MFT	£720,000.00

As mentioned in the workstation section the GE machines have not been managed well, they are not updated with the latest cyber security updates and operating systems are allowed to lapse past the end of support period. This poses a cyber security risk to the Trust. Along with this, the applications often have errors when launching; such as Java errors which, though being reported many times, have not been resolved.

Allowing the local teams to manage the workstation will provide a cost saving of around 1/3 the equivalent workstation costs over a 10-year period, equate to:

Trust owned 10 Year Workstation costs	
EKHUFT	£1,053,499.02
MTW	£363,004.80
MFT	£232,812.72

6.5 MARKET TESTING COSTS

Business case costs have been sort via a framework process, to replace the current PACS solution with a new PACS, providing the ability to truly share images and patient history as well as provide a Vendor Neutral Archive and an XDS component for the ability to transfer document. The Framework Business Case quote process provided a range costs from 8 suppliers

The costs have the workstations broken out of the PACS contract, as well the Viewpoint software for East Kent. Also included are costs for staffing and the transfer of the modalities to a new contract.

As we expected when asking for business case quotes, there is a large variation in the costs. Included below are from the top and bottom of the range of quotes, discounting the very highest and very the lowest, this still offers quite a large range of costs.

The Trust percentage split below is based on the number of images and the storage size at each Trust, this percentage figure may change slightly following the full completion and more information about off-line storage has been provided, which has currently been requested from GE:

Costs split per Trust – Subject to change at final procurement:

EKHUFT	38.23%
MTW	32.40%
MFT	29.37%

The programme costs include both capital and resource expenditure and cover licence fees, implementation, and on-going running costs for both the Trust and the supplier of the option.

6.6 COSTS FROM 2ND HIGHEST BIDDER KMMIC COMBINED

The cost table below is from the second highest bidder for all 3 Trusts combined and includes costs for the entire project.

Costs Top End - CAPITAL	Revenue 21/22	Capital 22/23	Revenue 22/23	Revenue 23/24	Revenue 24/25	Revenue 25/26	Revenue 26/27	Capital 27/28	Revenue 27/28	Revenue 28/29	Revenue 29/30	Revenue 30/31	Revenue 31/32	10 year totals
Overall Costs KMMIC Top End														
Workstations/monitors (2 monitors)		£824,658.27						£824,658.27						£1,649,316.54
RIS Transfer Costs			£150,000.00											£150,000.00
RIS Revenue			£455,000.00	£455,000.00	£455,000.00	£455,000.00	£455,000.00		£455,000.00	£455,000.00	£455,000.00	£455,000.00	£455,000.00	£4,550,000.00
PACS GE Exit costs			£119,000.00											
PACS		£7,581,006.54						£5,530,030.54						£13,111,037.08
PACS Revenue			£1,316,098.03	£1,316,098.03	£1,316,098.03	£1,316,098.03	£1,316,098.03		£1,316,098.03	£1,316,098.03	£1,316,098.03	£1,316,098.03	£1,316,098.03	£13,160,980.31
Traumacad														
Programme Manager	£88,396.80		£76,598.40											£164,995.20
Senior Project Manager	£18,660.00		£74,401.20	£37,200.00										£130,261.20
PACS Managers backfill			160,210.80											£160,210.80
Modality suppliers engineering @£700 each			249,200.00											£249,200.00
Radiologists backfill for procurement	£231,250													
Total	£338,306.80	£8,405,664.81	£2,600,508.43	£1,808,298.03	£1,771,098.03	£1,771,098.03	£1,771,098.03	£6,354,688.81	£1,771,098.03	£1,771,098.03	£1,771,098.03	£1,771,098.03	£1,771,098.03	£33,676,251.13

6.7 COSTS FROM 2ND LOWEST BIDDER KMMIC COMBINED

Below is the cost table from the second lowest bidder for all 3 Trusts combined and includes costs for the entire project

Costs Bottom End - Revenue	Revenue 21/22	Capital 22/23	Revenue 22/23	Revenue 23/24	Revenue 24/25	Revenue 25/26	Revenue 26/27	Capital 27/28	Revenue 27/28	Revenue 28/29	Revenue 29/30	Revenue 30/31	Revenue 31/32	10 year totals
Overall Costs KMMIC Bottom End														
Workstations/Monitors (2 monitors)		£824,658.27						£824,658.27						£1,649,316.54
RIS Transfer Costs			£150,000.00											£150,000.00
RIS Revenue			£455,000.00	£455,000.00	£455,000.00	£455,000.00	£455,000.00	£0.00	£455,000.00	£455,000.00	£455,000.00	£455,000.00	£455,000.00	£4,550,000.00
PACS GE Exit costs			£119,000.00											£119,000.00
PACS Capital														
PACS Revenue			£1,140,356.65	£1,140,356.65	£1,140,356.65	£1,140,356.65	£1,140,356.65	£0.00	£1,140,356.65	£1,140,356.65	£1,140,356.65	£1,140,356.65	£1,140,356.65	£11,403,566.50
Traumacad														
Programme Manager	£88,396.80		£76,598.40											£164,995.20
Senior Project Manager	£18,660.00		£74,401.20	£37,200.00										£130,261.20
PACS Managers backfill			£160,210.80											£160,210.80
Modality suppliers engineering @£700 each			£249,200.00											£249,200.00
Radiologists backfill for procurement	£231,250													£231,250.00
Total	£338,306.80	£824,658.27	£2,424,767.05	£1,632,556.65	£1,595,356.65	£1,595,356.65	£1,595,356.65	£824,658.27	£1,595,356.65	£1,595,356.65	£1,595,356.65	£1,595,356.65	£1,595,356.65	£18,807,800.24

6.8 COSTS SPREADSHEET PER TRUST

Embedded is the cost table for all Trusts figures, broken by individual Trust and includes costs for the entire project from the 2nd highest bidder and the 2nd lowest bidder.



OBC Costing
Options Trust Split.)

6.9 CURRENT AND FUTURE ANNUAL COSTS

Below is a table showing the existing yearly costs for KMMIC and MTW costs alongside the new lower and higher costs which is based on the initial market testing exercise.

6.10 CURRENT AND FUTURE ANNUAL - KMMIC

Existing KMMIC	New System Lower Estimate	New System Higher Estimate
£2,081,228	£1,880,779	£3,367,625.00

6.11 CURRENT AND FUTURE ANNUAL - MTW

Existing MTW	New System Lower Estimate	New System Higher Estimate
£540,780.00	£594,416.58	£1,076,154.39

6.12 BIDS FOR NATIONAL FUNDING

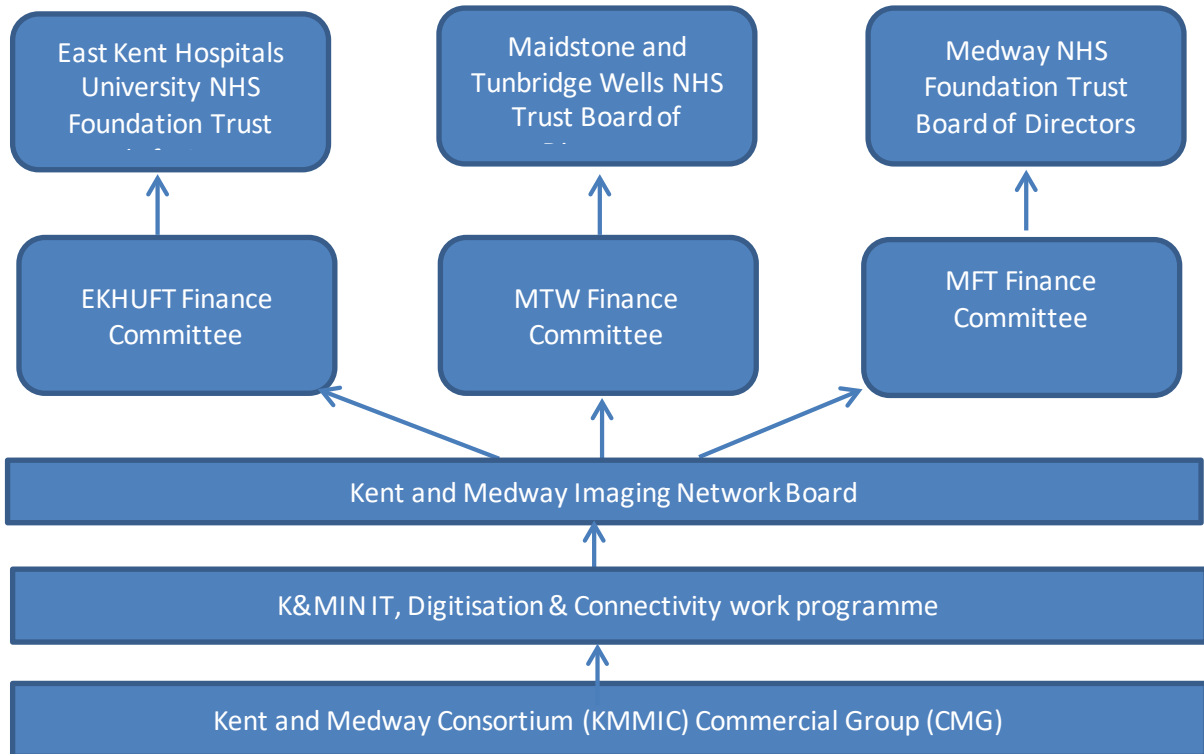
As mentioned in the background section there is national funds available for the Kent and Medway imaging network, which may be available to provide some funding to assist in any costs for the contract change over period; as well as provide some revenue assistance with the first two years of the contract, these funds should allow the connection to Dartford who have left KMMIC but are still part of the Kent and Medway Imaging Network (K&MIN)

Below is a summary table of the bids that have been requested from the national funds which are relevant to the PACS replacement. Whether we received these funds or not (for the PACS and RIS) will not be known until next year, however the workstation and Program manager funds should be decided by the end of July of 2021.

Bids for National Funding	Revenue 21/22	Capital 21/23	Capital 22/23	Revenue 22/23	Revenue 23/24
Workstations/Monitors		£1,694,376.26			
PACS replacement			£2,050,609.08	£2,050,609.08	£2,050,609.08
RIS replacement				£486,154.00	£486,154.00
Programme Manager	£64,076.16			£76,598.40	
Project Manager				£74,401.20	£37,200.00

6.13 APPROVAL PROCESS

There will be a series of meeting where the approval will be sort for both Governance and Financial sign off by the individual Trusts. The approval process is expected to be similar to the diagram below.



7 MANAGEMENT CASE

The Management Case sets out how the programme of work will be managed through a structured implementation programme.

7.1 PROGRAMME ORGANISATIONAL STRUCTURE

The programme will be managed using the principles of Managing Successful Programmes (MSP). Component Workstreams and Projects will be managed using the principles of Projects in Controlled Environments (PRINCE2) methodologies. Adoption of these methodologies requires a programme management structure that has clear channels of communication to governance and decision-making forums. The construct of the Programme Team will be supported by role descriptions that specify the responsibilities, goals, limits of authority, relationships, skills, knowledge, and experience for all roles within the programme organisation.

7.2 PROGRAMME BOARD AND KEY ROLES

The programme board will provide the overall direction to the PACS replacement programme. It has responsibility to formally commission enabling projects and committing the required resources. It has the authority to sign off the completion of each phase and authorises the start of the next phase. The PACS replacement programme board will approve project Initiation documentation for each Trust project and provide permission to proceed. The programme board will be responsible for project governance standards and monitor project progress reporting. The programme board will

operate within financial delegations of authority, to be agreed with the Trusts Financial Planning Group.

7.3 SENIOR PROJECT MANAGER

The project will be led by an experienced senior project manager, who will be full time and in post for the duration of the project. The senior project manager will have day-to-day responsibility for the successful delivery of the overall project and will report to the programme board. They will be the main point of contact and will represent the Project Team on the programme Board. The senior project manager will be PRINCE2 qualified to ensure that they can deliver the project aligned to these standards.

7.4 SENIOR RESPONSIBLE OWNER AND PROGRAMME BOARD CHAIR

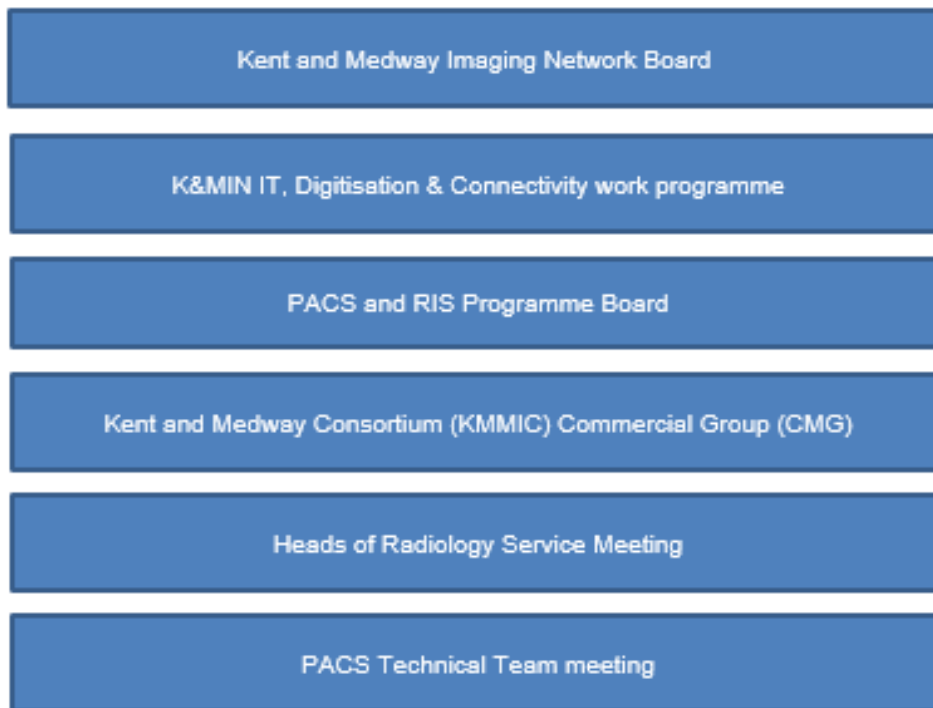
The SRO is the lead individual responsible for ensuring that the Programme meets its objectives and delivers the projected benefits.

The SRO:

- is the visible owner of the overall business change and the evangelist for the programme as a whole;
- is recognised throughout the organisation;
- is the key leadership figure in driving the programme forward;
- creates, communicates, and evangelises the programme vision both inside and outside the organisation;
- is responsible for overall direction, leadership, and guidance for the programme;
- ensures the programme delivers the right capabilities to achieve its strategic outcomes;
- oversees and ensures the ongoing delivery and assessment of benefits associated with the programme;
- provides ownership of the Programme's Business Case, including continuous confirmation of its viability;
- sets and reviews overall strategy and interfaces with other initiatives;
- authorises the start and continuation of the programme from the corporate perspective;
- commissions assurance and audit reviews;
- chairs Programme Board meetings.

7.5 CURRENT AND FUTURE PROGRAMME GOVERNANCE

The below diagram shows the current structure for the PACS replacement programme and its integration into existing Trust and Imaging network governance structures. It reflects the need to represent the organisations, end user and the external quality assurance role. There is an expectation that the programme, once underway, will need to report to the various Trust Board.



7.6 TECHNICAL AND CLINICAL DESIGN

Given the pan-organizational arrangement of the KMMIC organization decisions on clinical and technical aspects that would otherwise be sovereign to a Trust will require consideration at a Network level; and therefore, decisions might be delegated to a body that has representation from all Trusts and other organizations.

In this programme the K&MIN IT, Digitization & Connectivity work programme will act as the clinical and technical design authority as it contains both Clinical and IT representation.

The K&MIN IT, Digitization & Connectivity review will additionally maintain an overview of all significant IT and clinical projects and initiatives being undertaken across the whole health economy in order to ensure that risks and issues do not arise from aspects such as resource clashes and IT change freezes etc.

7.7 WORKSTREAM LEADS

The work of the project team will be managed and completed within focused workstreams. Each workstream will be led by an appropriately skilled and knowledgeable manager who will have the necessary experience to ensure that all work undertaken by the workstream meets the required quality criteria. Work will be described in detail within work packages, following detailed planning, in which system users and workstream leads will be fully involved. The work packages will contain all necessary information including quality expectations, reporting arrangements, agreements on timescales and risk management thresholds. Workstream Leads will be responsible for all the work within the workstream and will agree the work packages on behalf of the workstream.

7.8 SPECIALIST RESOURCES

Within the project's resource structure, there will be several resources working with Senior Project Manager. Examples include, IT Infrastructure Managers, Training Manager, Information Governance leads, Testing Manager and PACS Administrators. The responsibilities of these roles will be more fully defined during the Initiation stage of the project, once approval to proceed to Initiation has been achieved. Specialist resources are likely to be required from each Trust in KMMIC.

7.9 KEY STAKEHOLDERS

The stakeholders are from both a Trust and National Level and include members of the local KMMIC teams as well as the K&MIN. Stakeholders are consulted in a series of meetings and feedback is taken into consideration on all aspects of the project.

Kent and Medway Diagnostics Network, NHS National Teams and Primary Care	Diagnostic Lead K&MIN - Oliver Mckinley South East England Digital Diagnostics Lead - Jane Ciller's Lesley Wright - Diagnostics Specialist Advisor. Dr Jack Jacobs - Clinical Director Ashford Rural Primary Care Network
EKUHFT	SRO – Liz Shutler (TBC) Director of IT – Andy Barker Clinical lead - Dr Paul Mctravers (TBC) Radiology General Manager – Cara Barlow Business Manager (KMMIC) – Colin Fell Lillian Rosser – Radiology Applications Manager
Medway	Director of IT – Michael Beckett Clinical lead - Dr Fabian Sebastian n(TBC) Head of Imaging – Lorraine Beconsall Radiology Information Manager (KMMIC) – Adrian Lewis
MTW	Director of IT – Sue Forsey Clinical lead – Neil Crundwell (TBC) Radiology General Manager – Susie White Radiology IT Manager (KMMIC) - Mike Tatlow

7.10 PROJECT MILESTONES

Detailed planning for the implementation stage of the Project will be undertaken following authorization to proceed. Given the county-wide nature of the project; the implementation will be large in scale. A Project Initiation Document (PID, will be developed during the Project Initiation stage of the implementation project. The PID will detail the approach to managing the implementation project and effectively form a contract between the Project Board, the Senior Project Manager and Project Team. The PID will contain the various management strategies, such as Communications Management, Risk Management, Configuration Management and Benefits Management.

The table below provides an overview of the key milestones and the indicative timescale in months. It is expected that the implementation will be completed concurrently across all Trusts leaving only phased training and cutover which is expected to be a few weeks apart at each Trust.

a successful deployment will need assurance that all necessary staff including clinicians have been sufficiently trained prior to go-live and will form part of the cutover planning arrangements and approval to go-live.

Due to the amount of data involved that requires migrating, it is expected at the initial go-live stage, there will be approximately 2 years' worth of images transferred and that the remaining data will be transferred over the following 6-9 months with smart pre-fetching of images to cater for patient appointments.

PACS/RIS recruitment for programme manager	Apr-21
Requirements gathering	Apr-21
Framework and supply chain engagement	May-21
Business case quote	May-21
Supplier engagement	May-21
Business (OBC) case circulated for	July-21
Competition documents completed	July-21
OBC Business case signed off for funding (Trusts/National)	July- 2021
Decision on funding bid from NHSI	Jul-21
PACS/RIS Competition start	August - 2021
Clarifications, demos, reference site Aug/September/October	Aug- Nov 2021
Communications programme start	Dec-21
project manager (s) recruitment	Dec-21
PACS/RIS competition completed	Nov-21
FBC Signed off for approval	Nov/Jan 2022
Contracts finalised	Jan/Feb 2022
Project planning and initiation	Feb-22
Install hardware/software across sites	Apr-22
Begin migration work per Trust	June -November-22
User acceptance testing (UAT) commences	November - Jan - 22-23
Go Lives Phased one per trust	Feb-March-23
Hypercare period.	Feb, March, April 23
PACS/RIS lessons learned	May-23
Cardiology migration (where applicable)	June-November-23
PACS Breast screening migration to PACS - KMMIC- (TBC) could be part of initial roll out)	November - May - 23-24

7.11 PRELIMINARY RISK ASSESSMENT

The PACS procurement utilizes a risk register as one of its management tools, which will continue to be updated and managed through to procurement implementation and transition to the new system. The identified risks are assigned to a risk family and risk owner and RAG rated according to their impact and probability to formulate the Gross Risk Analysis score (Impact x Probability). A risk management strategy is then assigned to each risk on the basis of either:

- Accepting the risk
- Reducing the risk
- Avoiding the risk
- Transferring the risk

A residual risk target is allocated to each risk based on mitigating actions and progress is monitored against this. The risk register will be reviewed as the project proceeds at the Contract Management Meeting (CMG) meeting along with management actions based on the review date assigned to each individual risk along with any new risks that have arisen in the period.

The scoring matrix for the risk register is illustrated below:

Probability	Very Likely 5	5	10	15	20	25
	Likely 4	4	8	12	16	20
	Feasible 3	3	6	9	12	15
	Slight 2	2	4	6	8	10
	Very Unlikely 1	1	2	3	4	5
	Insignificant 1	Minor 2	Significant 3	Major 4	Critical 5	
	Impact					

The preliminary risk assessment has identified the risks below

Description	Impact	Probability	RAG	Mitigation	Owner
Failure to meet the timescale for OBC approvals in October 2021	3	4	12	Extension of GE contract	Radiology programme Manager /Procurement
Poor Trust engagement	4	1	4	Gain support through Trust Radiology heads	Workstream lead
Additional funding unable to be sourced for new PACS deployment	5	2	10	Identify and agree funding stream/s asap	Radiology programme Manager/ NHSI/ CFO

Schedule delays due to any governance group not approving OBC or requesting additional info.	3	3	9	Engage and inform early – no surprises for members.	IT Directors/ Radiology Heads of service/CFO
FBC not being approved by three Trust Boards	4	2	8	Engage and inform early – no surprises for Trusts. Extension of GE contract	Radiology programme Manager
Availability of required resources	4	2	8	Obtain funding required and commitment from Trusts to release SMEs.	Radiology programme Manager
Financial bids to NHSI may not be approved	3	3	9	Use existing staff. Fund new workstations and end user devices/ screens and project staff internally.	CFO's
DOF's may wish to keep GE due to the like for like cost as new contract will be more expensive.	4	3	12	Ensure completion is scored 70% technical and 30% cost and contract failings are highlighted.	Radiology programme Manager
Lack of continued support from GE for data migration tasks if another supplier wins the competition.	5	4	20	Ensure GE meet their contractual obligations and any exit costs and timescales are agreed.	Contact management group. To ensure that we hold GE to their contractual obligations.
Radiologist schedule does not allow for scoring the competition.	3	3	9	Agree with Heads of Radiology to allow the Radiologists time to be ringfenced.	programme manager, Heads of service.
Data migration schedules are not met and GE contract needs to be extended, incurring extra cost.	4	3	12	Plan project delivery to priorities data migration	Project manager
Disagreement from each Trust evaluators on solution	3	3	9	Appoint a lead radiologist from each Trust for decision making	Lead Radiologists/ Programme manager

8 APPENDICES

7.1 IMAGE AND POPULATION GROWTH INFORMATION

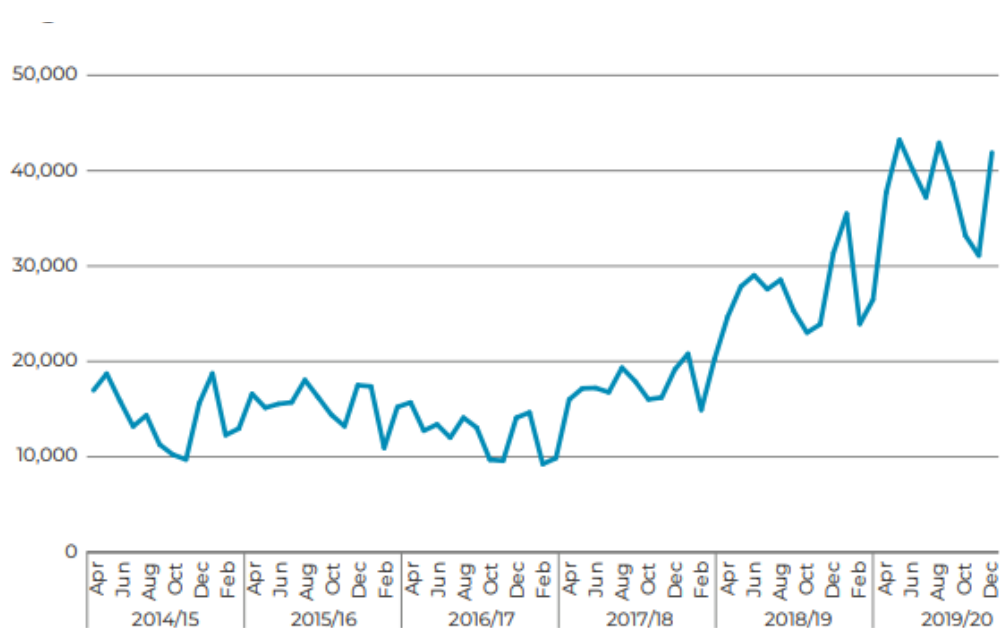
Image size as well as population growth is directly related to the cost of a new PACS system as the contracts are costed on the number of images and the size of the storage; the current increase percentages during the life of the contract are based on:

Predicted Storage Demand Increase / Decrease (%)	Increase 10% yearly
Predicted Study Demand Increase / Decrease (%)	Increase 5% yearly

As more Community Diagnostic Hubs are implemented, these figures may need to be increased via a CCN change.

Below is some other information on image and population growth which could affect the PACS storage and image requirements.

Number of patients waiting 6+ weeks at month end for a diagnostic test



Source: NHS England. [Monthly Diagnostic Waiting Times and Activity Data \(DM01\)](#)

Growth in imaging activity 2014/15 to 2018/19

	2014/15	2018/19	Average growth p.a.	Average additional activity
Plain X-ray (DID)	22.6m	23.5m	0.9%	208k
Non-obstetric ultrasound (DMOI)	6.6m	7.6m	3.8%	261k
CT (DMOI)	4.7m	6.1m	6.8%	352k
MRI (DMOI)	2.9m	3.6m	5.6%	176k
DEXA (DMOI)	389k	455k	4.0%	16k
PET-CT (DID)	89k	177k	18.7%	22k
Mammography*	2.7m	2.8m	1.2%	32k

Source: NHS England. [Diagnostic Imaging Dataset](#) and [Monthly Diagnostic Waiting Times and Activity Data \(DMOI\)](#)

7.2 IMAGE AND POPULATION GROWTH ANALYSIS FROM LABORATORY INFORMATION SYSTEM (LIMS) PROJECT.

Using the KCC model the following was derived:

- Total population for Kent & Medway is forecast to increase from 1.88m in 2020 to 2.16m in 2038 (14.9%)
- Population aged 0-19 is forecast to grow steadily from 455.2k in 2020 to 489.2k in 2038 (7.5%) with a levelling off starting in 2028
- Population aged 20-39 is forecast to grow at a constant rate from 448.4k in 2020 to 465.8k in 2038 (3.9%)
- Population aged 40-59 is forecast to grow from 498.3k in 2020 to 544.3k in 2038 (9.2%) with a greater percentage change occurring from 2028.
- Population aged 60-79 is forecast to grow at a constant rate from 380.6k in 2020 to 489.9k in 2038 (28.7%)
- Population aged 80+ is forecast to grow from 100.3k in 2020 to 174.3k in 2038 (73.8%) with the greatest percentage increase occurring between 2025 and 2029
- For all Kent & Medway, average population age increases from 41.0 in 2020 to 43.5 in 2038
- Canterbury has the greatest percentage of population aged 20-24, which is not forecast to change significantly between 2020 and 2038 whereas Sevenoaks and Tunbridge Wells have significantly lower percentage of their population aged 20-24, which are also not forecast to change materially.
- Between 2020 and 2038 Dartford and Gravesham and Medway will see a lower percentage increase in those aged 60+ than other parts of Kent & Medway.
- Compared to the remainder of Kent & Medway, Dover, Folkestone and Hythe and Thanet have a greater proportion of their populations aged over 55.
- Across all age ranges, Swale largely matches the Kent & Medway average percentage of population.

Additional documents including recent reviews of Radiology and information about the formation of the Imaging networks.

7.3 RICHARDS REVIEW



diagnostics-recovery-and-renewal-index.pdf

7.4 GETTING IT RIGHT FIRST TIME REPORT (GIRFT)



GIRFT-radiology-report.pdf

7.5 ROYAL COLLEGE OF RADIOLOGISTS, WHO SHARES WINS REPORT



rcr164_who-shares-wins.pdf

7.6 DIAGNOSTIC IMAGING NETWORK IMPLEMENTATION GUIDE



B0030-Implementation-guide.pdf

Costs Top End - CAPITAL	Revenue 21/22	Capital 22/23	Revenue 22/23	Revenue 23/24	Revenue 24/25	Revenue 25/26	Revenue 26/27	Capital 27/28	Revenue 27/28	Revenue 28/29	Revenue 29/30	Revenue 30/31	Revenue 31/32	10 year totals
Overall Costs KMMIC Top End														
Workstations/Monitors (2 monitors)		£824,658.27						£824,658.27						£1,649,316.54
RIS Transfer Costs			£150,000.00											£150,000.00
RIS Revenue			£455,000.00	£455,000.00	£455,000.00	£455,000.00	£455,000.00		£455,000.00	£455,000.00	£455,000.00	£455,000.00	£455,000.00	£4,550,000.00
PACS GE Exit costs			£119,000.00											£119,000.00
PACS Capital		£7,581,006.54						£5,530,030.54						£13,111,037.08
PACS Revenue			£1,316,098.03	£1,316,098.03	£1,316,098.03	£1,316,098.03	£1,316,098.03		£1,316,098.03	£1,316,098.03	£1,316,098.03	£1,316,098.03	£1,316,098.03	£13,160,980.31
Traumacad														
Programme Manager	£88,396.80		£76,598.40											£164,995.20
Senior Project Manager	£18,660.00		£74,401.20	£37,200.00										£130,261.20
PACS Managers backfill			£160,210.80											£160,210.80
Modality suppliers engineering @£700 each			£249,200.00											£249,200.00
Radiologists backfill for procurement	£231,250													£231,250.00
Total	£338,306.80	£8,405,664.81	£2,600,508.43	£1,808,298.03	£1,771,098.03	£1,771,098.03	£1,771,098.03	£6,354,688.81	£1,771,098.03	£1,771,098.03	£1,771,098.03	£1,771,098.03	£1,771,098.03	£33,676,251.13

Costs Top End - REVENUE	Revenue 21/22	Capital 22/23	Revenue 22/23	Revenue 23/24	Revenue 24/25	Revenue 25/26	Revenue 26/27	Capital 27/28	Revenue 27/28	Revenue 28/29	Revenue 29/30	Revenue 30/31	Revenue 31/32	10 year totals
Overall Costs KMMIC Top End														
Workstations/Monitors (2 monitors)		£824,658.27						£824,658.27						£1,649,316.54
RIS Transfer Costs			£150,000.00											£150,000.00
RIS Revenue			£455,000.00	£455,000.00	£455,000.00	£455,000.00	£455,000.00		£455,000.00	£455,000.00	£455,000.00	£455,000.00	£455,000.00	£4,550,000.00
PACS GE Exit costs			£119,000.00											£119,000.00
PACS														
PACS Revenue			£2,627,201.74	£2,627,201.74	£2,627,201.74	£2,627,201.74	£2,627,201.74		£2,627,201.74	£2,627,201.74	£2,627,201.74	£2,627,201.74	£2,627,201.74	£26,272,017.39
Traumacad														
Programme Manager	£88,396.80		£76,598.40											£164,995.20
Senior Project Manager	£18,660.00		£74,401.20	£37,200.00										£130,261.20
PACS Managers backfill			£160,210.80											£160,210.80
Modality suppliers engineering @£700 each			£249,200.00											£249,200.00
Radiologists backfill for procurement	£231,250													£231,250.00
Total	£338,306.80	£824,658.27	£3,911,612.14	£3,119,401.74	£3,082,201.74	£3,082,201.74	£3,082,201.74	£824,658.27	£3,082,201.74	£3,082,201.74	£3,082,201.74	£3,082,201.74	£3,082,201.74	£33,676,251.13

Costs EKHUFT Top End	Revenue 21/22	Capital 22/23	Revenue 22/23	Revenue 23/24	Revenue 24/25	Revenue 25/26	Revenue 26/27	Capital 27/28	Revenue 27/28	Revenue 28/29	Revenue 29/30	Revenue 30/31	Revenue 31/32	10 year totals
Workstations/Monitors		£526,749.51						£526,749.51						£1,053,499.02
RIS Transfer Costs			£50,000.00											£50,000.00
RIS Revenue			£173,946.50	£173,946.50	£173,946.50	£173,946.50	£173,946.50		£173,946.50	£173,946.50	£173,946.50	£173,946.50	£173,946.50	£1,739,465.00
PACS GE Exit costs			£45,493.70											£45,493.70
PACS Capital		£2,898,218.80						£2,114,130.67						£5,012,349.48
PACS Revenue			£503,144.28	£503,144.28	£503,144.28	£503,144.28	£503,144.28		£503,144.28	£503,144.28	£503,144.28	£503,144.28	£503,144.28	£5,031,442.77
Programme Manager	£33,794.10		£29,283.57											£63,077.66
Senior Project Manager	£7,133.72		£28,443.58	£14,221.56										£49,798.86
PACS Managers backfill			£53,403.41											£53,403.41
Viewpoint/Obstetrics			£19,874.00	£19,874.00	£19,874.00	£19,874.00	£19,874.00		£19,874.00	£19,874.00	£19,874.00	£19,874.00	£19,874.00	£198,740.00
Traumacad														
Modality suppliers engineering @£700 each			£111,300.00											£111,300.00
Radiologists backfill for procurement	£77,083.03													£77,083.03
Total	118,010.84	£3,424,968.31	£1,014,889.03	£711,186.34	£696,964.78	£696,964.78	£696,964.78	£2,640,880.18	£696,964.78	£696,964.78	£696,964.78	£696,964.78	£696,964.78	£13,485,652.93

Costs - MTW Top End	Revenue 21/22	Capital 22/23	Revenue 22/23	Revenue 23/24	Revenue 24/25	Revenue 25/26	Revenue 26/27	Capital 27/28	Revenue 27/28	Revenue 28/29	Revenue 29/30	Revenue 30/31	Revenue 31/32	10 year totals
Workstations/Monitors		£181,502.40						£181,502.40						£363,004.80
RIS Transfer Costs			£50,000.00											£50,000.00
RIS Revenue			£147,420.00	£147,420.00	£147,420.00	£147,420.00	£147,420.00		£147,420.00	£147,420.00	£147,420.00	£147,420.00	£147,420.00	£1,474,200.00
PACS GE Exit costs			£38,556.00											£38,556.00
PACS Capital		£2,456,246.12						£1,791,729.89						£4,247,976.01
PACS Revenue			£426,415.76	£426,415.76	£426,415.76	£426,415.76	£426,415.76		£426,415.76	£426,415.76	£426,415.76	£426,415.76	£426,415.76	£4,264,157.62
Programme Manager	£28,640.56		£24,817.88											£53,458.44
Senior Project Manager	£6,045.84		£24,105.99	£12,052.80										£42,204.63
PACS Managers backfill			£53,403.41											£53,403.41
Enovation Costs for RIS move			£5,100.00											£5,100.00
Modality suppliers engineering @£700 each			£92,400.00											£92,400.00

Radiologists backfill for procurement	£77,083.03															£77,083.03
Total	£111,769.43	£2,637,748.52	£862,219.04	£585,888.56	£573,835.76	£573,835.76	£573,835.76	£1,973,232.29	£573,835.76	£573,835.76	£573,835.76	£573,835.76	£573,835.76	£573,835.76	£573,835.76	£10,761,543.95

Costs - MFT Top End	Revenue 21/22	Capital 22/23	Revenue 22/23	Revenue 23/24	Revenue 24/25	Revenue 25/26	Revenue 26/27	Capital 27/28	Revenue 27/28	Revenue 28/29	Revenue 29/30	Revenue 29/30	Revenue 31/32	10 year totals
Workstations/Monitors		£116,406.36						£116,406.36						£232,812.72
RIS Transfer Costs			£50,000.00											£50,000.00
RIS Revenue			£133,633.50	£133,633.50	£133,633.50	£133,633.50	£133,633.50		£133,633.50	£133,633.50	£133,633.50	£133,633.50	£133,633.50	£1,336,335.00
PACS GE Exit costs			£34,950.30											£34,950.30
PACS Capital		£2,226,541.62						£1,624,169.97						£3,850,711.59
PACS Revenue			£386,537.99	£386,537.99	£386,537.99	£386,537.99	£386,537.99		£386,537.99	£386,537.99	£386,537.99	£386,537.99	£386,537.99	£3,865,379.92
Programme Manager	£25,962.14		£22,496.95											£48,459.09
Senior Project Manager	£5,480.44		£21,851.63	£10,925.64										£38,257.71
PACS Managers backfill			£53,403.41											£53,403.41
Modality suppliers engineering @£700 each			£45,500.00											£45,500.00
Radiologists backfill for procurement	£77,083.03													£77,083.03
Total	£108,525.61	£2,342,947.98	£748,373.78	£531,097.13	£520,171.49	£520,171.49	£520,171.49	£1,740,576.33	£520,171.49	£520,171.49	£520,171.49	£520,171.49	£520,171.49	£9,632,892.77

Costs Bottom End - CAPITAL	Revenue 21/22	Capital 22/23	Revenue 22/23	Revenue 23/24	Revenue 24/25	Revenue 25/26	Revenue 26/27	Capital 27/28	Revenue 27/28	Revenue 28/29	Revenue 29/30	Revenue 30/31	Revenue 31/32	10 year totals
Overall Costs KMMIC Bottom End														
Workstations/Monitors (2 monitors)		£824,658.27						£824,658.27						£1,649,316.54
RIS Transfer Costs			£150,000.00											£150,000.00
RIS Revenue			£455,000.00	£455,000.00	£455,000.00	£455,000.00	£455,000.00	£0.00	£455,000.00	£455,000.00	£455,000.00	£455,000.00	£455,000.00	£4,550,000.00
PACS GE Exit costs			£119,000.00											£119,000.00
PACS Capital														
PACS Revenue			£1,140,356.65	£1,140,356.65	£1,140,356.65	£1,140,356.65	£1,140,356.65	£0.00	£1,140,356.65	£1,140,356.65	£1,140,356.65	£1,140,356.65	£1,140,356.65	£11,403,566.50
Traumacad														
Programme Manager	£88,396.80		£76,598.40											£164,995.20
Senior Project Manager	£18,660.00		£74,401.20	£37,200.00										£130,261.20
PACS Managers backfill			£160,210.80											£160,210.80
Modality suppliers engineering @£700 each			£249,200.00											£249,200.00
Radiologists backfill for procurement	£231,250													£231,250.00
Total	£338,306.80	£824,658.27	£2,424,767.05	£1,632,556.65	£1,595,356.65	£1,595,356.65	£1,595,356.65	£824,658.27	£1,595,356.65	£1,595,356.65	£1,595,356.65	£1,595,356.65	£1,595,356.65	£18,807,800.24

Costs Bottom End - Revenue	Revenue 21/22	Capital 22/23	Revenue 22/23	Revenue 23/24	Revenue 24/25	Revenue 25/26	Revenue 26/27	Capital 27/28	Revenue 27/28	Revenue 28/29	Revenue 29/30	Revenue 30/31	Revenue 31/32	10 year totals
Overall Costs KMMIC Bottom End														
Workstations/Monitors (2 monitors)		£824,658.27						£824,658.27						£1,649,316.54
RIS Transfer Costs			£150,000.00											£150,000.00
RIS Revenue			£455,000.00	£455,000.00	£455,000.00	£455,000.00	£455,000.00	£0.00	£455,000.00	£455,000.00	£455,000.00	£455,000.00	£455,000.00	£4,550,000.00
PACS GE Exit costs			£119,000.00											£119,000.00
PACS Capital														
PACS Revenue			£1,140,356.65	£1,140,356.65	£1,140,356.65	£1,140,356.65	£1,140,356.65	£0.00	£1,140,356.65	£1,140,356.65	£1,140,356.65	£1,140,356.65	£1,140,356.65	£11,403,566.50
Traumacad														
Programme Manager	£88,396.80		£76,598.40											£164,995.20
Senior Project Manager	£18,660.00		£74,401.20	£37,200.00										£130,261.20
PACS Managers backfill			£160,210.80											£160,210.80
Modality suppliers engineering @£700 each			£249,200.00											£249,200.00
Radiologists backfill for procurement	£231,250													£231,250.00
Total	£338,306.80	£824,658.27	£2,424,767.05	£1,632,556.65	£1,595,356.65	£1,595,356.65	£1,595,356.65	£824,658.27	£1,595,356.65	£1,595,356.65	£1,595,356.65	£1,595,356.65	£1,595,356.65	£18,807,800.24

Costs - EKHUFT Bottom End	Revenue 21/22	Capital 22/23	Revenue 22/23	Revenue 23/24	Revenue 24/25	Revenue 25/26	Revenue 26/27	Capital 27/28	Revenue 27/28	Revenue 28/29	Revenue 29/30	Revenue 30/31	Revenue 31/32	10 year totals
Workstations/Monitors		£526,749.51						£526,749.51						£1,053,499.02
RIS Transfer Costs			£50,000.00											£50,000.00
RIS Revenue			£173,946.50	£173,946.50	£173,946.50	£173,946.50	£173,946.50		£173,946.50	£173,946.50	£173,946.50	£173,946.50	£173,946.50	£1,739,465.00
PACS GE Exit costs			£45,493.70											£45,493.70
PACS Capital														
PACS Revenue			£435,958.35	£435,958.35	£435,958.35	£435,958.35	£435,958.35		£435,958.35	£435,958.35	£435,958.35	£435,958.35	£435,958.35	£4,359,583.47

Programme Manager	£33,794.10		£29,283.57													£63,077.66
Senior Project Manager	£7,133.72		£28,443.58	£14,221.56												£49,798.86
PACS Managers backfill			£53,403.41													£53,403.41
Viewpoint/Obstetrics			£19,874.00	£19,874.00	£19,874.00	£19,874.00	£19,874.00	£19,874.00	£19,874.00	£19,874.00	£19,874.00	£19,874.00	£19,874.00	£19,874.00	£19,874.00	£198,740.00
Traumacad																
Modality suppliers engineering @£700 each			£111,300.00													£111,300.00
Radiologists backfill for procurment	£77,083.03															£77,083.03
Total	£118,010.84	£526,749.51	£947,703.10	£644,000.41	£629,778.85	£629,778.85	£629,778.85	£526,749.51	£629,778.85	£629,778.85	£629,778.85	£629,778.85	£629,778.85	£629,778.85	£629,778.85	£7,801,444.15

Costs - MTW Bottom End	Revenue 21/22	Capital 22/23	Revenue 22/23	Revenue 23/24	Revenue 24/25	Revenue 25/26	Revenue 26/27	Capital 27/28	Revenue 27/28	Revenue 28/29	Revenue 29/30	Revenue 30/31	Revenue 31/32	10 year totals
Workstations/Monitors		£181,502.40						£181,502.40						£363,004.80
RIS Transfer Costs			£50,000.00											£50,000.00
RIS Revenue			£147,420.00	£147,420.00	£147,420.00	£147,420.00	£147,420.00		£147,420.00	£147,420.00	£147,420.00	£147,420.00	£147,420.00	£1,474,200.00
PACS GE Exit costs			£38,556.00											£38,556.00
PACS Capital														
PACS Revenue			£369,475.55	£369,475.55	£369,475.55	£369,475.55	£369,475.55		£369,475.55	£369,475.55	£369,475.55	£369,475.55	£369,475.55	£3,694,755.55
Programme Manager	£28,640.56		£24,817.88											£53,458.44
Senior Project Manager	£6,045.84		£24,105.99	£12,052.80										£42,204.63
PACS Managers backfill			£53,403.41											£53,403.41
Enovation Costs for RIS move			£5,100.00											£5,100.00
Modality suppliers engineering @£700 each			£92,400.00											£92,400.00
Radiologists backfill for procurment	£77,083.03													£77,083.03
														£0.00
Total	£111,769.43	£181,502.40	£805,278.84	£528,948.35	£516,895.55	£516,895.55	£516,895.55	£181,502.40	£516,895.55	£516,895.55	£516,895.55	£516,895.55	£516,895.55	£5,944,165.86

Costs - MFT Bottom End	Revenue 21/22	Capital 22/23	Revenue 22/23	Revenue 23/24	Revenue 24/25	Revenue 25/26	Revenue 26/27	Capital 27/28	Revenue 27/28	Revenue 28/29	Revenue 29/30	Revenue 30/31	Revenue 31/32	10 year totals
Workstations/Monitors		£116,406.36						£116,406.36						£232,812.72
RIS Transfer Costs			£50,000.00											£50,000.00
RIS Revenue			£133,633.50	£133,633.50	£133,633.50	£133,633.50	£133,633.50		£133,633.50	£133,633.50	£133,633.50	£133,633.50	£133,633.50	£1,336,335.00
PACS GE Exit costs			£34,950.30											£34,950.30
PACS Capital														
PACS Revenue			£334,922.75	£334,922.75	£334,922.75	£334,922.75	£334,922.75		£334,922.75	£334,922.75	£334,922.75	£334,922.75	£334,922.75	£3,349,227.48
Programme Manager	£25,962.14		£22,496.95											£48,459.09
Senior Project Manager	£5,480.44		£21,851.63	£10,925.64										£38,257.71
PACS Managers backfill			£53,403.41											£53,403.41
Modality suppliers engineering @£700 each			£45,500.00											£45,500.00
Radiologists backfill for procurment	£77,083.03													£77,083.03
														£0.00
Total	£108,525.61	£116,406.36	£696,758.54	£479,481.89	£468,556.25	£468,556.25	£468,556.25	£116,406.36	£468,556.25	£468,556.25	£468,556.25	£468,556.25	£468,556.25	£5,266,028.75

Bids for National Funding	Revenue 21/22	Capital 21/23	Capital 22/23	Revenue 22/23	Revenue 23/24
Workstations/Monitors		£1,694,376.26			
PACS replacement			£2,050,609.08	£2,050,609.08	£2,050,609.08
RIS replacement				£486,154.00	£486,154.00
Programme Manager		£64,076.16		£76,598.40	
Project Manager				£74,401.20	£37,200.00

Current Costs	KMMIC
PACS Per Year	£1,444,548.00
RIS Per Year	£636,680.00
Total	£2,081,228.00

Current Costs	EKHUFT
PACS Per Year	£680,412.00
RIS Per Year	£280,025.00

Total	£960,437.00
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Current Costs	MTW
PACS Per Year	£337,116.00
RIS Per Year	£203,664.00
Total	£540,780.00

Current Costs	MFT
PACS Per Year	£266,460.00
RIS Per Year	£153,011.00
Total	£419,471.00

Findings of the national inpatient survey 2020

Chief Nurse

Enclosed are the 2020 Adult Inpatient survey (MTW results) which were published on 19th October 2021 (Appendix 1).

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 19/10/21

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

Information, assurance and discussion

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

1. Background

This feedback exercise was undertaken by “Quality Health for Maidstone and Tunbridge Wells NHS Trust” between January 2021 and May 2021. The survey sought responses from patients who were in our care during November 2020. Patients were asked 47 questions related to their admission, the care and treatment received, any operations undertaken and their experience of procedures, leaving hospital and their overall experience at MTW. The final response rate for the Trust was 52% which equated to 608 responses from a sample of 1179 patients who stayed at least one night in our hospitals.

2. Findings

MTW outperformed other organisations in giving patients privacy and dignity when being examined or treated; scoring 97%. A further 8 questions were benchmarked within the top 20% of the national results.

While 39 of the scores are in the intermediate 60% range of Trusts surveyed by Quality Health, 9 of these are on the cusp of dropping into the bottom-20%. Six scores are already in the bottom-20% range. Please refer to the infographic in appendix 1.

3. Proposed actions

3.1 Overall recommendations;

- A number of short- and longer-term actions are proposed to further understand why some patients did not feel that they were always treated with respect and dignity during their time in hospital.
- Use in depth analysis to further interrogate the results and identify specific areas where issues may be prevalent

3.2 Short term actions

- Re-commence partnership working with our patient partners and stakeholders to review live feedback.
- To engage patients in the development of any solutions / improvement work linked to the areas that have been in highlighted in this report.
- Engagement will commence with divisional leads to feedback data from the actions via the “Patient Experience Working Group”.
- Divisional action plans will be devised, these will be based on the key themes derived from the survey specifically there will be a focus on prioritising...
 - Estates and Facilities
 - Surgery division
 - Workforce and staff bank
- Data will be reviewed from the tele-tracking system to monitor and evidence any improvements gained for our patients who are waiting for a bed on a ward
- Utilise the volunteer workforce to assist with befriending. This will aim to ensure our patients have consistent access to an appropriate level of emotional support whilst they are in hospital
- Implement a renewed focus on promoting the use of the Friends and Family test (FFT) to ensure patients can use this facility to share their feedback about the quality of their care

3.4. Mid to long term actions

- A redesign and relaunch of the Matrons quality checklist will be undertaken. This will aim to strengthen our internal assurance processes in relation to improving patient experience.
- Roll out and embed 'Always Events' as part of the trusts strategic quality objectives
- Review and improve upon the information provision for patients who are discharged from our hospitals
 - Rolling out a newly designed "discharge card" for all discharges
 - Reviewing and relaunching our information packs for patients and their carers
- Aligning this work to our "Exceptional People, Outstanding Care Vision" and our internal CQC peer reviews. It is anticipated oversight for this will be achieved via the Patient Experience Working Group

CQC Inpatient Survey Results 2020

Top 5 Scores

89.9% of patients had a discussion with staff about equipment needed on discharge

86.0% of patients were able to sleep without being disturbed by other patients

86.0% of patients were always treated with dignity and respect

86.0% of patients felt staff did everything to control their pain

83.5% of our patients had a good overall experience of care



Lowest 5 Scores

67.1% of patients felt they were not involved in decisions about them leaving hospital

67.4% of patients did not rate the hospital food as good

76.3% of patients said they did not receive a good explanation of how their operation and procedure had gone

79.9% of patients felt that we did not meet their dietary requirements

84.0% of patients had enough help from staff to wash or keep yourself clean

NHS Adult Inpatient Survey 2020 Benchmark Report

Maidstone and Tunbridge Wells NHS Trust



Ipsos MORI



Contents

1. Background & methodology	2. Headline results	3. Benchmarking	4. Trust results	5. Appendix
		Section 1. Admission to hospital	Section 1. Admission to hospital	
		Section 2. The hospital and ward	Section 2. The hospital and ward	
		Section 3. Doctors	Section 3. Doctors	
		Section 4. Nurses	Section 4. Nurses	
		Section 5. Your care and treatment	Section 5. Your care and treatment	
		Section 6. Operations and procedures	Section 6. Operations and procedures	
		Section 7. Leaving hospital	Section 7. Leaving hospital	
		Section 8. Feedback on care	Section 8. Feedback on care	
		Section 9. Respect and dignity	Section 9. Respect and dignity	
		Section 10. Overall experience	Section 10. Overall experience	

This work was carried out in accordance with the requirements of the international quality standard for Market Research, ISO 20252, and with the Ipsos MORI Terms and Conditions which can be found at <http://www.ipsos-mori.com/terms>.

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Background and methodology

This section includes:

- an explanation of the NHS Patient Survey Programme
- information on the Adult Inpatient 2020 survey
- a description of key terms used in this report
- navigating the report

Background and methodology

The NHS Patient Survey Programme

The NHS Patient Survey Programme (NPSP) collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services.

The NPSP is commissioned by the Care Quality Commission (CQC); the independent regulator of health and adult social care in England.

As part of the NPSP, the Adult Inpatient Survey has been conducted annually since 2002. The CQC use the results from the survey in the regulation, monitoring and inspection of NHS acute trusts in England.

To find out more about the survey programme and to see the results from previous surveys, please refer to the section on further information on this page.

The Adult Inpatient Survey 2020

The survey was administered by the Coordination Centre for Mixed Methods (CCMM) at Ipsos MORI. A total of 169,176 patients were invited to participate in the survey across 137 acute and specialist NHS trusts. Completed responses were received from 73,015 patients, an adjusted response rate of 45.9%.

Patients were eligible to participate in the survey if they were aged 16 years or over, had spent at least one night in hospital, and were not admitted to maternity or psychiatric units. A full list of eligibility criteria can be found in the survey [sampling instructions](#).

Trusts sampled patients who met the eligibility criteria and were discharged from hospital during November 2020. Trusts counted back from the last day of November 2020, sampling every consecutively discharged patient until they had selected 1,250 patients. Some smaller trusts, which treat fewer patients, included patients who were treated in hospital earlier than November 2020 (as far back as May 2020), to achieve a large enough sample.

Fieldwork took place between January and May 2021.

Trend data

The Adult Inpatient 2020 survey was significantly different to previous years' surveys with regards to methodology, sampling month and questionnaire content. This year's survey was conducted using a push-to-web methodology (offering both online and paper completion). The questionnaire was amended significantly, with changes to both question wording and order. The 2020 results are therefore not comparable with previous years' data and trend data is not available. In future years, trend data will be incorporated into these reports.

Further information about the survey

- For published results for other surveys in the NPSP, and for information to help trusts implement the surveys across the NPSP, please visit the [NHS Surveys website](#).
- To learn more about CQC's survey programme, please visit the [CQC website](#).

Key terms used in this report

The 'expected range' technique

This report shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part. It uses an analysis technique called the 'expected range' to determine if your trust is performing about the same, better or worse compared with most other trusts. This is designed to help understand the performance of individual trusts and identify areas for improvement.

This report also includes site level benchmarking. This allows you to compare the results for sites within your trust with all other sites across trusts. It is important to note that the performance ratings presented here may differ from that presented in the trust level benchmarking.

More information can be found in the [Appendix](#).

Standardisation

Demographic characteristics, such as age and gender, can influence patients' experience of care and the way they report it. For example, research shows that men tend to report more positive experiences than women, and older people more so than younger people.

Since trusts have differing profiles of patients, this could make fair trust comparisons difficult. To account for this, we 'standardise' the results, which means we apply a weight to individual patient responses to account for differences in demographic profile between trusts.

For each trust, results have been standardised by the age, sex and method of admission (emergency or elective) of respondents to reflect the 'national' age, sex, and method of admission distribution (based on all respondents to the survey). This helps ensure that no trust will appear better or worse than another because of its profile, and enables a fairer and more useful comparison of results across trusts. In most cases this standardisation will not have a large impact on trust results. Site level results are standardised in the same way.

Scoring

For each question in the survey, the individual (standardised) responses are converted into scores on a scale of 0 to 10. A score of 10 represents the best possible result and a score of 0 the worst. The higher the score for each question, the better the trust is performing. Only evaluative questions in the questionnaire are scored. Some questions are

descriptive (for example Q1) and others are 'routing questions', which are designed to filter out respondents to whom the following questions do not apply (for example Q6). These questions are not scored. Section scoring is computed as the arithmetic mean of question scores for the section after weighting is applied.

Trust average

The 'trust average' mentioned in this report is the arithmetic mean of all trusts' scores after weighting is applied.

Suppressed data

If fewer than 30 respondents have answered a question, no score will be displayed for that question (or the corresponding section the question contributes to).

Further information about the methods

For further information about the statistical methods used in this report, please refer to the [survey technical document](#).

Using the survey results

Navigating this report

This report is split into five sections:

- **Background and methodology** – provides information about the survey programme, how the survey is run, and how to interpret the data.
- **Headline results** – includes key trust-level findings relating to the patients who took part in the survey, benchmarking, and top and bottom scores. This section provides an overview of results for your trust, identifying areas where your organisation performs better than the average and where you may wish to focus improvement activities.
- **Benchmarking** – shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part; using the ‘expected range’ analysis technique. This allows you to see the range of scores achieved and compare yourself with the other organisations that took part in the survey. Benchmarking can provide you with an indication of where you perform better than the average, and what you should aim for in areas where you may wish to improve.

- **Trust results** – includes the score for your trust; a comparison with other trusts in your region; a breakdown of scores across sites within your trust. It may be helpful to compare yourself with regional trusts, so you can learn from and share learnings with trusts in your area who care for similar populations. Internal benchmarking may be helpful so you can compare sites within your organisation, sharing best practice within the trust and identifying any sites that may need attention.
- **Appendix** – includes additional data for your trust; further information on the survey methodology; interpretation of graphs in this report.

How to interpret the graphs in this report

There are several types of graphs in this report which show how the score for your trust compares to the scores achieved by all trusts that took part in the survey.

The two chart types used in the section ‘benchmarking’ use the ‘expected range’ technique to show results. For information on how to interpret these graphs, please refer to the [Appendix](#).

Other data sources

More information is available about the following topics at their respective websites, listed below:

- Full national results; A-Z list to view the results for each trust; technical document: www.cqc.org.uk/inpatientsurvey
- National and trust-level data for all trusts who took part in the Adult Inpatient 2020 survey: <https://nhssurveys.org/surveys/survey/02-adults-inpatients/year/2020/>. Full details of the methodology for the survey, instructions for trusts and contractors to carry out the survey, and the survey development report can also be found on the NHS Surveys website.
- Information on the NHS Patient Survey Programme, including results from other surveys: www.cqc.org.uk/content/surveys
- Information about how the CQC monitors hospitals: www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-nhs-acute-hospitals

Headline results

This section includes:

- information about your trust population
- an overview of benchmarking for your trust
- the top and bottom scores for your trust

Who took part in the survey?

This slide is included to help you interpret responses and to provide information about the population of patients who took part in the survey.



1,250 invited to take part



607 completed

27% urgent/emergency admission

73% planned admission



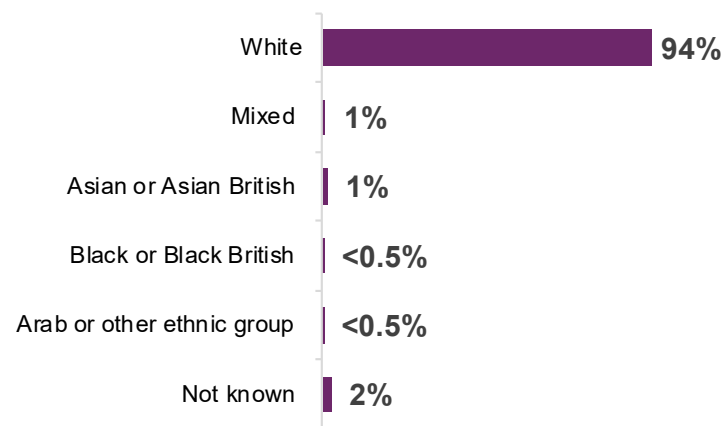
51% response rate

46% average response rate for all trusts

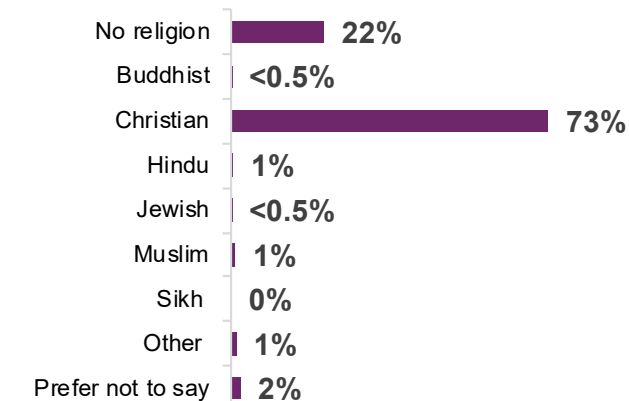
52% response rate for your trust last year



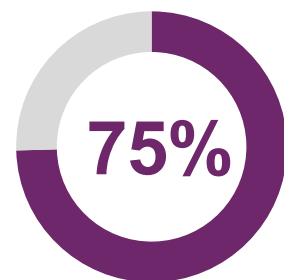
Ethnicity



Religion



Long-term conditions

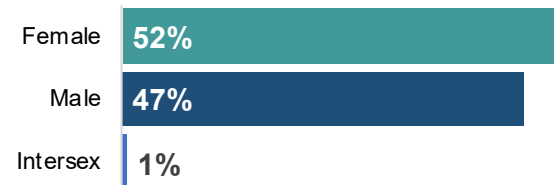


of participants said they have **physical or mental health conditions, disabilities or illnesses** that have lasted or are expected to last 12 months or more (excluding those who selected "I would prefer not to say").



Sex

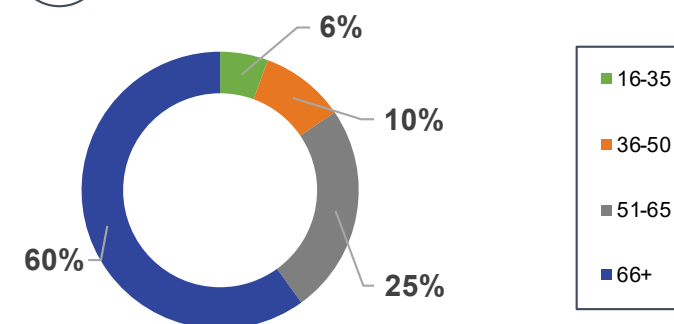
At birth were you registered as...



0% of participants said their gender is different from the sex they were registered with at birth.



Age



Summary of findings for your trust

Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.



Comparison with last year's results

Results for the Adult Inpatient 2020 survey are not comparable with results from previous years. This is because of a change in survey methodology, extensive redevelopment of the questionnaire, and a different sampling month. More information on this is available in the [survey development report](#).

The Adult Inpatient 2021 benchmark reports will include an overview of the number of questions at which your trust's performance has significantly improved, significantly declined, or not significantly changed compared with your result from the previous year.

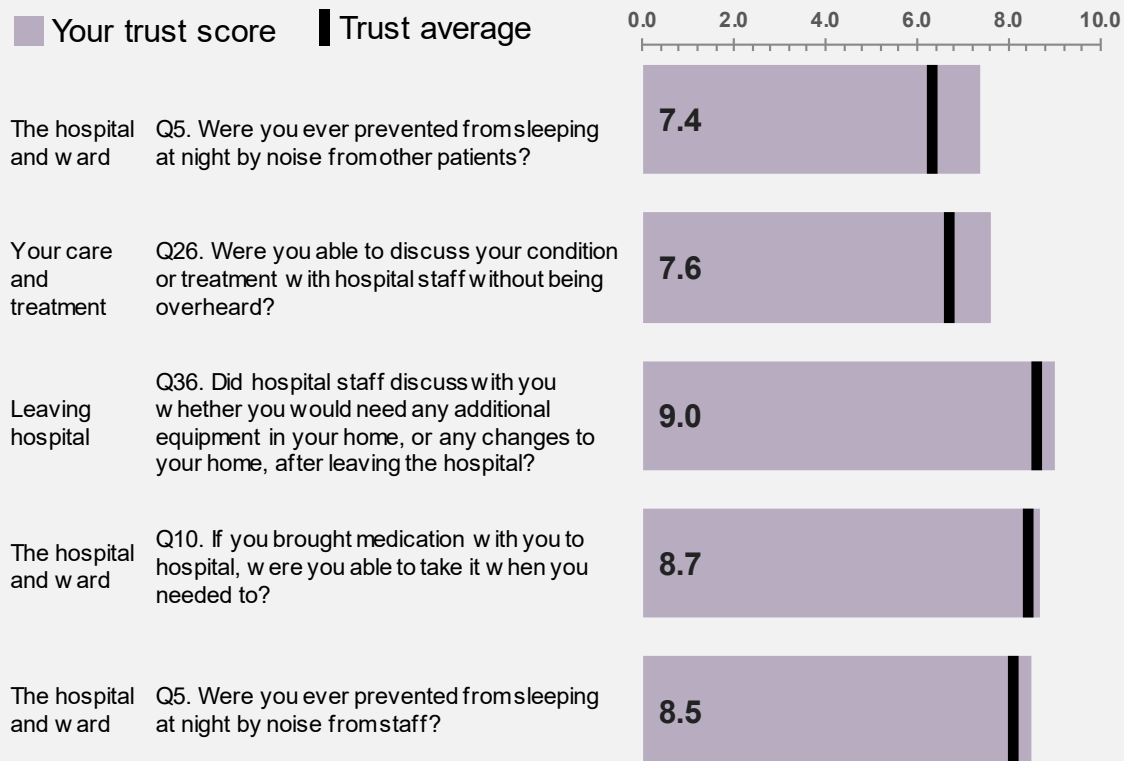
For a breakdown of the questions where your trust has performed better or worse compared with all other trusts, please refer to the appendix section ["comparison to other trusts"](#).

Best and worst performance relative to the trust average

These five questions are calculated by comparing your trust's results to the trust average.

- **Top five scores:** These are the five results for your trust that are highest compared with the trust average. If none of the results for your trust are above the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's best performance may be worse than the trust average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the trust average. If none of the results for your trust are below the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's worst performance may be better than the trust average.

Top five scores (compared with trust average)



Bottom five scores (compared with trust average)



Benchmarking

This section includes:

- how your trust scored for each evaluative question in the survey, compared with other trusts that took part
- an analysis technique called the 'expected range' to determine if your trust is performing about the same, better or worse compared with most other trusts

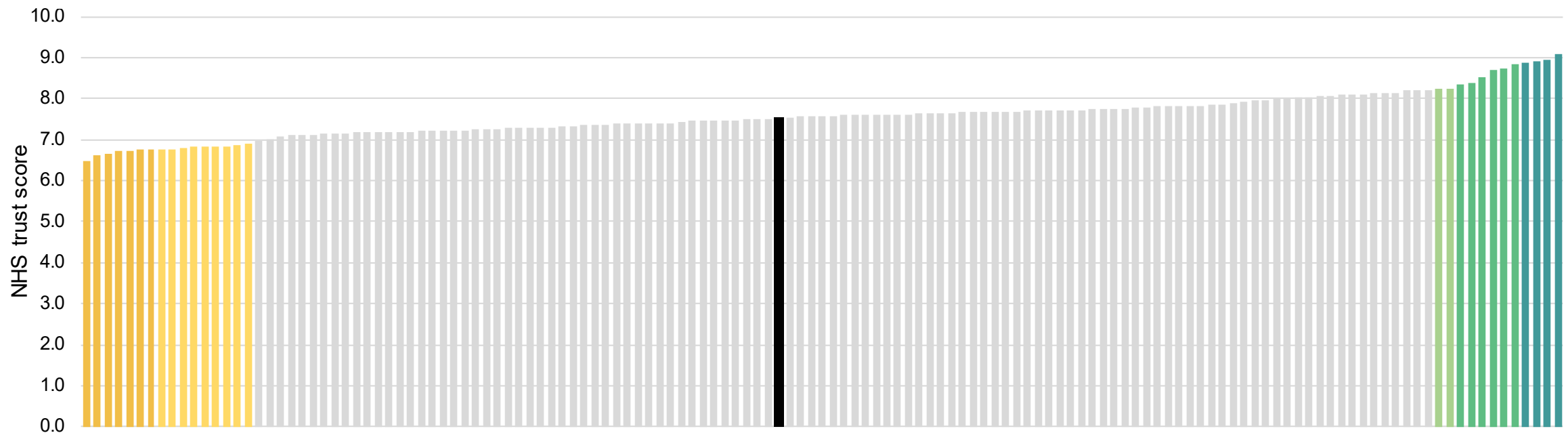
Section 1. Admission to hospital

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



Your trust section score = 7.5 (About the same)

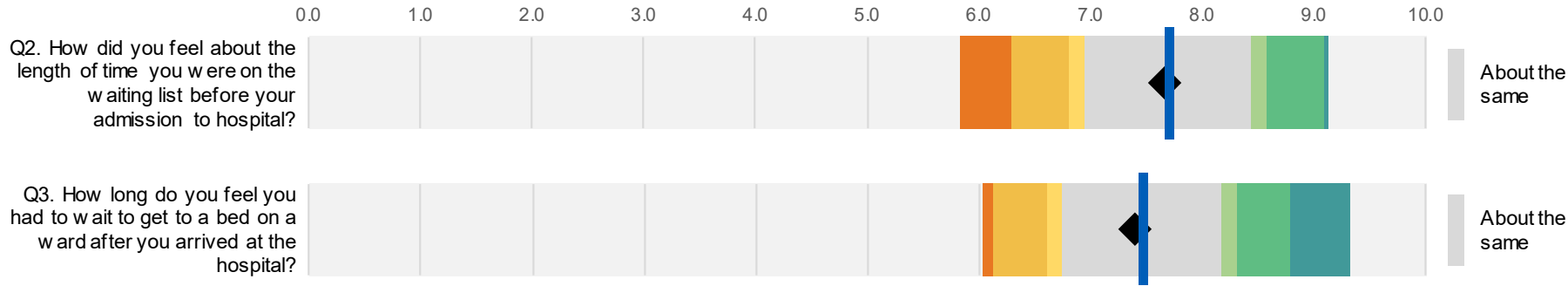
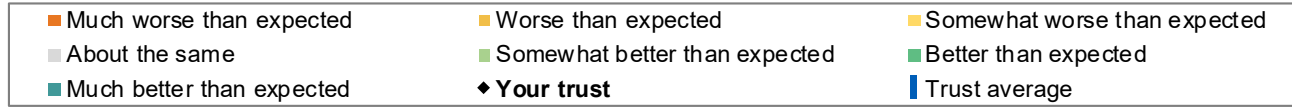


Each vertical line represents an individual NHS trust.
Trust score is not shown when there are fewer than 30 respondents.

Section 1. Admission to hospital (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.



		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
165	7.7	7.7	5.8	9.1

583	7.4	7.5	6.0	9.3
-----	-----	-----	-----	-----

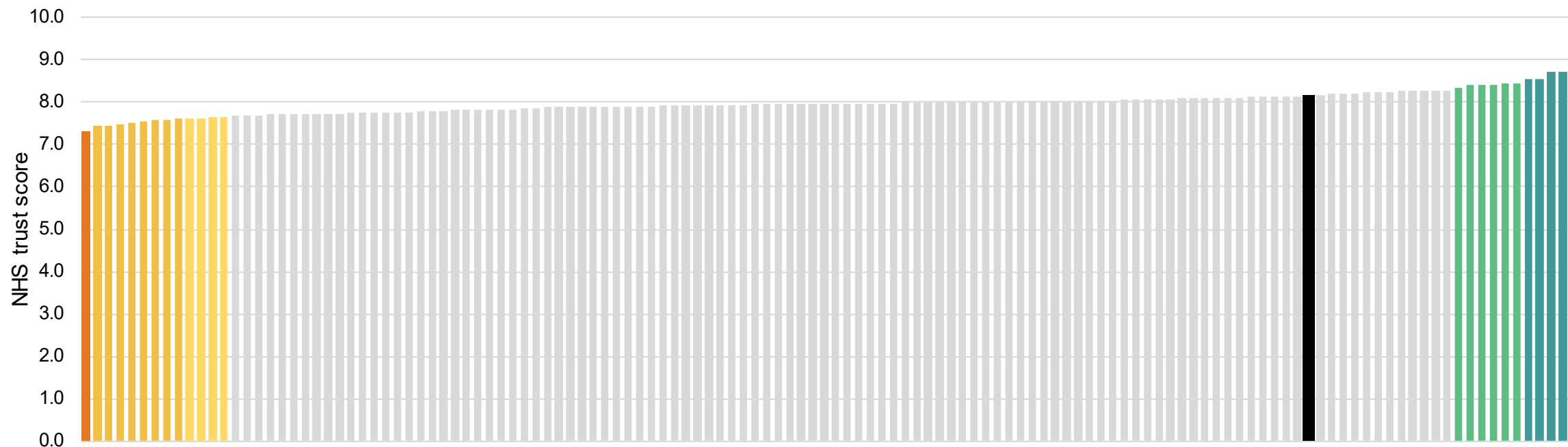
Section 2. The hospital and ward

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



Your trust section score = 8.2 (About the same)

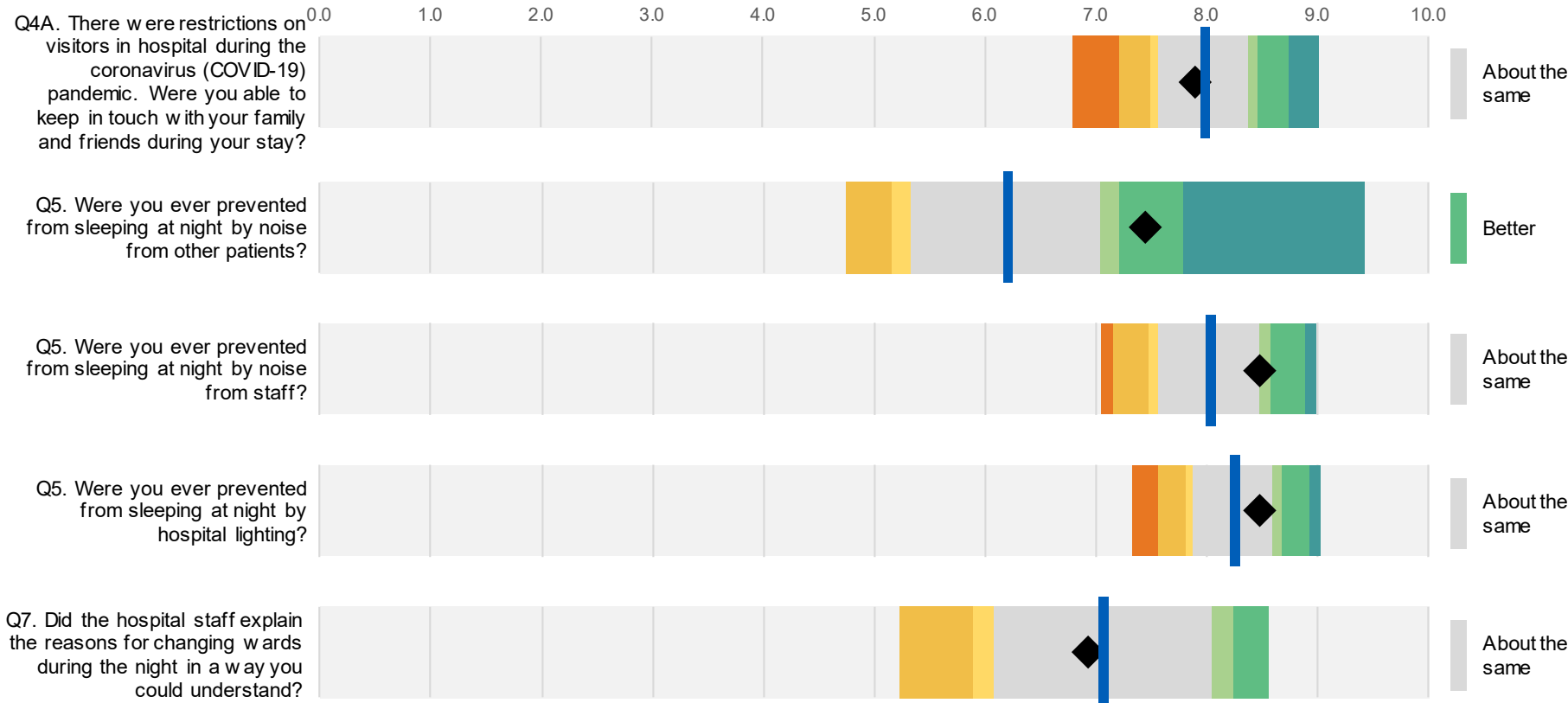
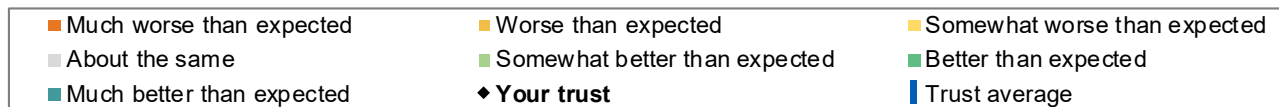


Each vertical line represents an individual NHS trust.
Trust score is not shown when there are fewer than 30 respondents.

Section 2. The hospital and ward (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.



All trusts in England				
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
517	7.9	8.0	6.8	9.0

536	7.4	6.2	4.7	9.4
-----	-----	-----	-----	-----

536	8.5	8.0	7.0	9.0
-----	-----	-----	-----	-----

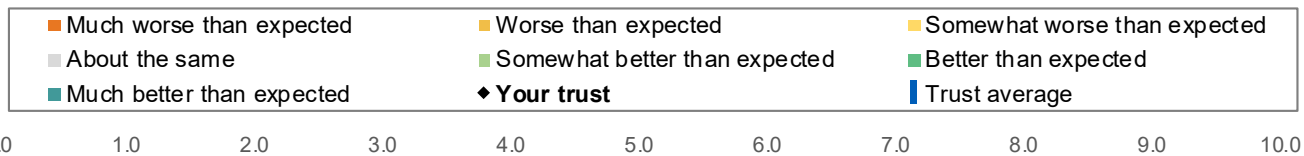
536	8.5	8.2	7.3	9.0
-----	-----	-----	-----	-----

73	6.9	7.1	5.2	8.5
----	-----	-----	-----	-----

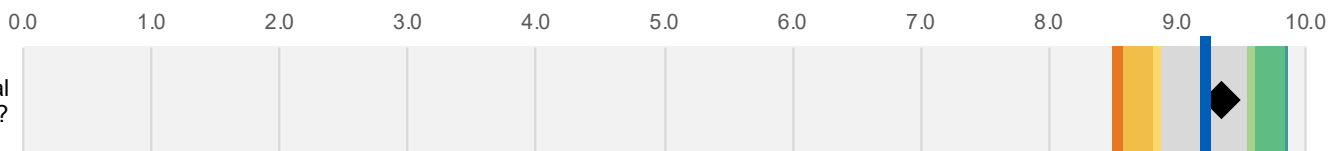
Section 2. The hospital and ward (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.



Q8. How clean was the hospital room or ward that you were in?



About the same

Number of respondents (your trust)	Your trust score	All trusts in England		
		Trust average score	Lowest score	Highest score
598	9.3	9.2	8.5	9.9

Q9. Did you get enough help from staff to wash or keep yourself clean?



About the same

421	8.4	8.5	7.4	9.7
-----	-----	-----	-----	-----

Q10. If you brought medication with you to hospital, were you able to take it when you needed to?



Somewhat better

355	8.7	8.3	7.3	9.5
-----	-----	-----	-----	-----

Q11. Were you offered food that met any dietary requirements you had?



About the same

286	8.0	8.3	7.0	9.3
-----	-----	-----	-----	-----

Q12. How would you rate the hospital food?



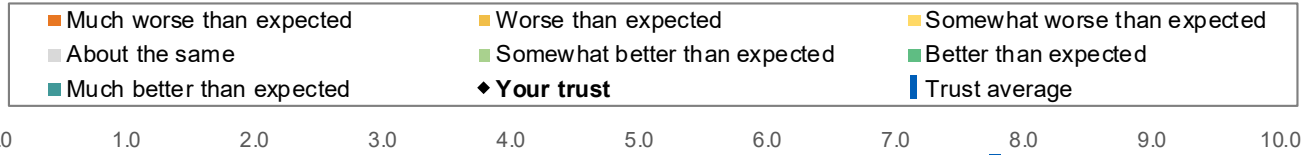
About the same

583	6.8	7.0	6.2	8.9
-----	-----	-----	-----	-----

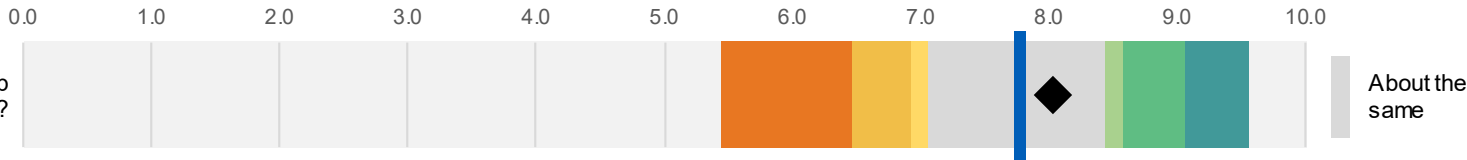
Section 2. The hospital and ward (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

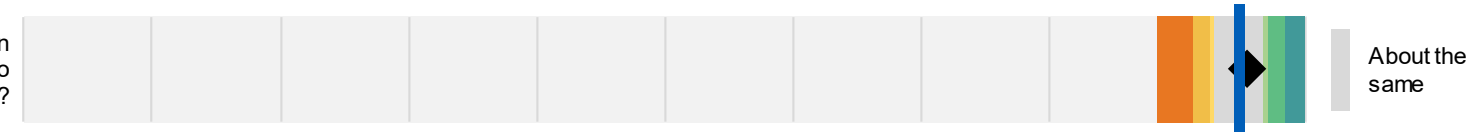


Q13. Did you get enough help from staff to eat your meals?



About the same

Q14. During your time in hospital, did you get enough to drink?



About the same

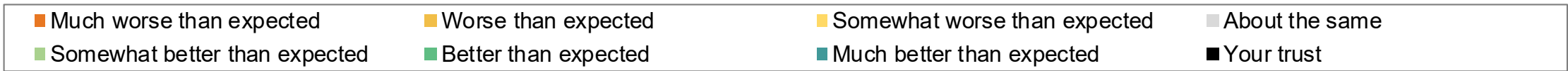
		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
112	8.0	7.8	5.5	9.6

551	9.5	9.5	8.8	10.0
-----	-----	-----	-----	------

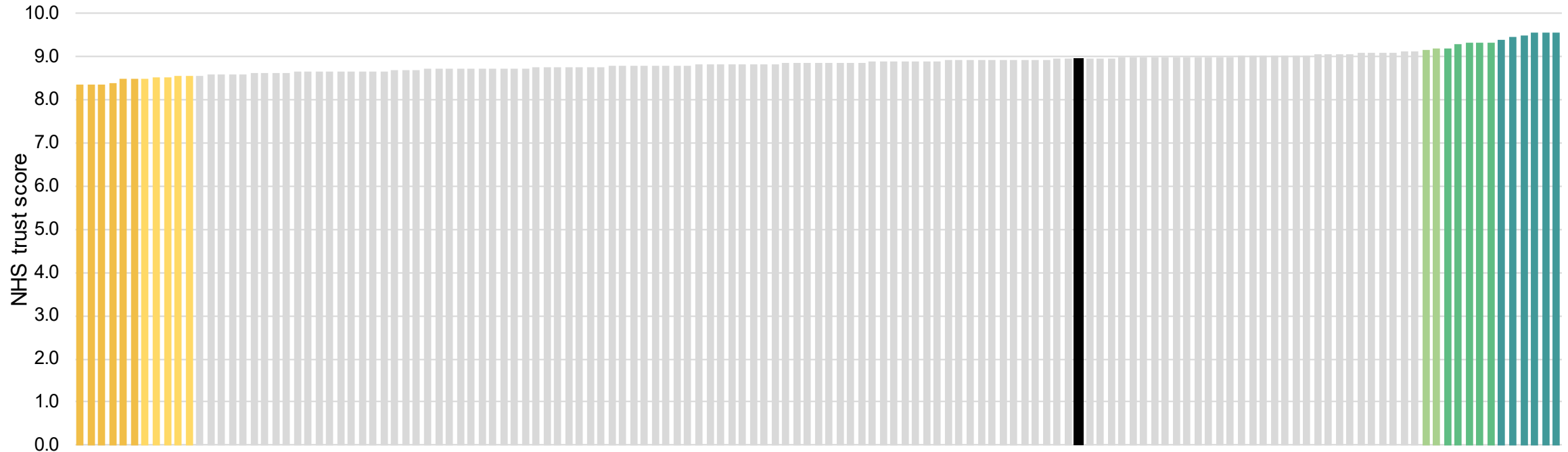
Section 3. Doctors

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



Your trust section score = 9.0 (About the same)

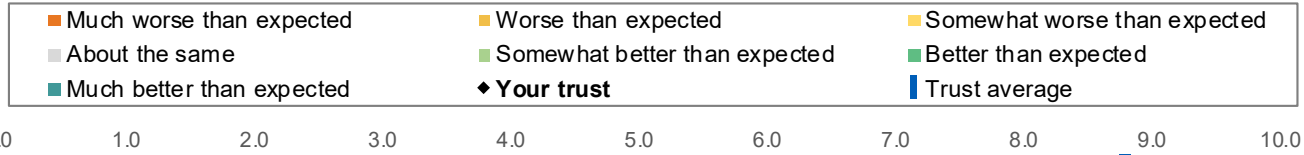


Each vertical line represents an individual NHS trust.
Trust score is not shown when there are fewer than 30 respondents.

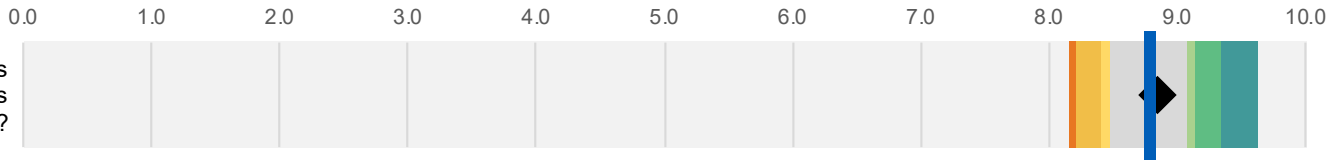
Section 3. Doctors (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.



Q15. When you asked doctors questions, did you get answers you could understand?



About the same

Number of respondents (your trust)	Your trust score	All trusts in England		
		Trust average score	Lowest score	Highest score
567	8.8	8.8	8.2	9.6

Q16. Did you have confidence and trust in the doctors treating you?



About the same

603	9.2	9.2	8.7	9.9
-----	-----	-----	-----	-----

Q17. When doctors spoke about your care in front of you, were you included in the conversation?



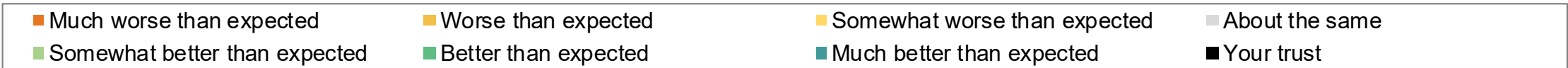
About the same

599	8.8	8.6	7.9	9.6
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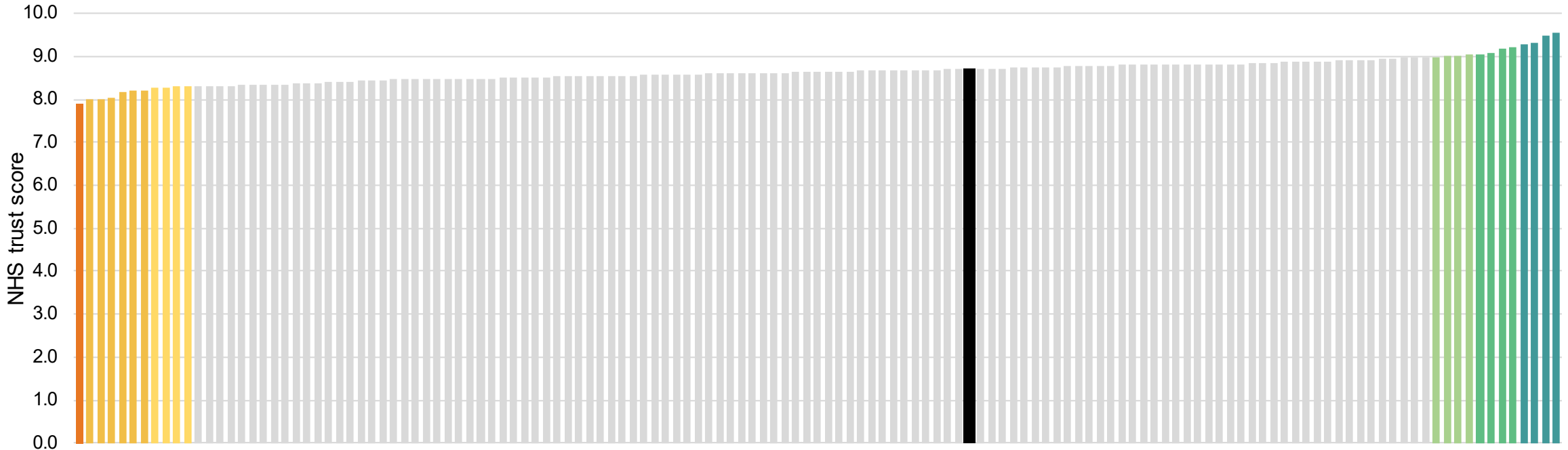
Section 4. Nurses

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



Your trust section score = 8.7 (About the same)

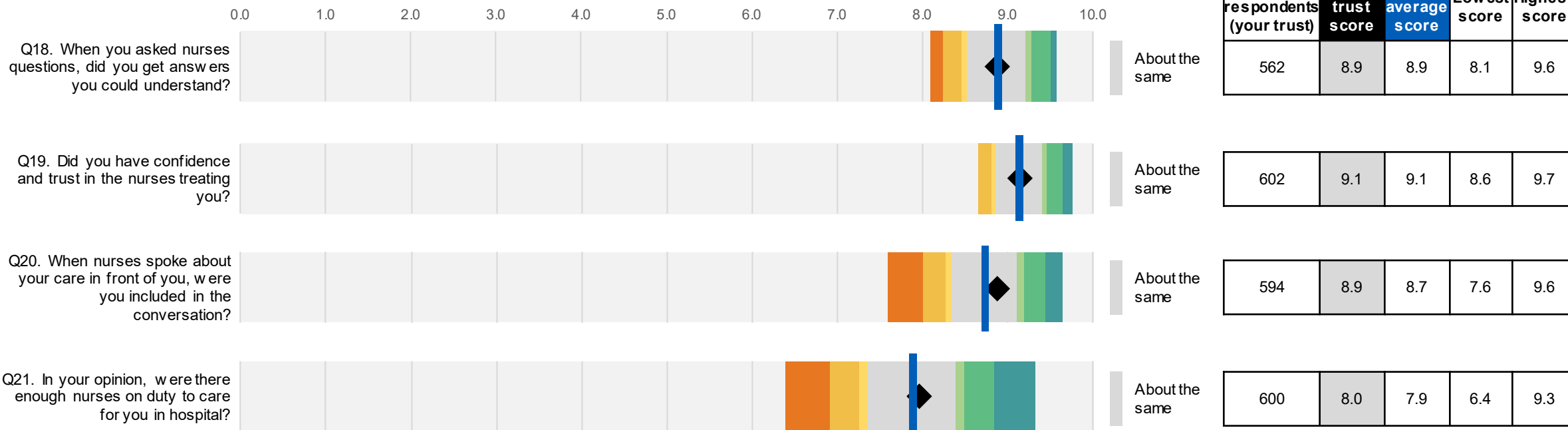
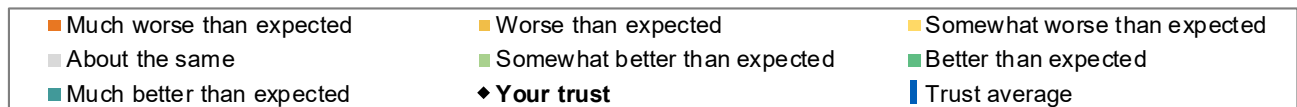


Each vertical line represents an individual NHS trust.
Trust score is not shown when there are fewer than 30 respondents.

Section 4. Nurses (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.



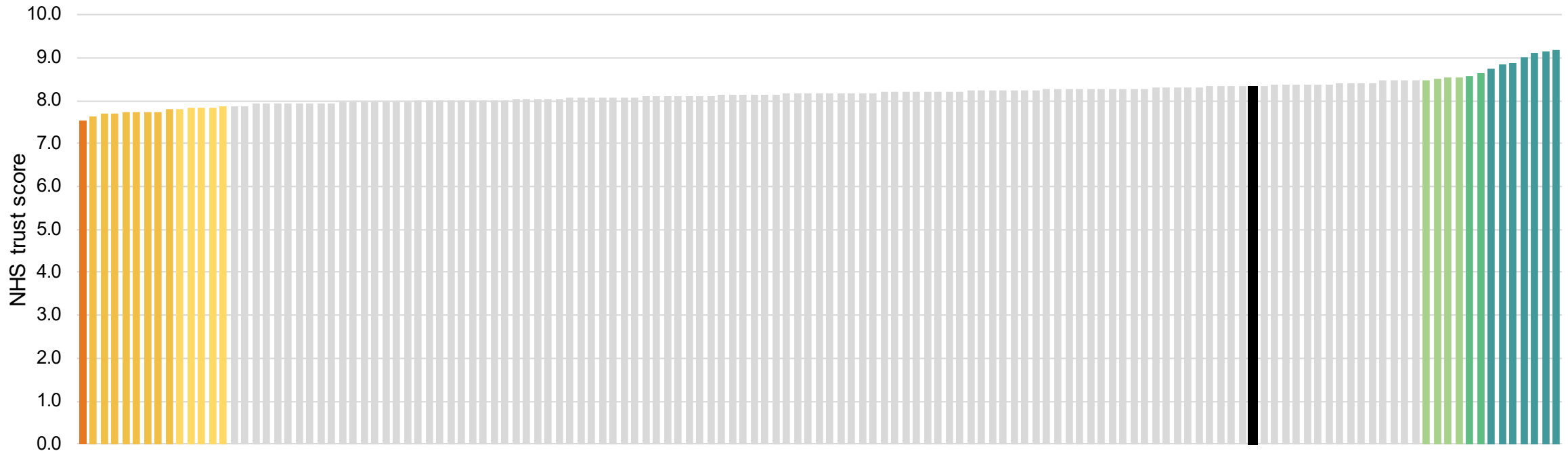
Section 5. Your care and treatment

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



Your trust section score = 8.3 (About the same)

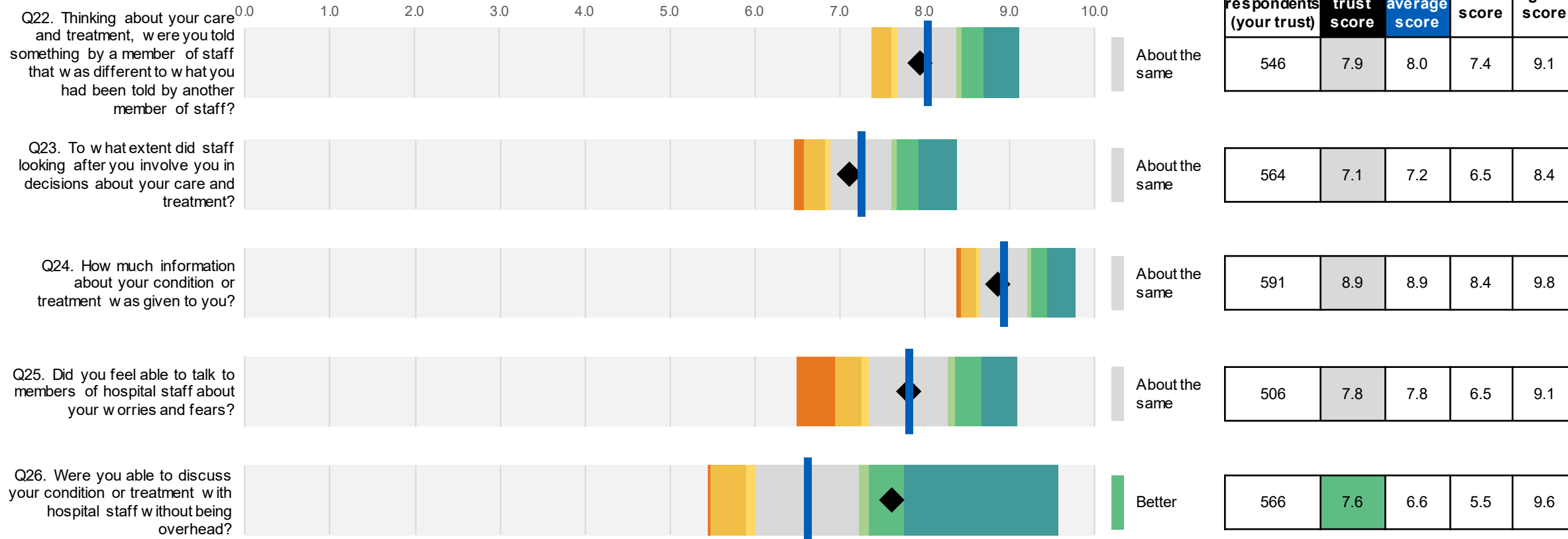
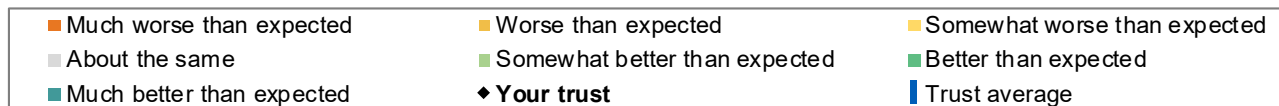


Each vertical line represents an individual NHS trust.
Trust score is not shown when there are fewer than 30 respondents.

Section 5. Your care and treatment (continued)

Question scores

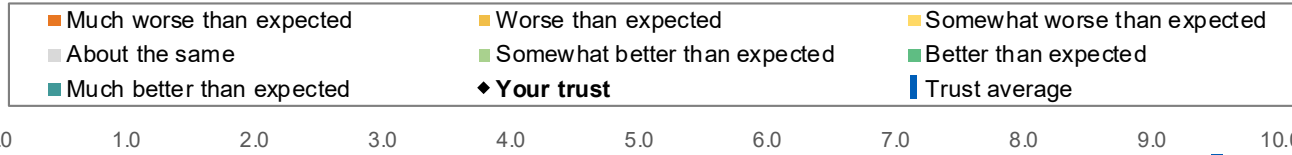
Trust score is not shown when there are fewer than 30 respondents.



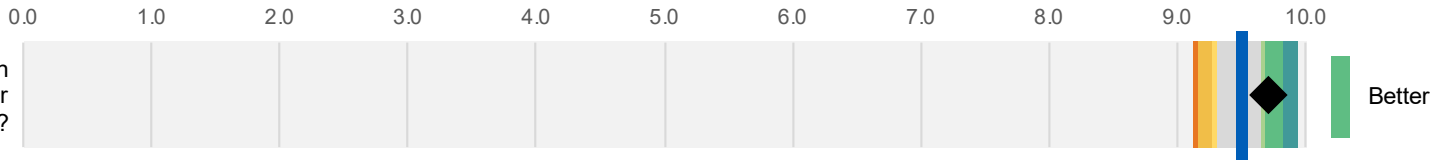
Section 5. Your care and treatment (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

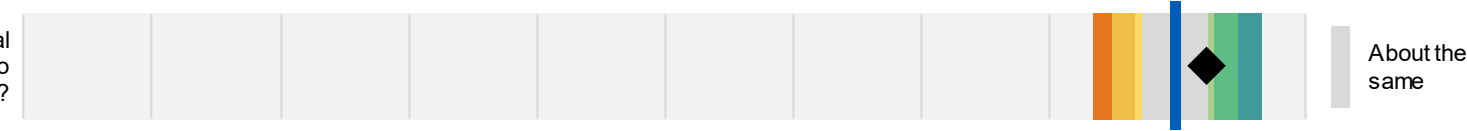


Q27. Were you given enough privacy when being examined or treated?



		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
600	9.7	9.5	9.1	9.9

Q28. Do you think the hospital staff did everything they could to help control your pain?



493	9.2	9.0	8.3	9.7
-----	-----	-----	-----	-----

Q29. Were you able to get a member of staff to help you when you needed attention?

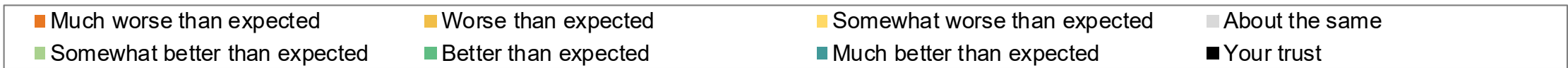


553	8.5	8.3	7.4	9.5
-----	-----	-----	-----	-----

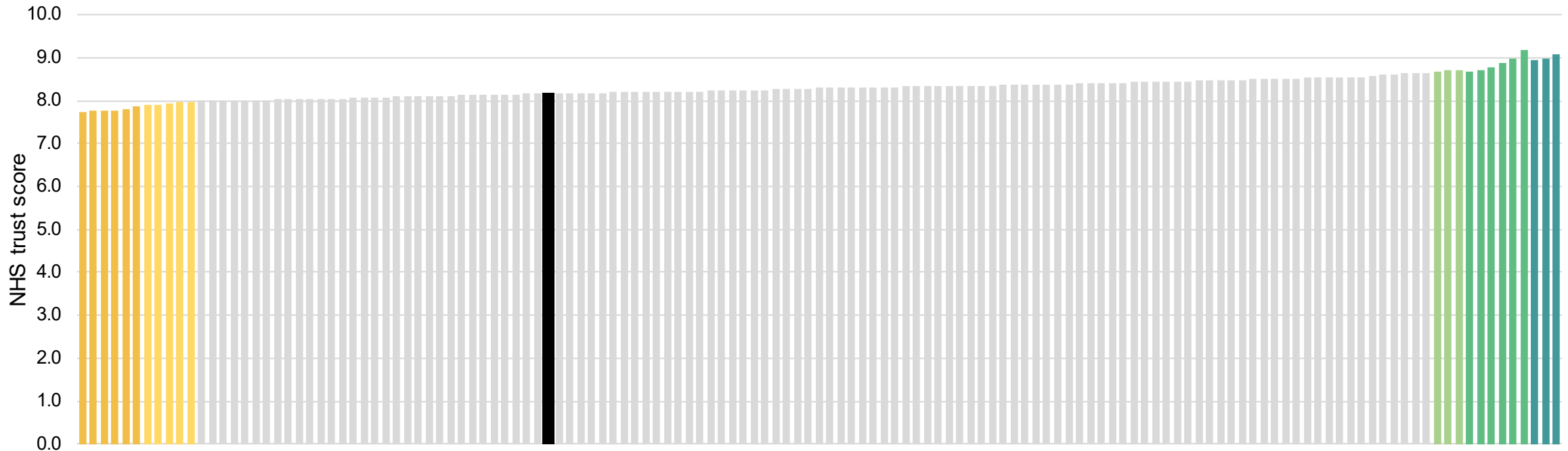
Section 6. Operations and procedures

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



Your trust section score = 8.2 (About the same)

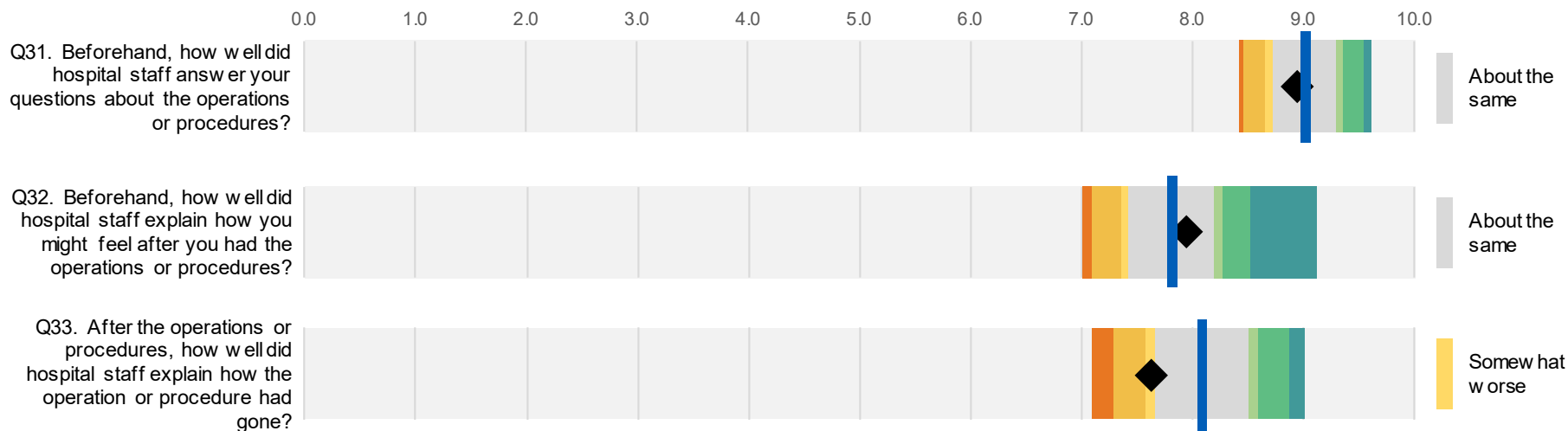
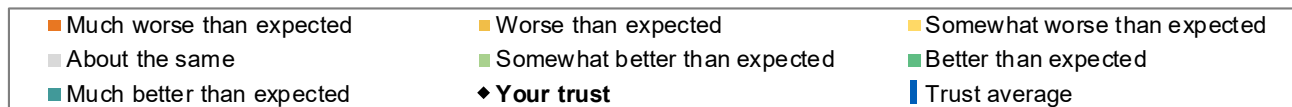


Each vertical line represents an individual NHS trust.
Trust score is not shown when there are fewer than 30 respondents.

Section 6. Operations and procedures (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.



		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
310	8.9	9.0	8.4	9.6

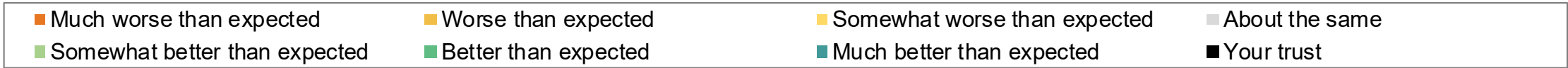
323	7.9	7.8	7.0	9.1
-----	-----	-----	-----	-----

323	7.6	8.1	7.1	9.0
-----	-----	-----	-----	-----

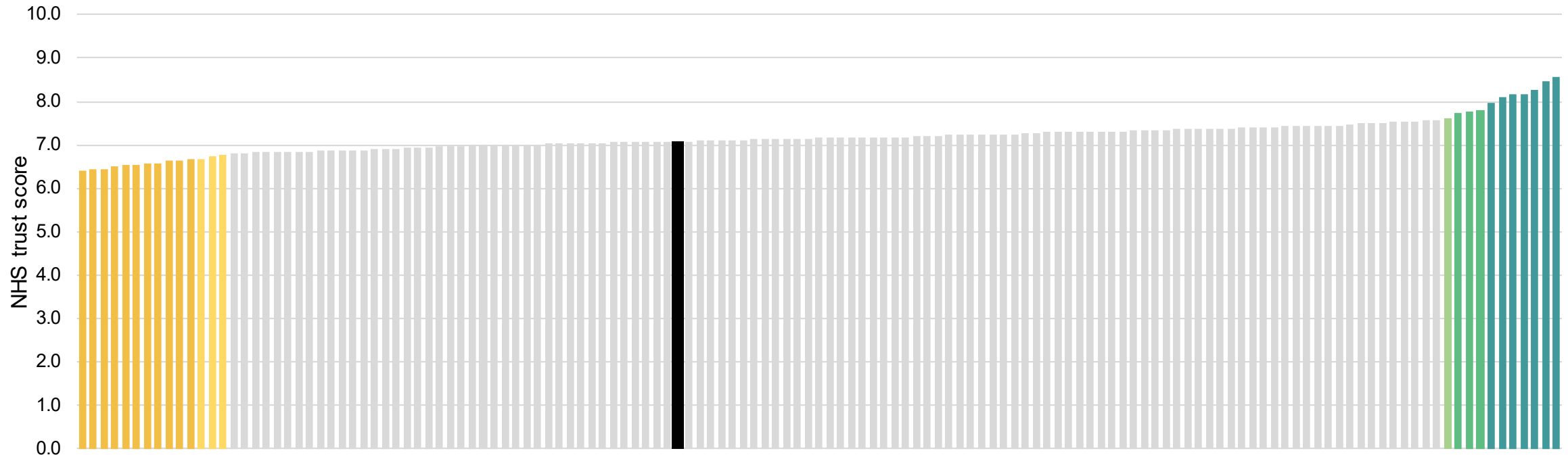
Section 7. Leaving hospital

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



Your trust section score = 7.1 (About the same)

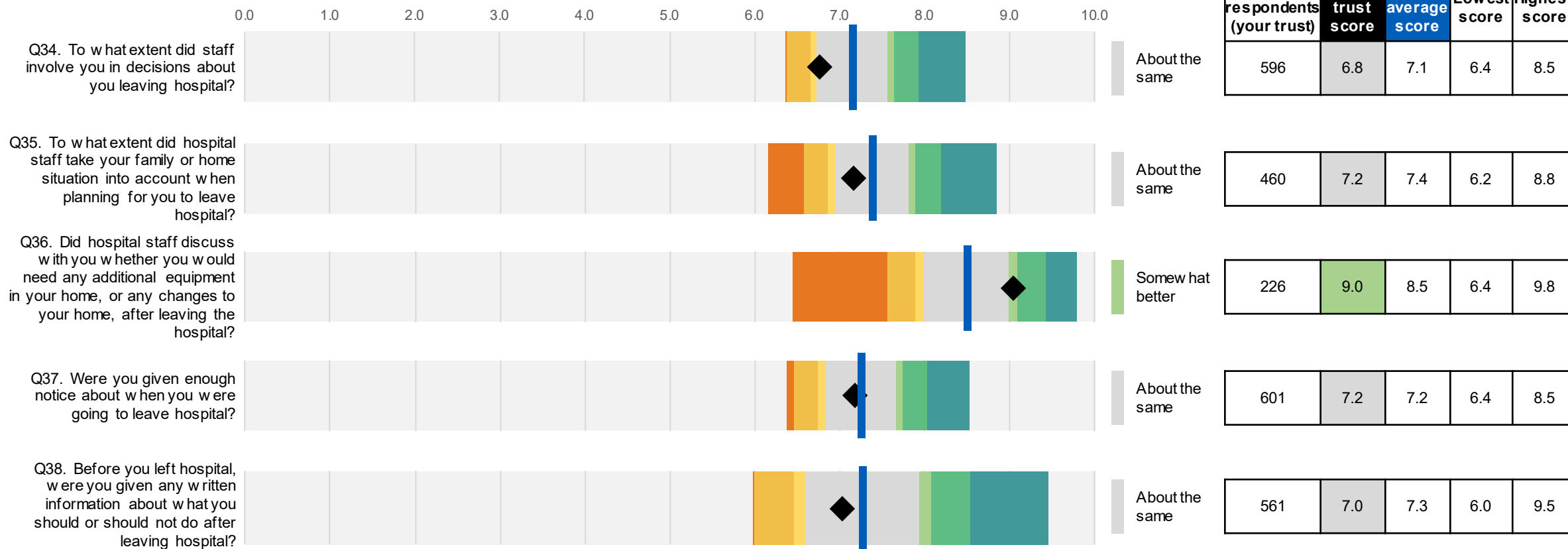
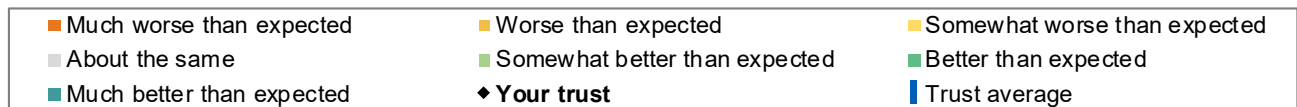


Each vertical line represents an individual NHS trust.
Trust score is not shown when there are fewer than 30 respondents.

Section 7. Leaving hospital (continued)

Question scores

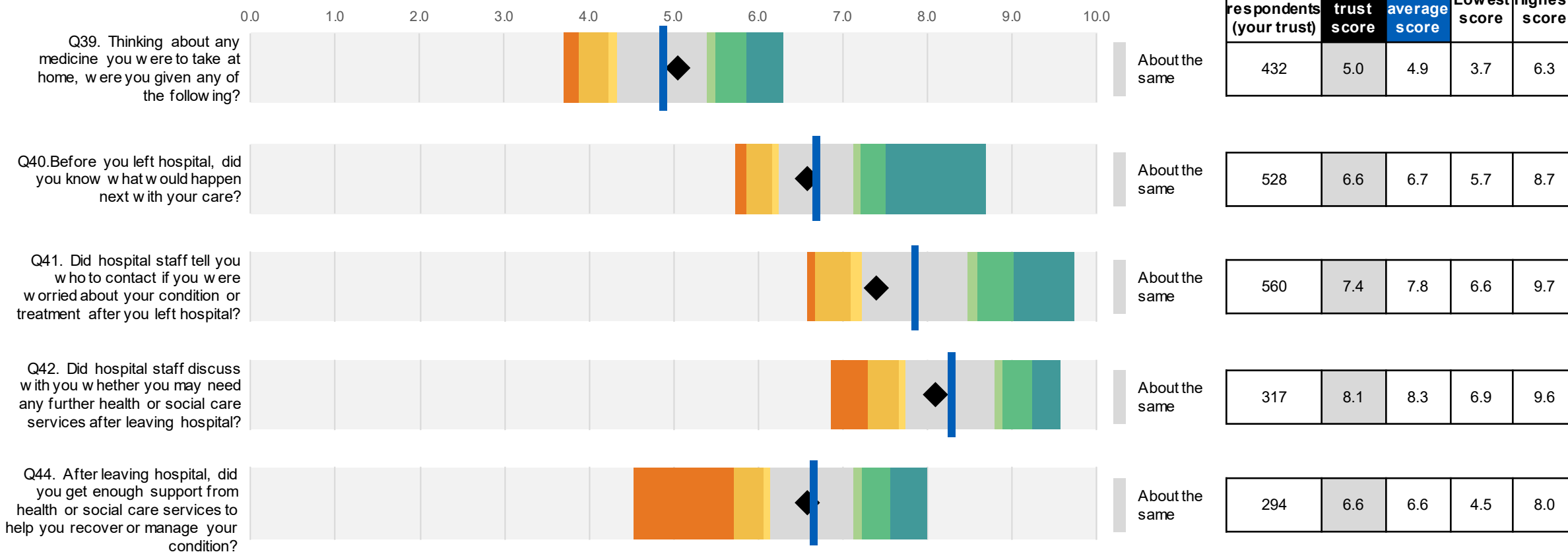
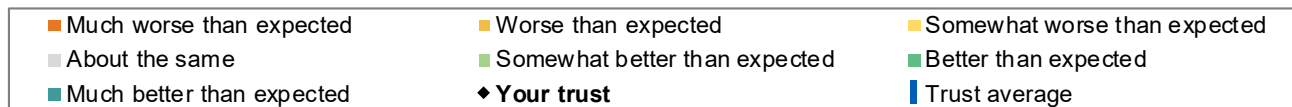
Trust score is not shown when there are fewer than 30 respondents.



Section 7. Leaving hospital (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.



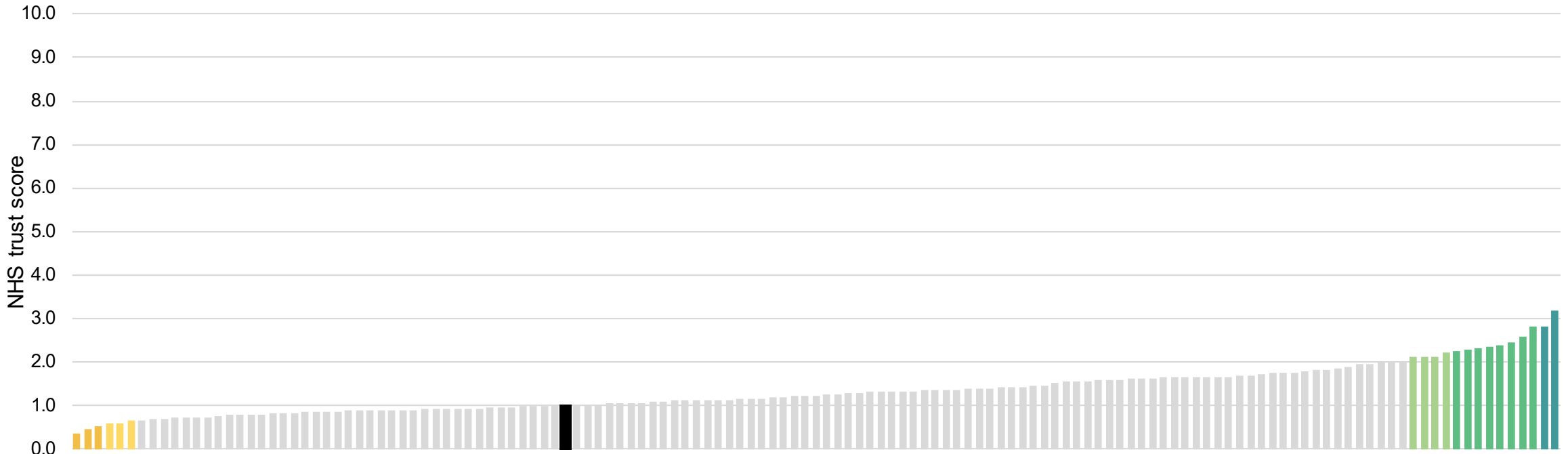
Section 8. Feedback on the quality of your care

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



Your trust section score = 1.0 (About the same)

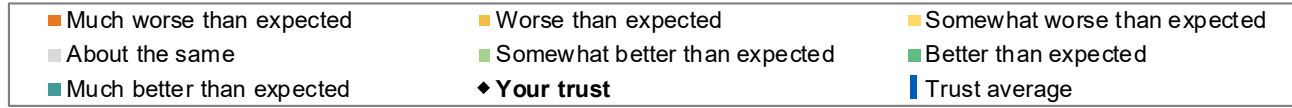


Each vertical line represents an individual NHS trust. Trust score is not shown when there are fewer than 30 respondents.

Section 8. Feedback on the quality of your care (continued)

Question score

Trust score is not shown when there are fewer than 30 respondents.



		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
535	1.0	1.3	0.4	3.2

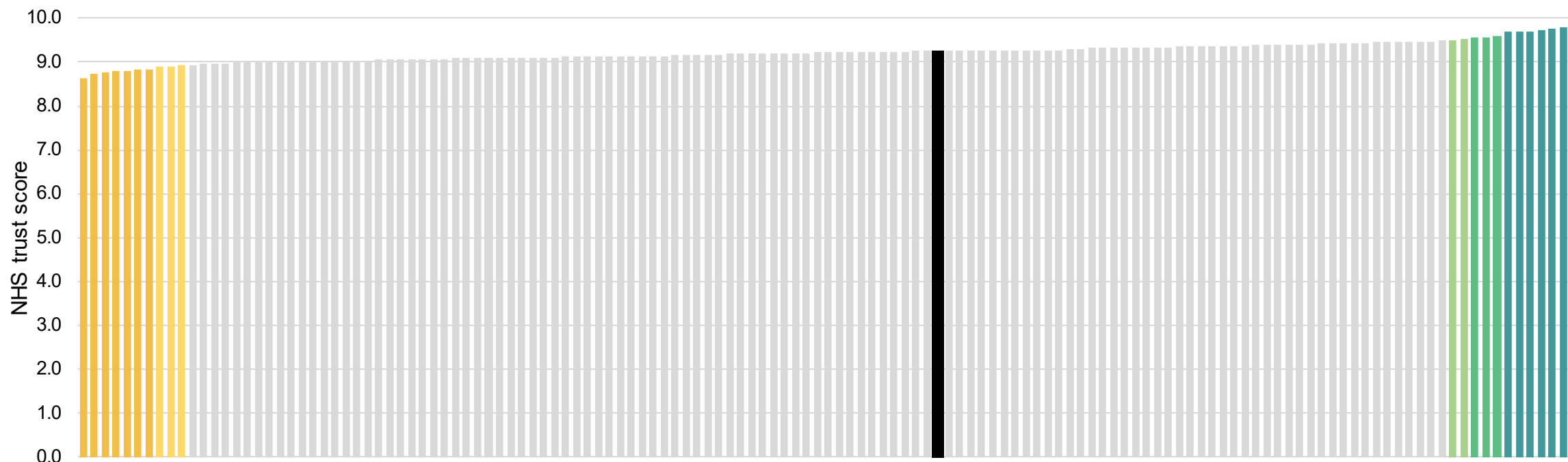
Section 9. Respect and dignity

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



Your trust section score = 9.3 (About the same)

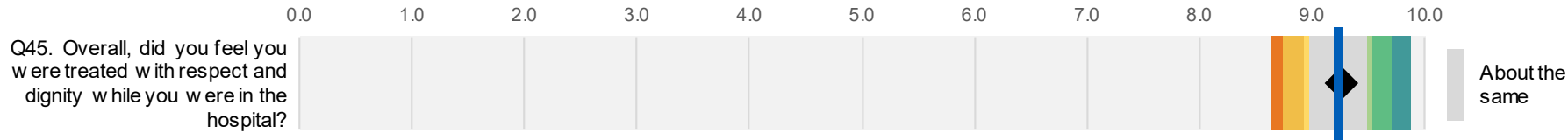
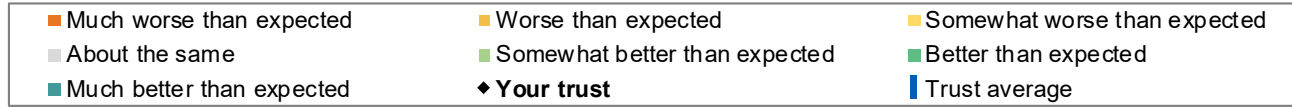


Each vertical line represents an individual NHS trust.
Trust score is not shown when there are fewer than 30 respondents.

Section 9. Respect and dignity (continued)

Question score

Trust score is not shown when there are fewer than 30 respondents.

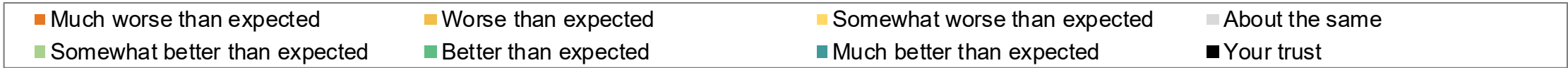


		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
595	9.3	9.2	8.6	9.9

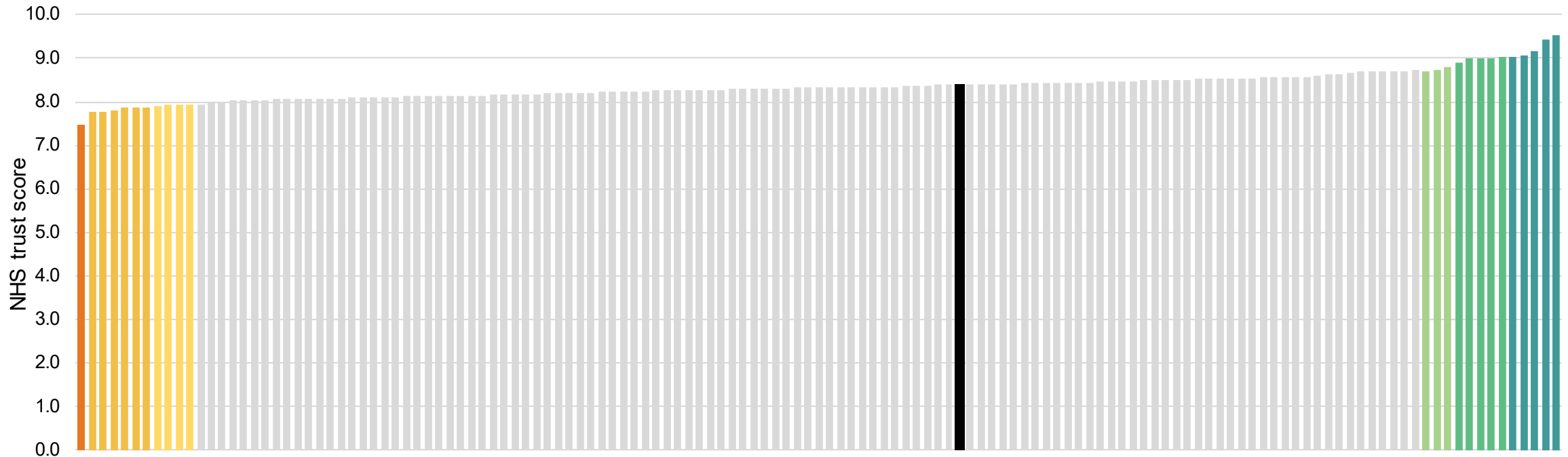
Section 10. Overall experience

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



Your trust section score = 8.4 (About the same)

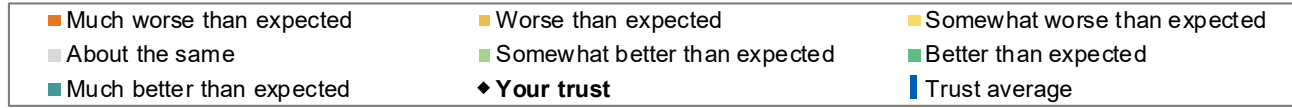


Each vertical line represents an individual NHS trust.
Trust score is not shown when there are fewer than 30 respondents.

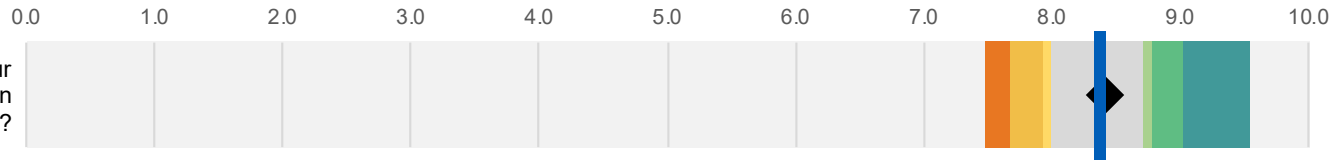
Section 10. Overall experience (continued)

Question score

Trust score is not shown when there are fewer than 30 respondents.



Q46. Overall, how was your experience while you were in the hospital?



About the same

		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
589	8.4	8.4	7.5	9.5

Trust results

This section includes:

- an overview of results for your trust for each question, including:
 - the score for your trust
 - a comparison with other trusts in your region
 - a breakdown of scores across sites within your trust

Admission to hospital: Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital?

Results for your trust



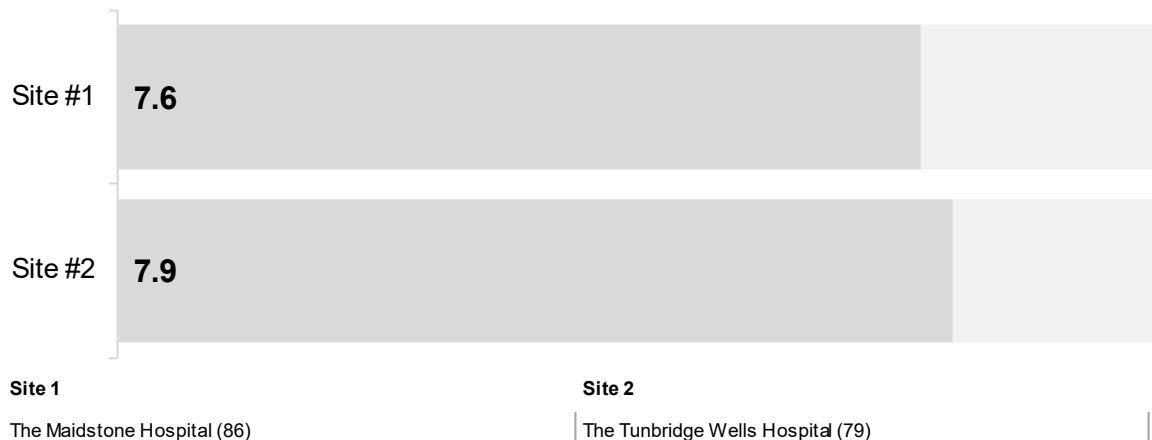
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

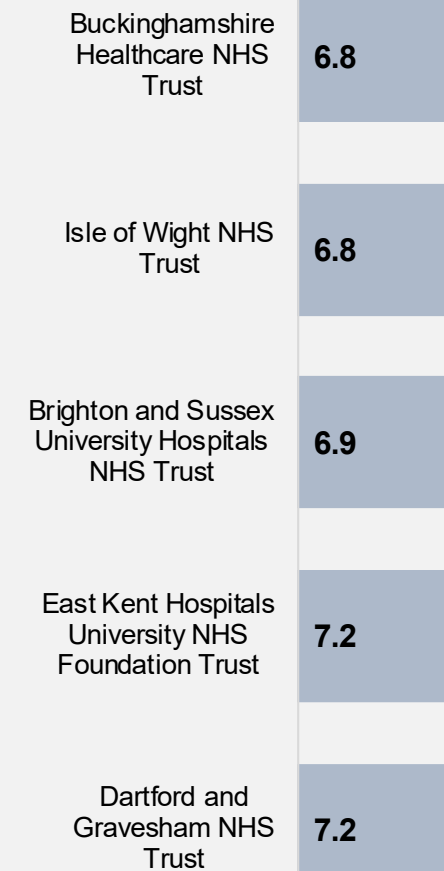


Comparison with other trusts within your region

Top five trusts

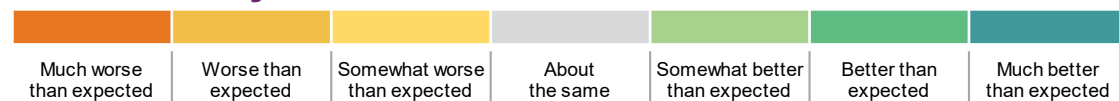


Bottom five trusts



Admission to hospital: Q3. How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?

Results for your trust



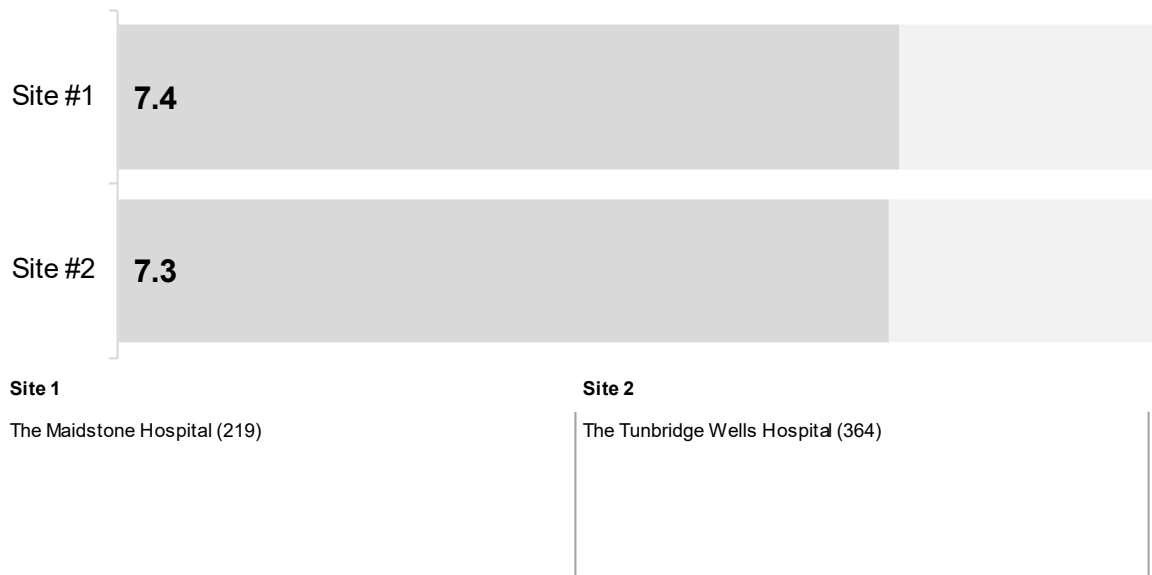
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Comparison with other trusts within your region

Top five trusts

Queen Victoria Hospital NHS Foundation Trust

9.1

University Hospital Southampton NHS Foundation Trust

8.3

Oxford University Hospitals NHS Foundation Trust

8.0

Royal Surrey NHS Foundation Trust

7.8

East Sussex Healthcare NHS Trust

7.8

Bottom five trusts

Medway NHS Foundation Trust

6.0

Buckinghamshire Healthcare NHS Trust

6.8

Brighton and Sussex University Hospitals NHS Trust

6.9

Ashford and St Peter's Hospitals NHS Foundation Trust

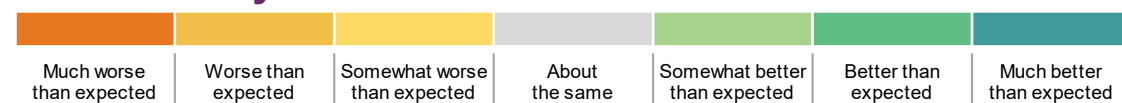
7.1

East Kent Hospitals University NHS Foundation Trust

7.1

The hospital and ward: Q4A. There were restrictions on visitors in hospital during the coronavirus (COVID-19) pandemic. Were you able to keep in touch with your family and friends during your stay?

Results for your trust



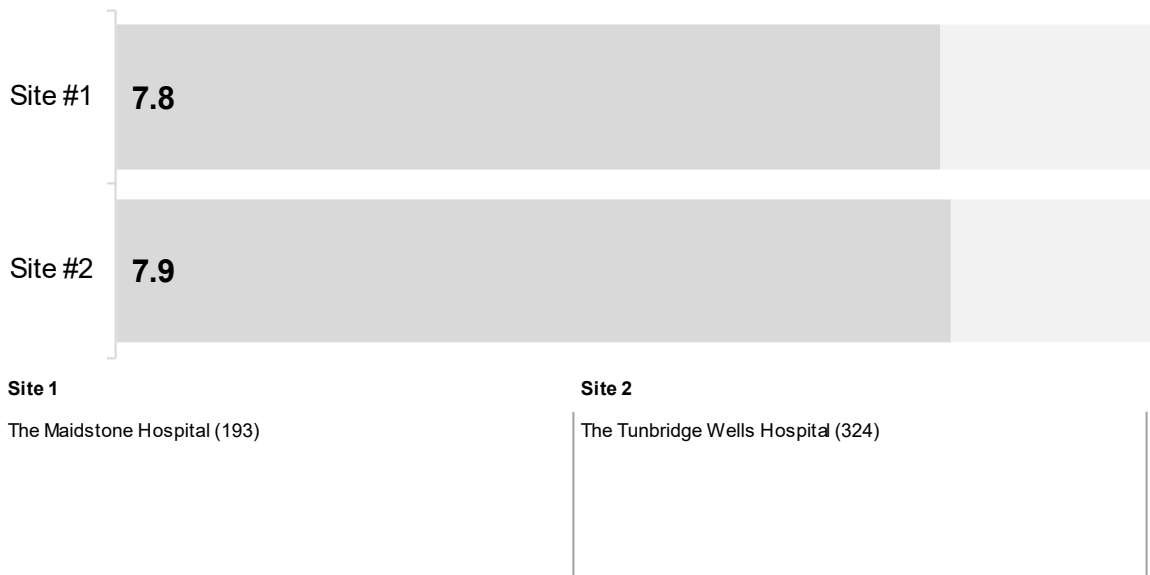
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



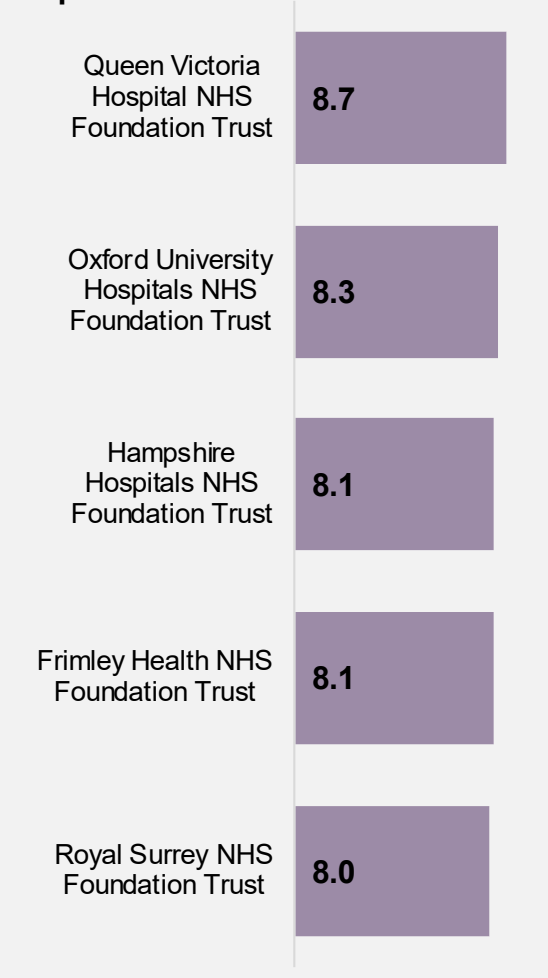
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

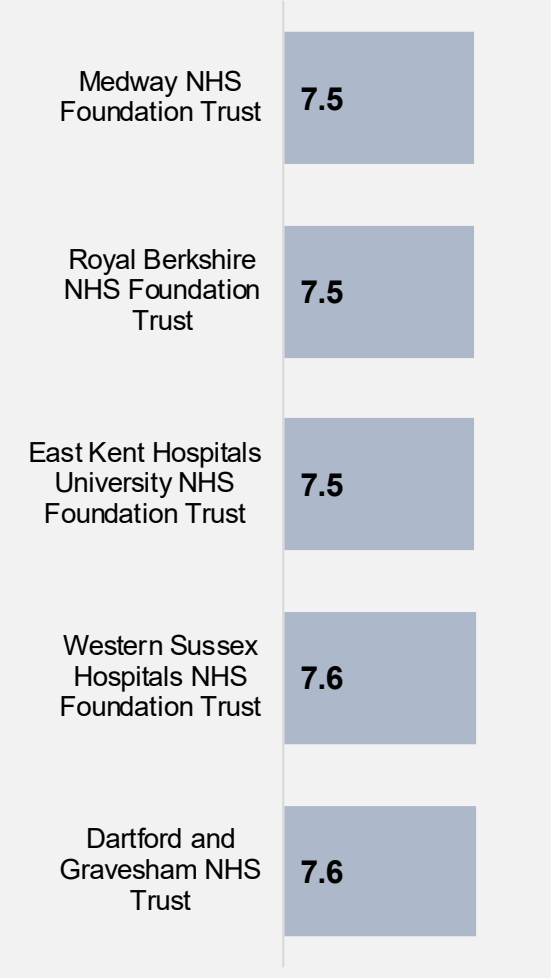


Comparison with other trusts within your region

Top five trusts



Bottom five trusts



The hospital and ward: Q5. Were you ever prevented from sleeping at night by noise from other patients?

Results for your trust



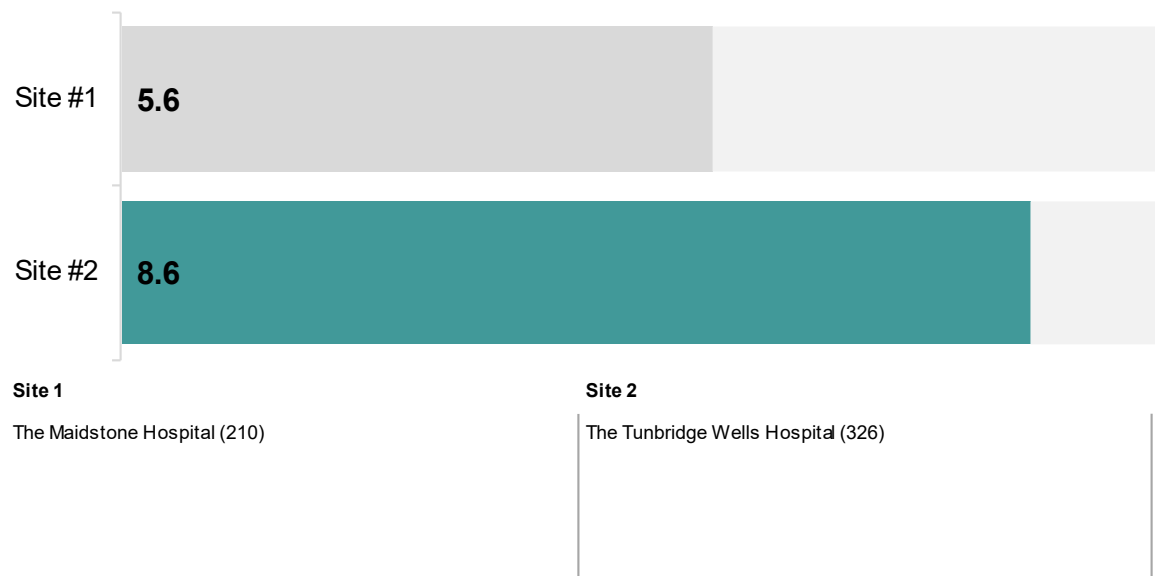
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



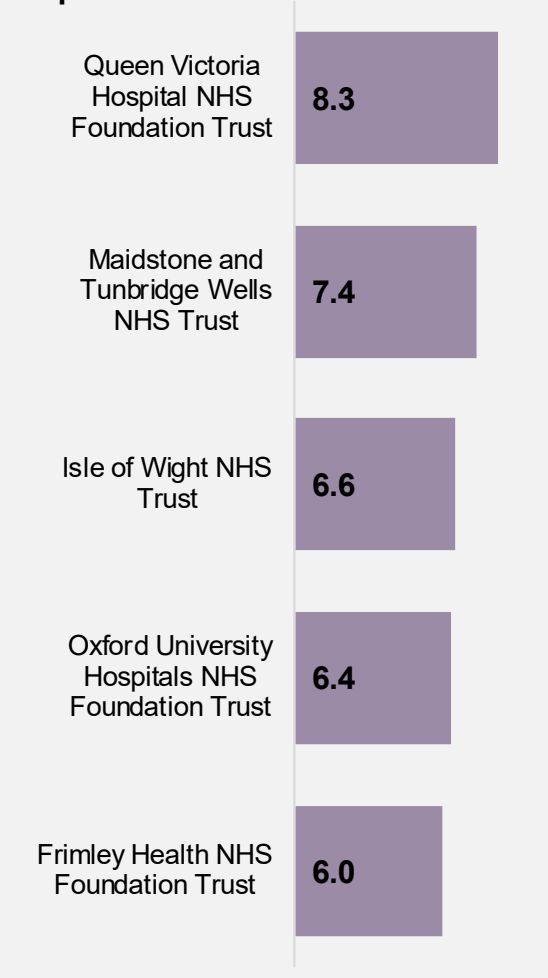
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

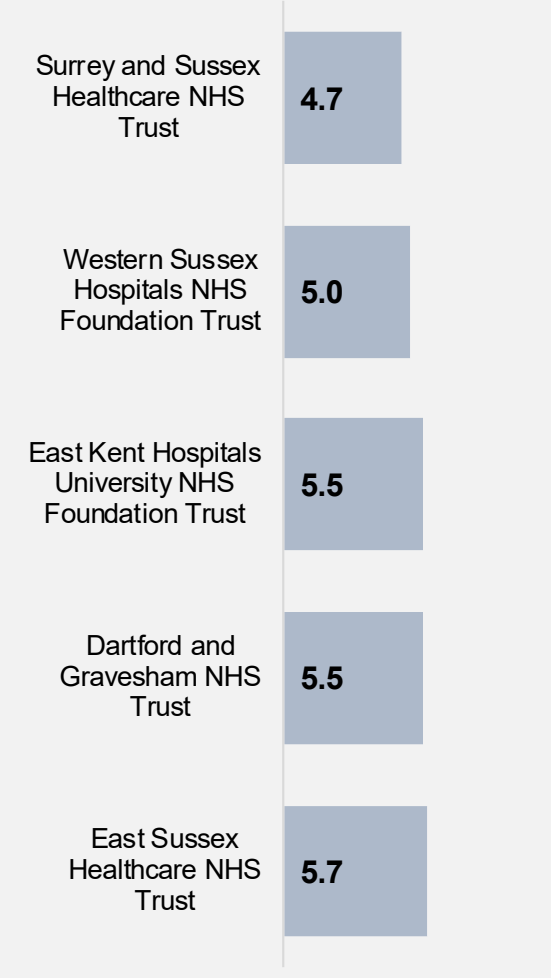


Comparison with other trusts within your region

Top five trusts

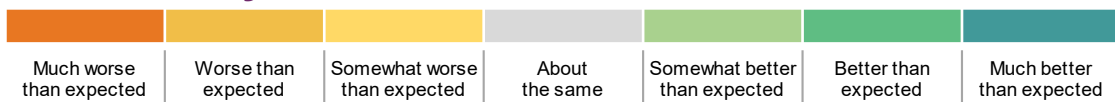


Bottom five trusts



The hospital and ward: Q5. Were you ever prevented from sleeping at night by noise from staff?

Results for your trust



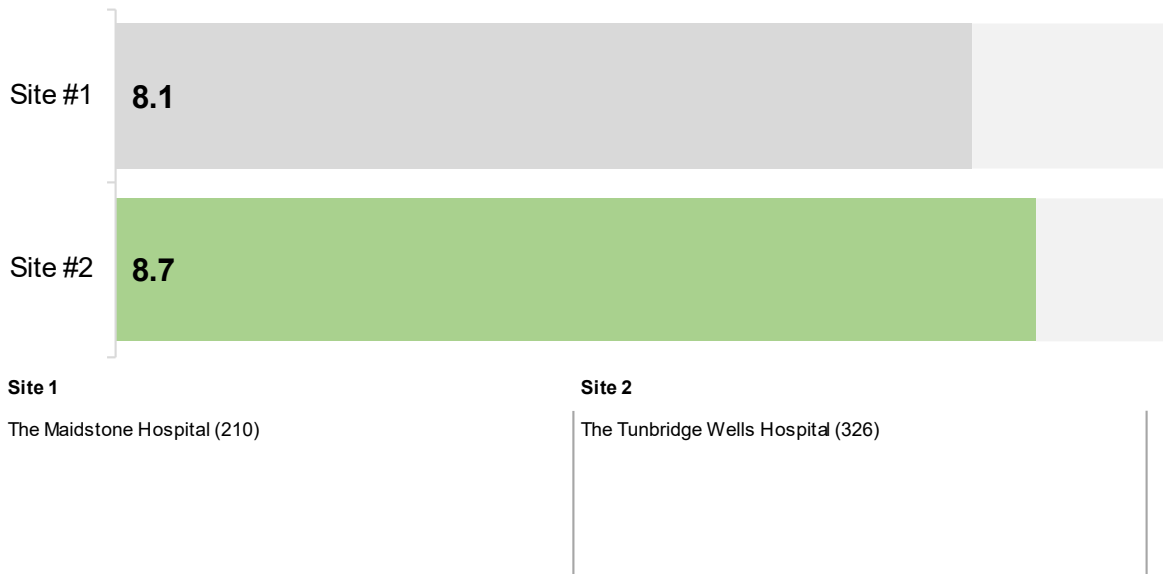
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



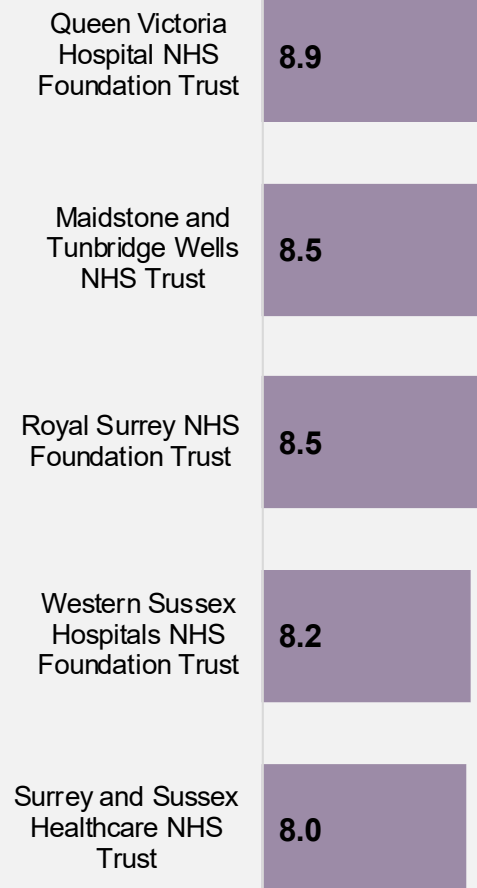
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

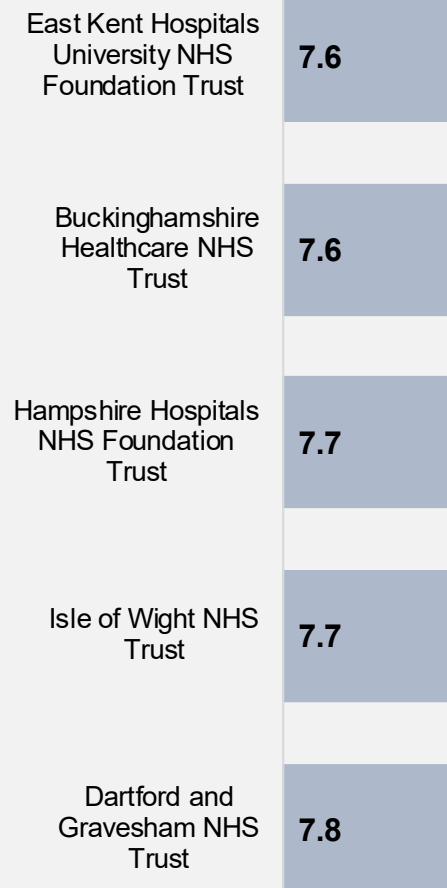


Comparison with other trusts within your region

Top five trusts



Bottom five trusts



The hospital and ward: Q5. Were you ever prevented from sleeping at night by hospital lighting?

Results for your trust



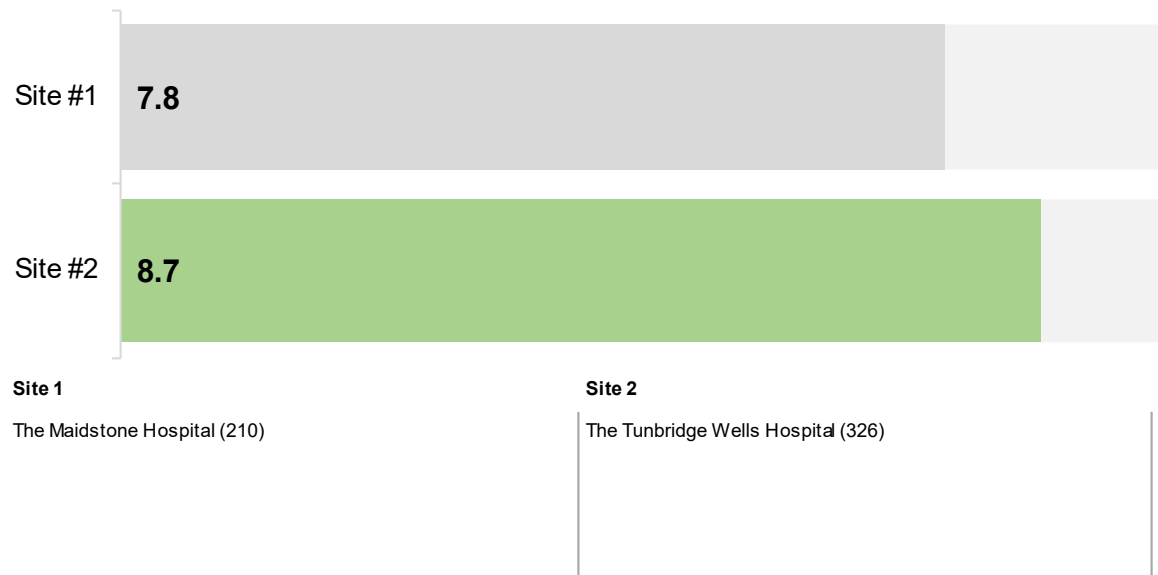
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Comparison with other trusts within your region

Top five trusts

Queen Victoria Hospital NHS Foundation Trust

9.0

Dartford and Gravesham NHS Trust

8.6

Maidstone and Tunbridge Wells NHS Trust

8.5

Royal Surrey NHS Foundation Trust

8.5

Medway NHS Foundation Trust

8.4

Bottom five trusts

Buckinghamshire Healthcare NHS Trust

7.6

University Hospital Southampton NHS Foundation Trust

7.7

Hampshire Hospitals NHS Foundation Trust

8.0

East Kent Hospitals University NHS Foundation Trust

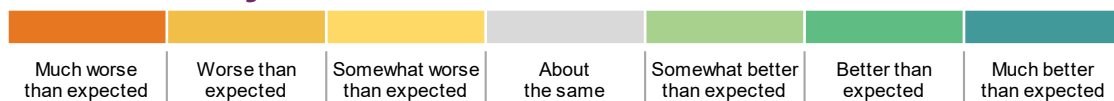
8.0

Royal Berkshire NHS Foundation Trust

8.0

The hospital and ward: Q7. Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?

Results for your trust



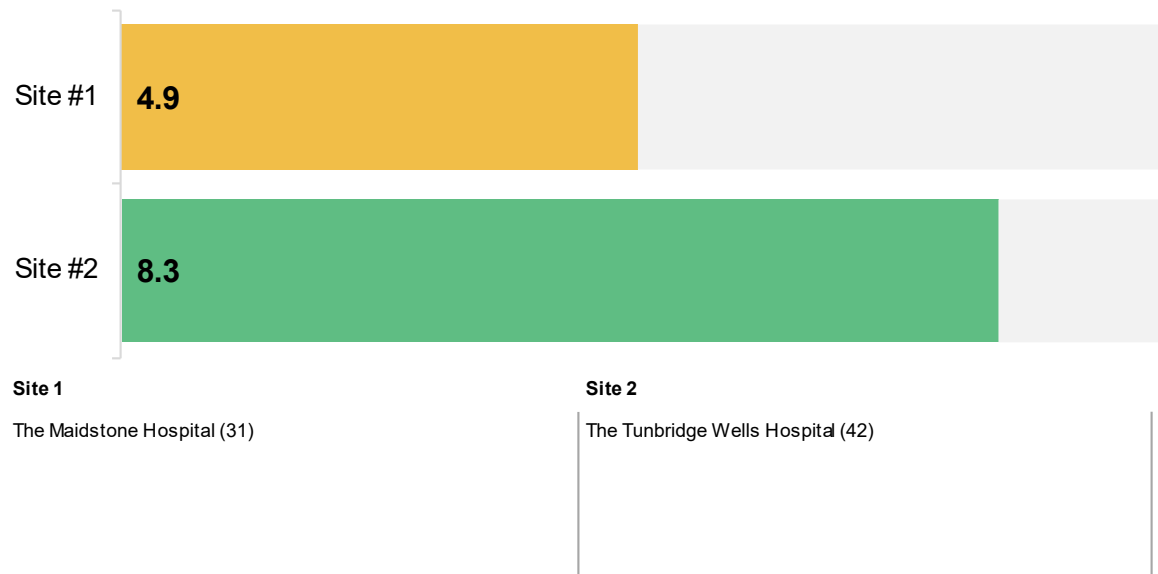
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



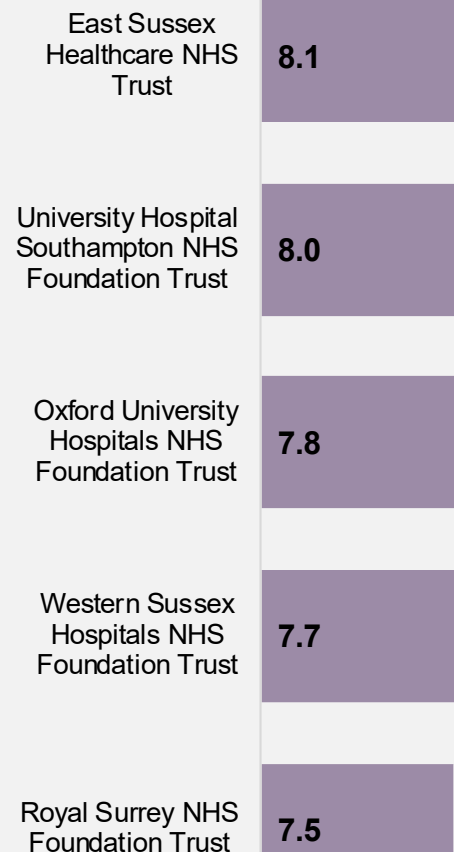
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

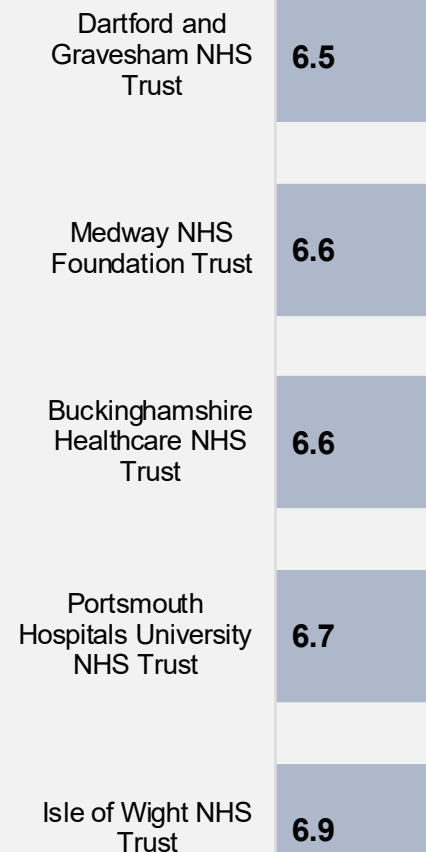


Comparison with other trusts within your region

Top five trusts

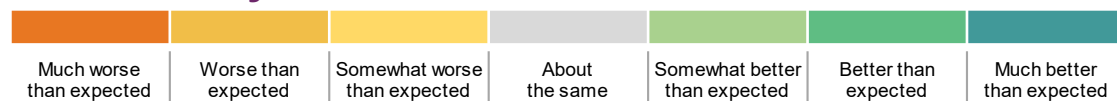


Bottom five trusts



The hospital and ward: Q8. How clean was the hospital room or ward that you were in?

Results for your trust



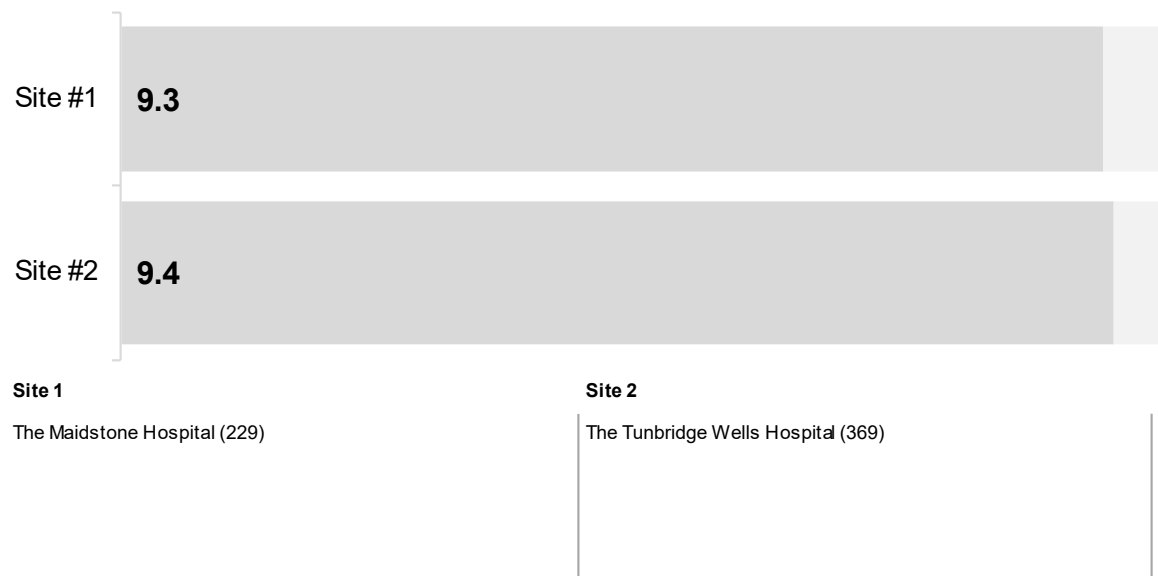
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



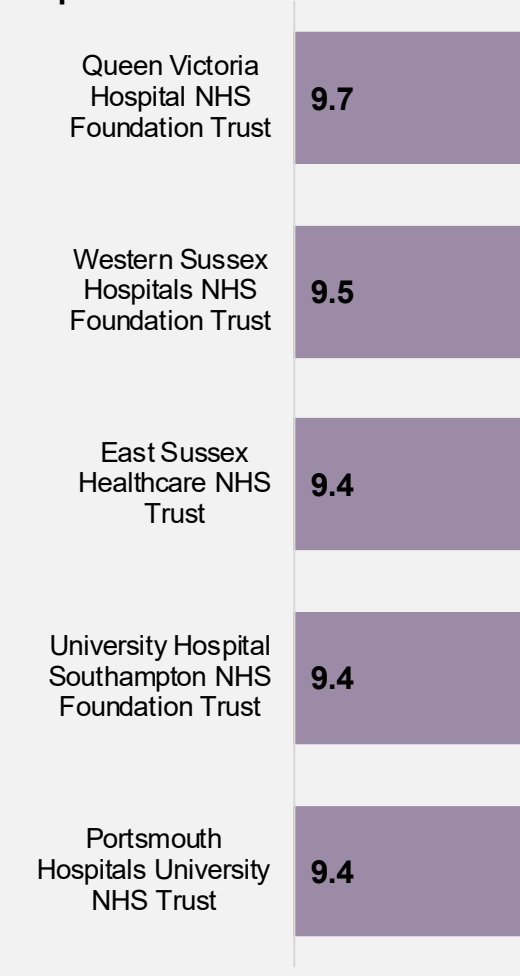
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

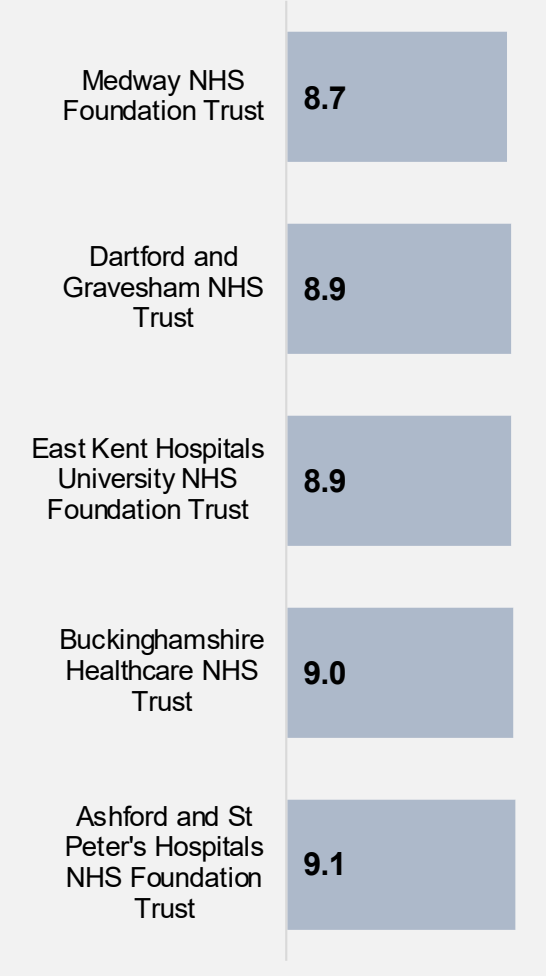


Comparison with other trusts within your region

Top five trusts

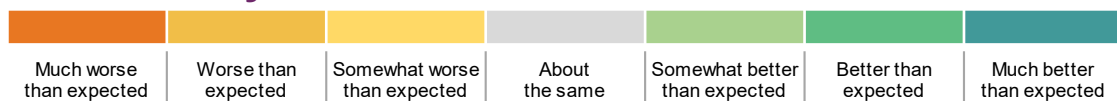


Bottom five trusts



The hospital and ward: Q9. Did you get enough help from staff to wash or keep yourself clean?

Results for your trust



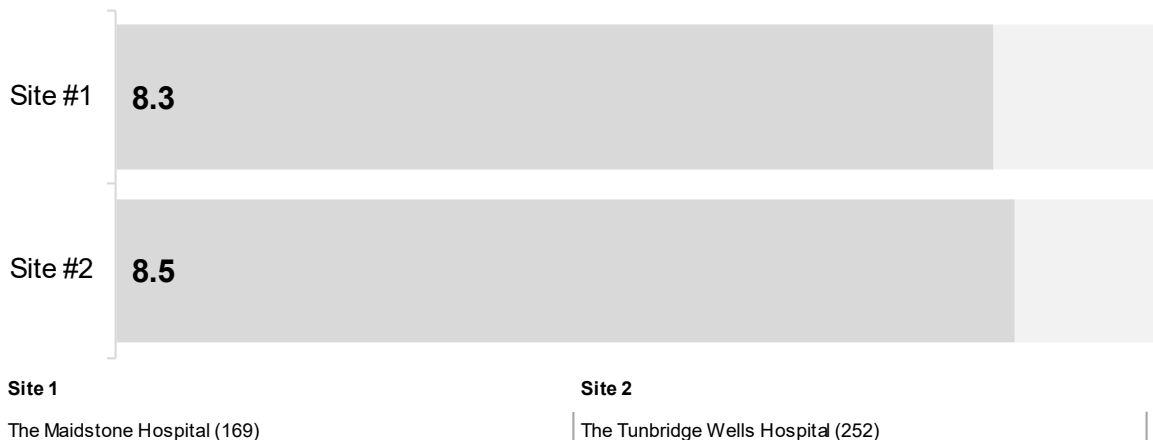
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Comparison with other trusts within your region

Top five trusts

Queen Victoria Hospital NHS Foundation Trust

9.1

East Sussex Healthcare NHS Trust

8.9

Isle of Wight NHS Trust

8.8

Western Sussex Hospitals NHS Foundation Trust

8.8

Oxford University Hospitals NHS Foundation Trust

8.7

Bottom five trusts

Medway NHS Foundation Trust

7.7

Dartford and Gravesham NHS Trust

7.8

East Kent Hospitals University NHS Foundation Trust

8.1

Portsmouth Hospitals University NHS Trust

8.2

Frimley Health NHS Foundation Trust

8.3

The hospital and ward: Q10. If you brought medication with you to hospital, were you able to take it when you needed to?

Results for your trust



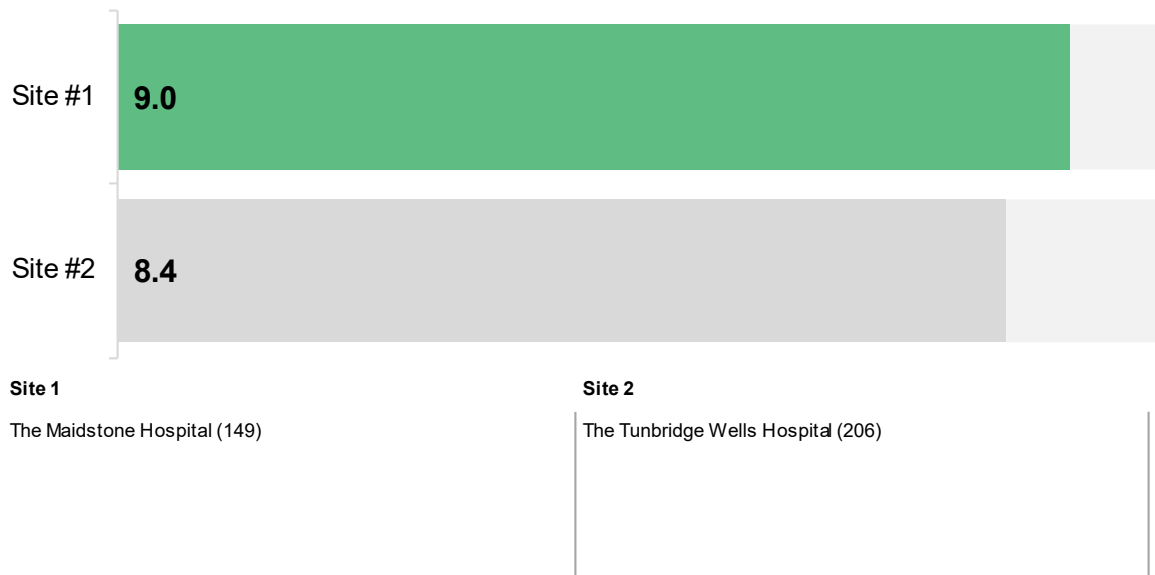
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Comparison with other trusts within your region

Top five trusts

Queen Victoria Hospital NHS Foundation Trust

9.5

Royal Surrey NHS Foundation Trust

8.9

East Sussex Healthcare NHS Trust

8.8

Maidstone and Tunbridge Wells NHS Trust

8.7

Dartford and Gravesham NHS Trust

8.5

Bottom five trusts

Isle of Wight NHS Trust

7.7

Portsmouth Hospitals University NHS Trust

7.9

Buckinghamshire Healthcare NHS Trust

8.0

Royal Berkshire NHS Foundation Trust

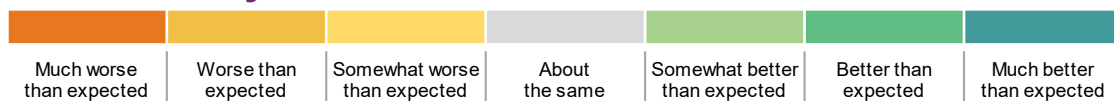
8.0

Hampshire Hospitals NHS Foundation Trust

8.2

The hospital and ward: Q11. Were you offered food that met any dietary requirements you had?

Results for your trust



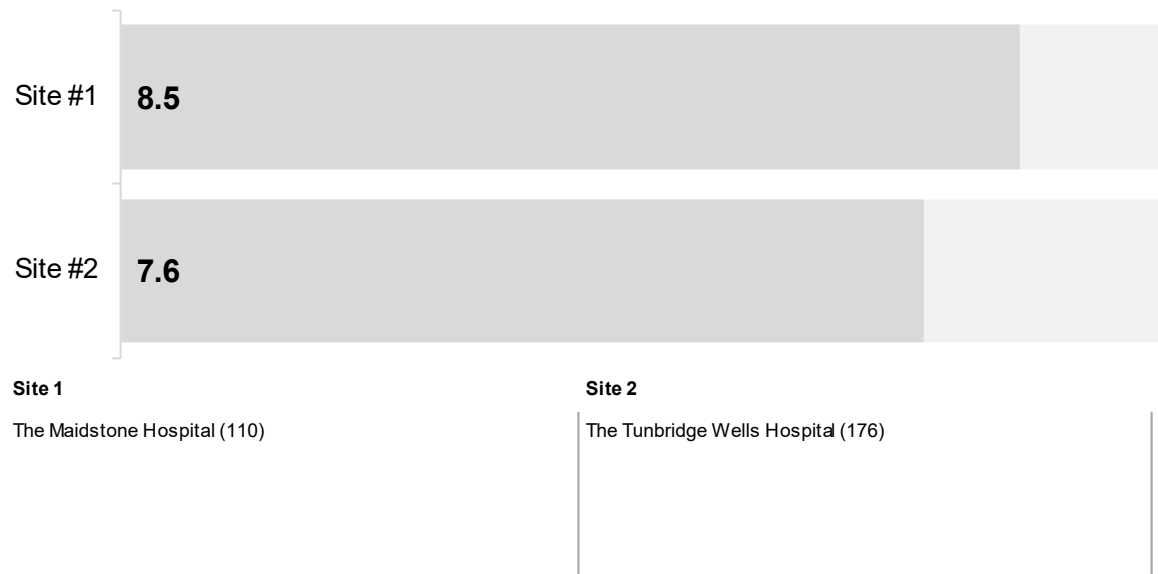
Your trust score compared with all other trusts:

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Breakdown of scores for sites within your trust:

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Comparison with other trusts within your region

Top five trusts

University Hospital Southampton NHS Foundation Trust

9.2

Ashford and St Peter's Hospitals NHS Foundation Trust

8.9

East Sussex Healthcare NHS Trust

8.9

Surrey and Sussex Healthcare NHS Trust

8.9

Oxford University Hospitals NHS Foundation Trust

8.7

Bottom five trusts

Medway NHS Foundation Trust

7.9

Brighton and Sussex University Hospitals NHS Trust

8.0

Maidstone and Tunbridge Wells NHS Trust

8.0

Dartford and Gravesham NHS Trust

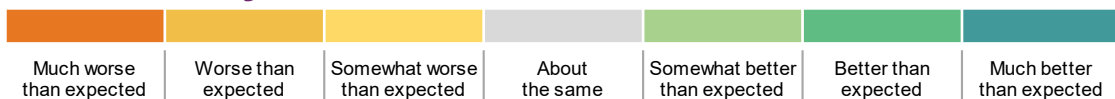
8.1

East Kent Hospitals University NHS Foundation Trust

8.1

The hospital and ward: Q12. How would you rate the hospital food?

Results for your trust



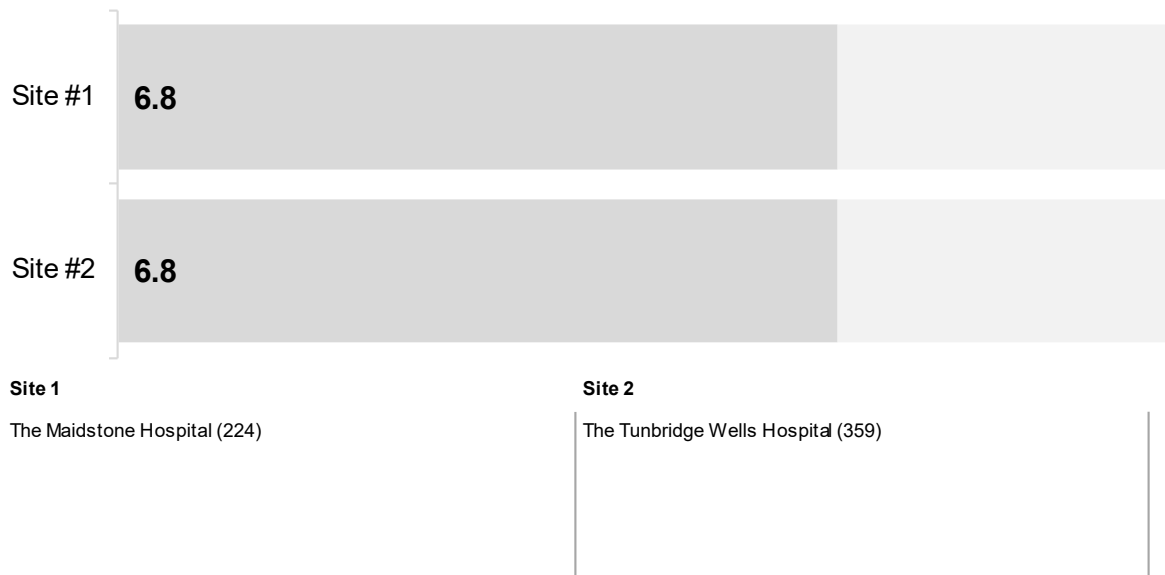
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



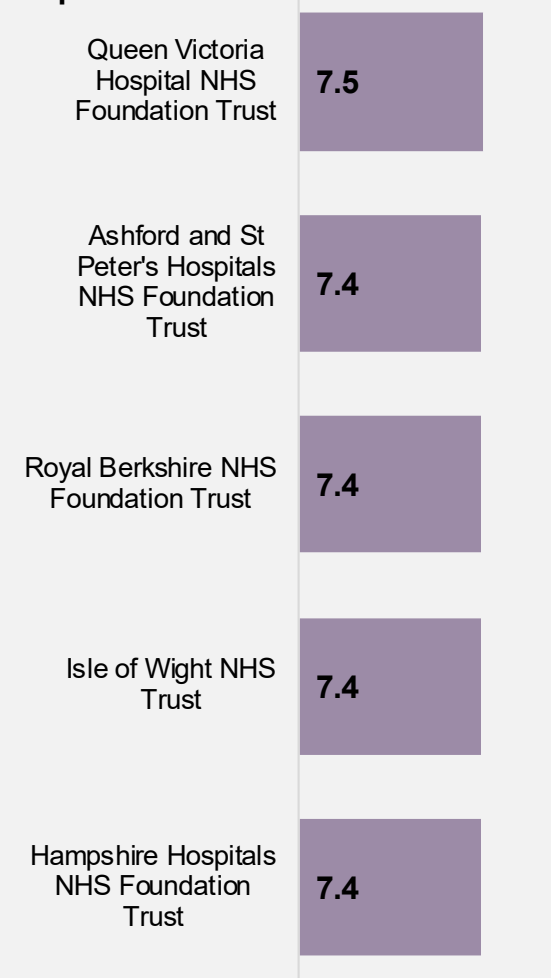
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

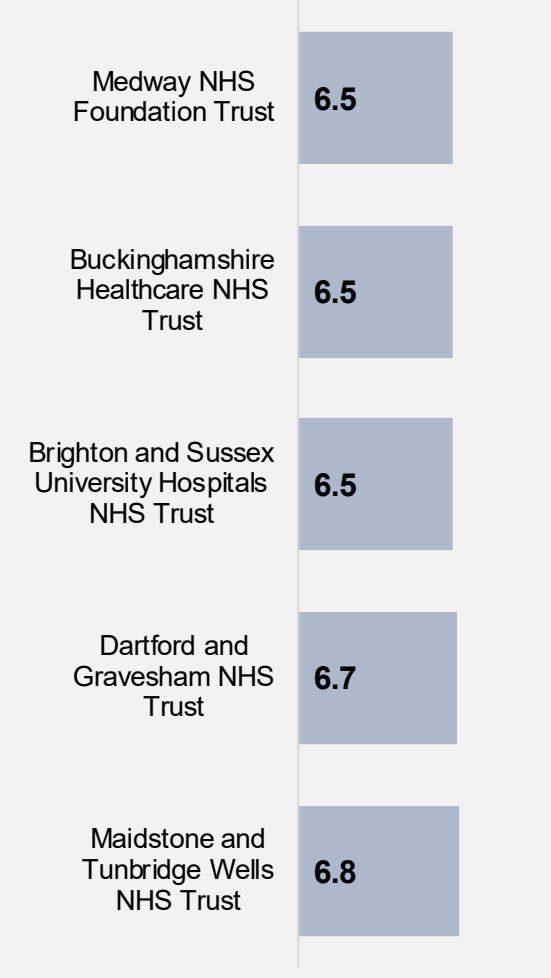


Comparison with other trusts within your region

Top five trusts

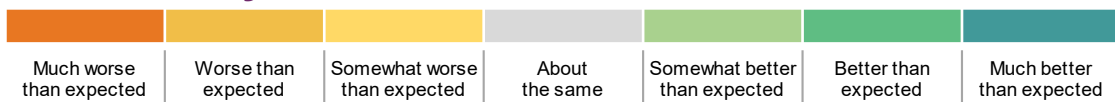


Bottom five trusts



The hospital and ward: Q13. Did you get enough help from staff to eat your meals?

Results for your trust



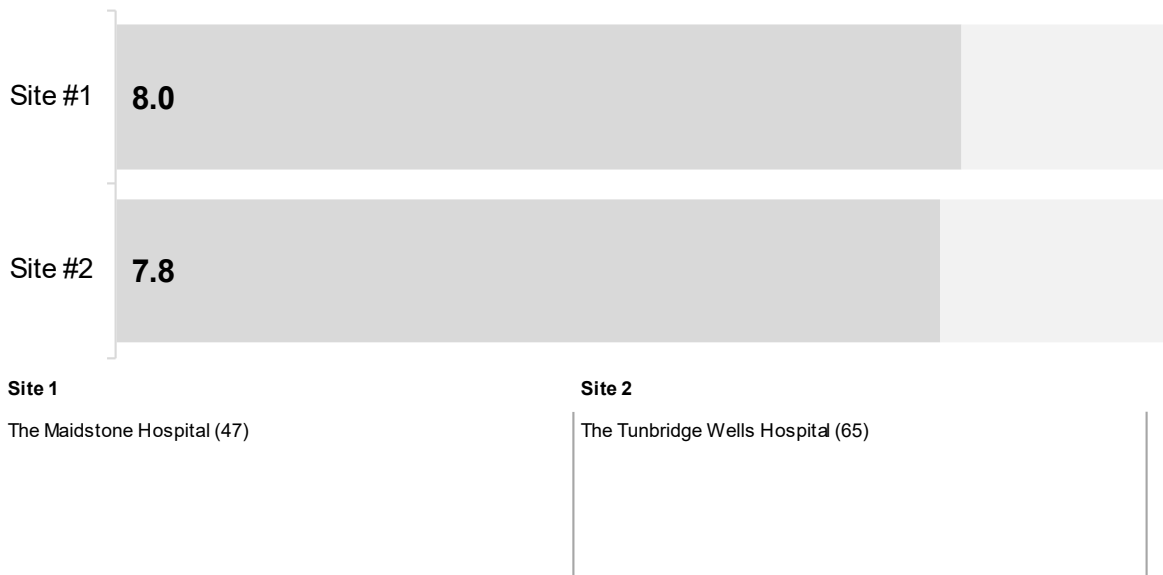
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



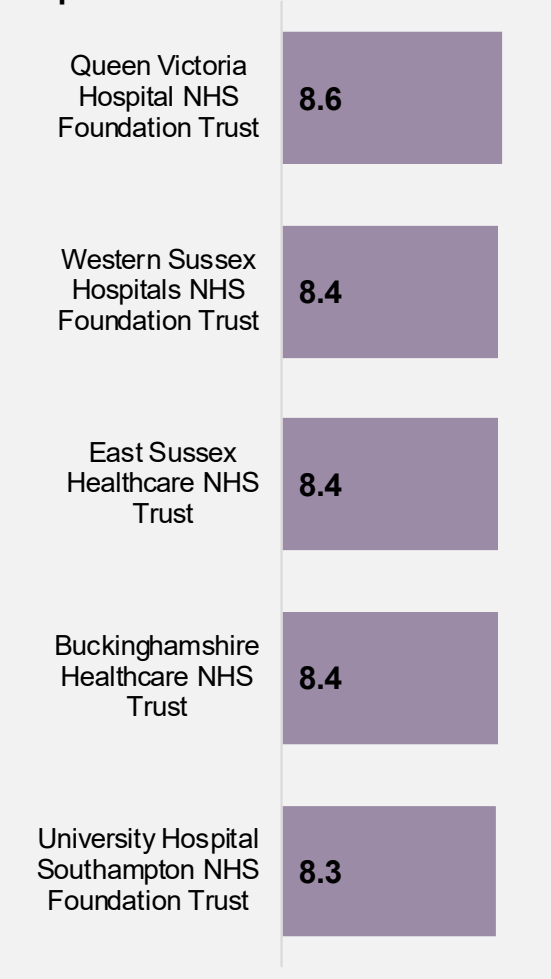
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

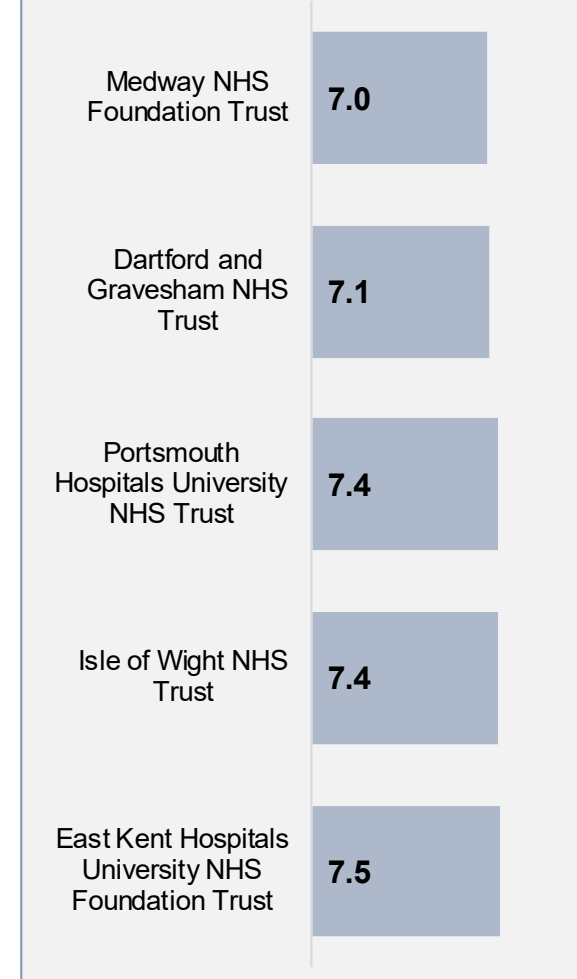


Comparison with other trusts within your region

Top five trusts

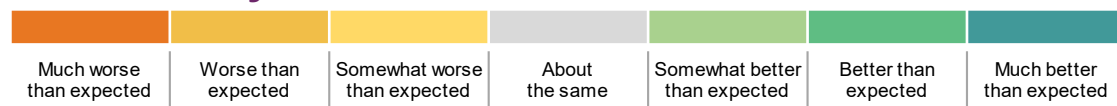


Bottom five trusts



The hospital and ward: Q14. During your time in hospital, did you get enough to drink?

Results for your trust



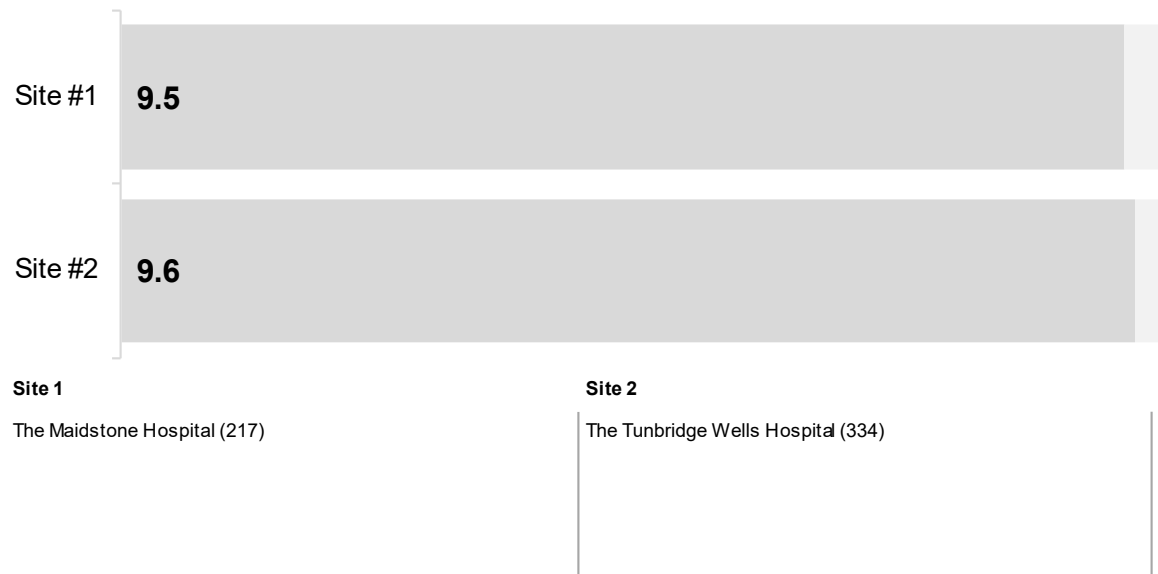
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Comparison with other trusts within your region

Top five trusts

Queen Victoria Hospital NHS Foundation Trust

9.9

University Hospital Southampton NHS Foundation Trust

9.7

East Sussex Healthcare NHS Trust

9.7

Ashford and St Peter's Hospitals NHS Foundation Trust

9.6

Western Sussex Hospitals NHS Foundation Trust

9.6

Bottom five trusts

Medway NHS Foundation Trust

8.8

Buckinghamshire Healthcare NHS Trust

9.3

East Kent Hospitals University NHS Foundation Trust

9.3

Isle of Wight NHS Trust

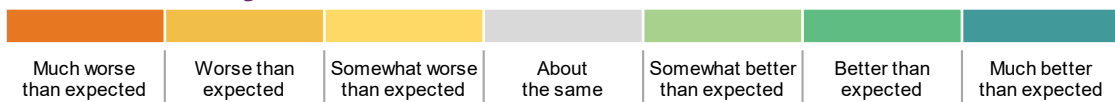
9.4

Dartford and Gravesham NHS Trust

9.4

Doctors: Q15. When you asked doctors questions, did you get answers you could understand?

Results for your trust



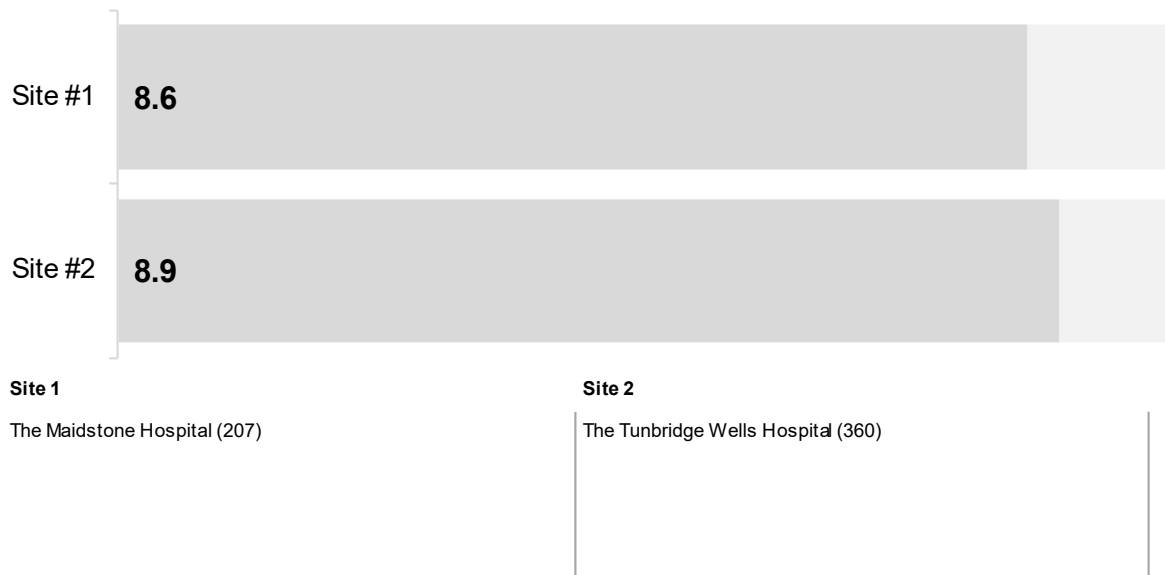
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



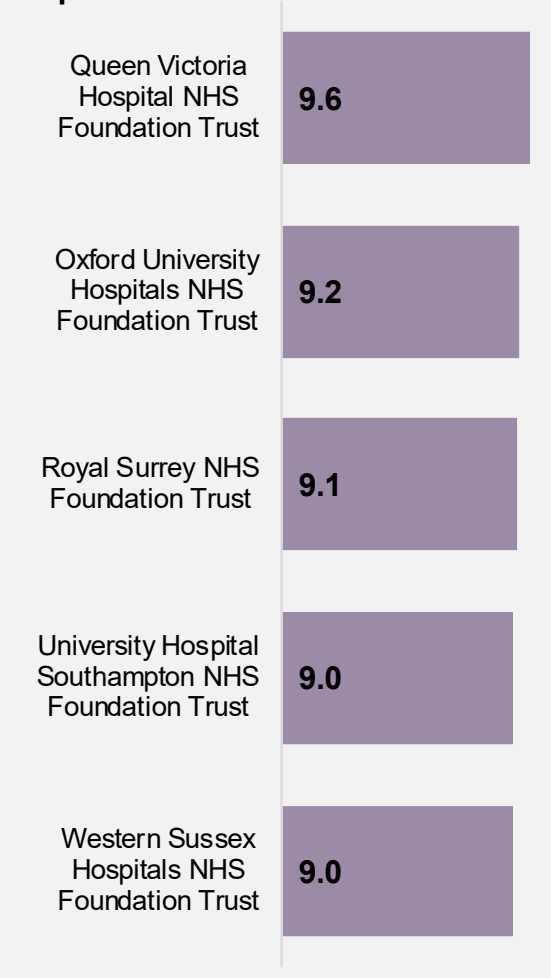
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

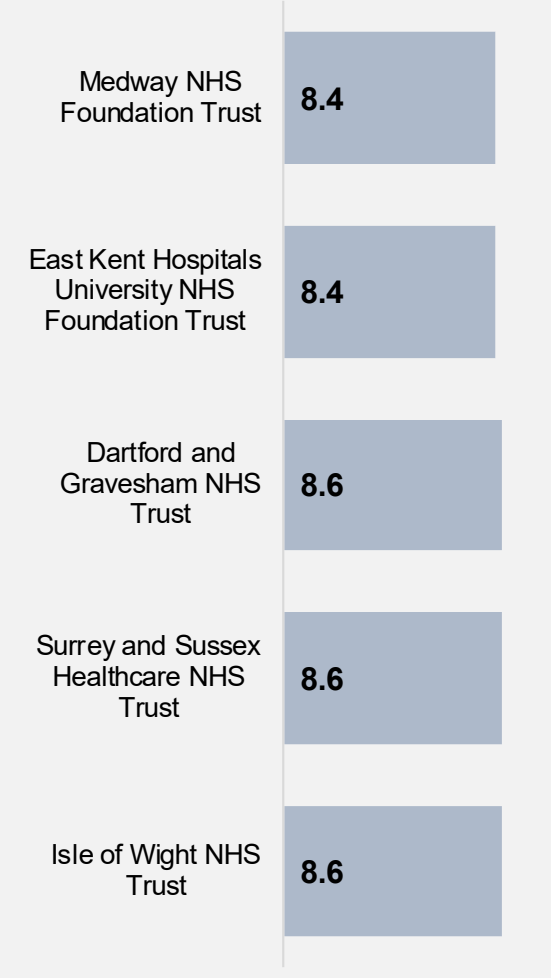


Comparison with other trusts within your region

Top five trusts

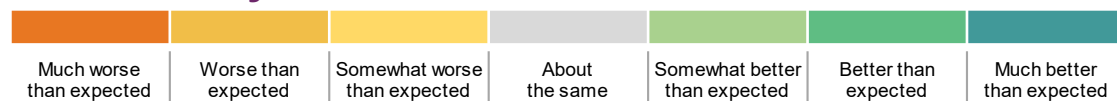


Bottom five trusts



Doctors: Q16. Did you have confidence and trust in the doctors treating you?

Results for your trust



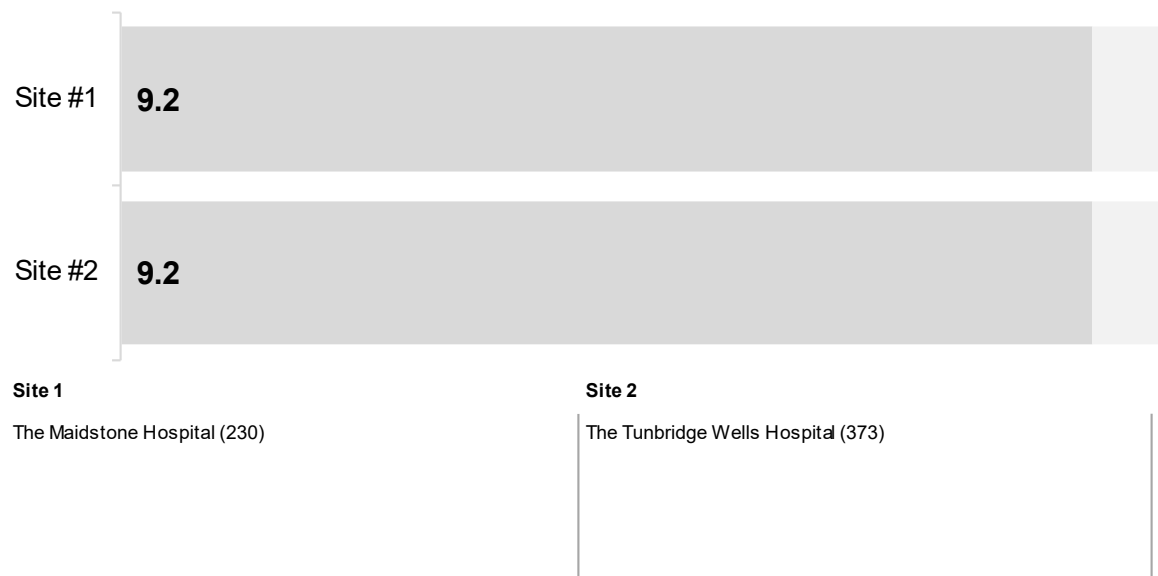
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



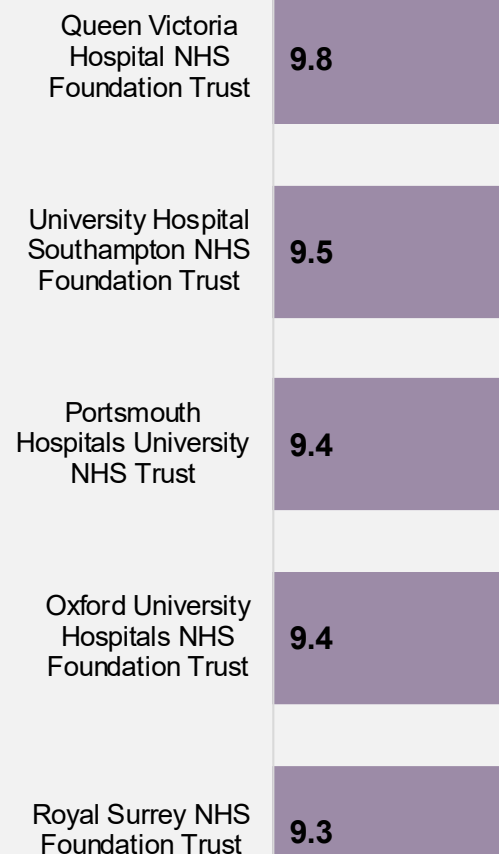
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

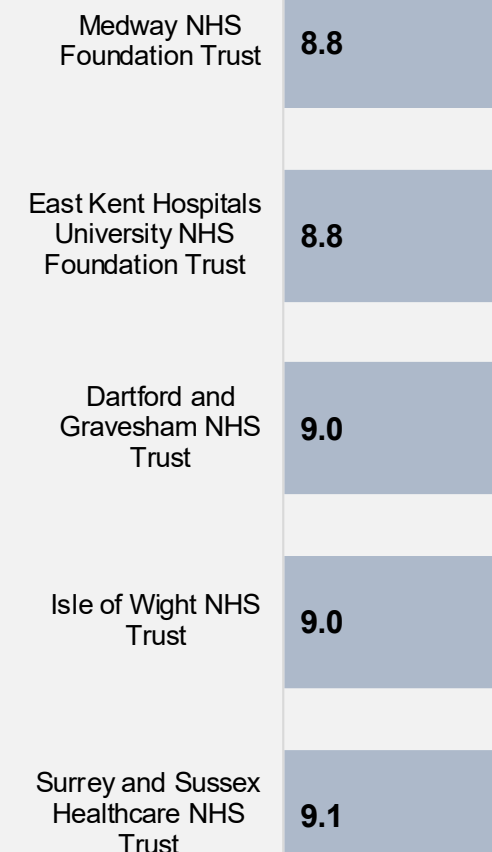


Comparison with other trusts within your region

Top five trusts

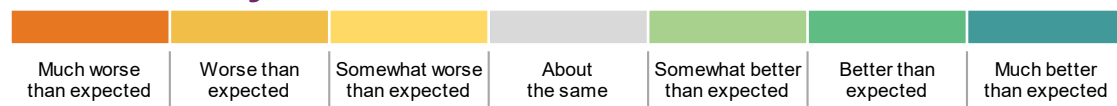


Bottom five trusts



Doctors: Q17. When doctors spoke about your care in front of you, were you included in the conversation?

Results for your trust



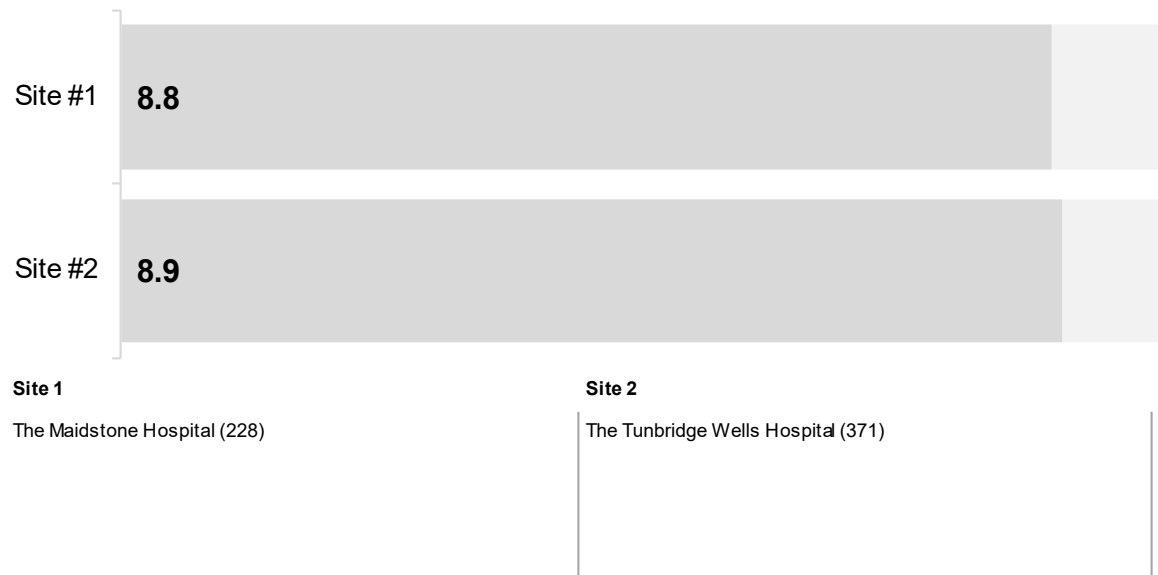
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Comparison with other trusts within your region

Top five trusts

Queen Victoria Hospital NHS Foundation Trust

9.2

University Hospital Southampton NHS Foundation Trust

8.9

Maidstone and Tunbridge Wells NHS Trust

8.8

Royal Surrey NHS Foundation Trust

8.7

Oxford University Hospitals NHS Foundation Trust

8.7

Bottom five trusts

Dartford and Gravesham NHS Trust

8.3

East Kent Hospitals University NHS Foundation Trust

8.3

Isle of Wight NHS Trust

8.3

Medway NHS Foundation Trust

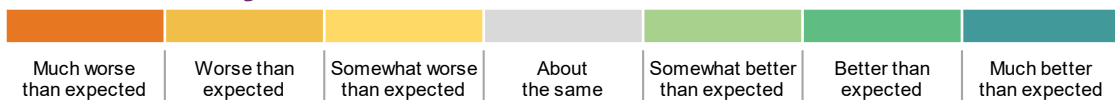
8.4

Brighton and Sussex University Hospitals NHS Trust

8.5

Nurses: Q18. When you asked nurses questions, did you get answers you could understand?

Results for your trust



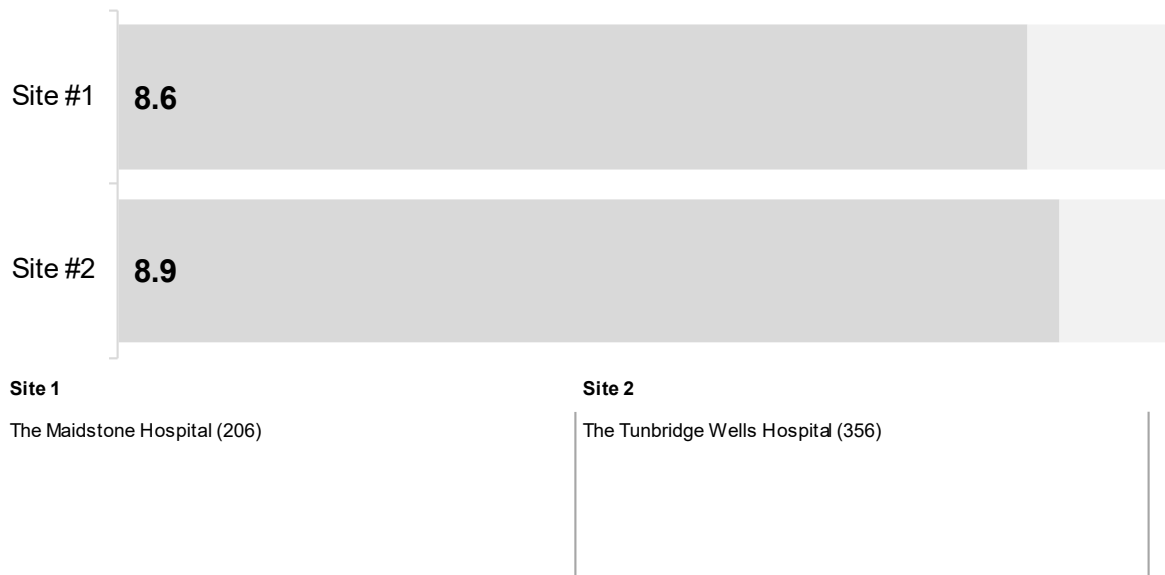
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



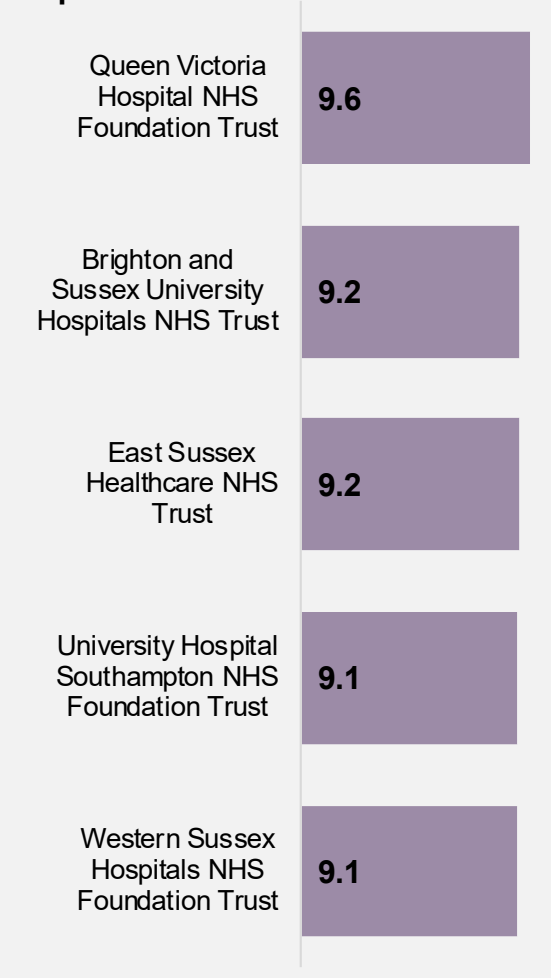
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

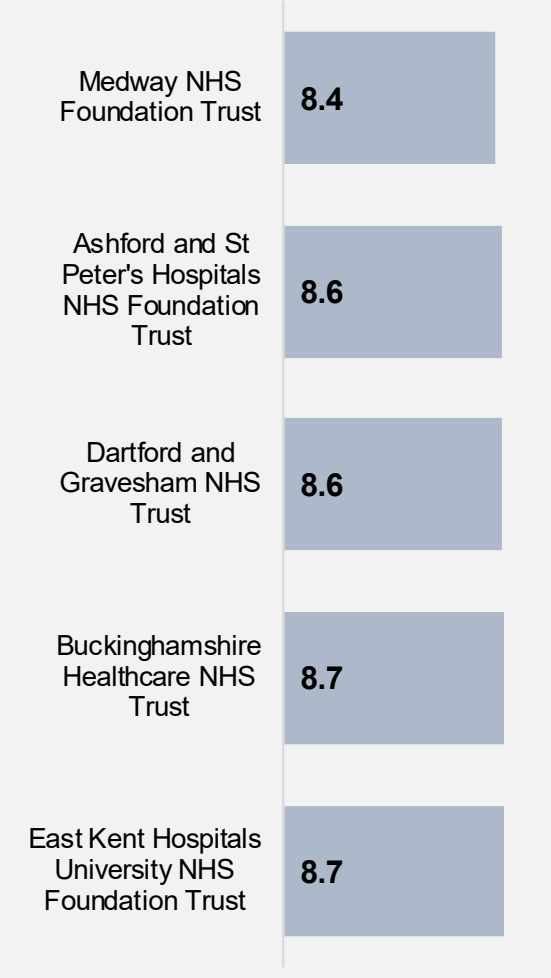


Comparison with other trusts within your region

Top five trusts

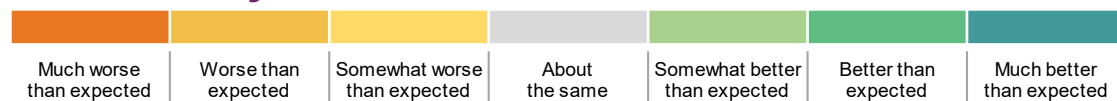


Bottom five trusts



Nurses: Q19. Did you have confidence and trust in the nurses treating you?

Results for your trust



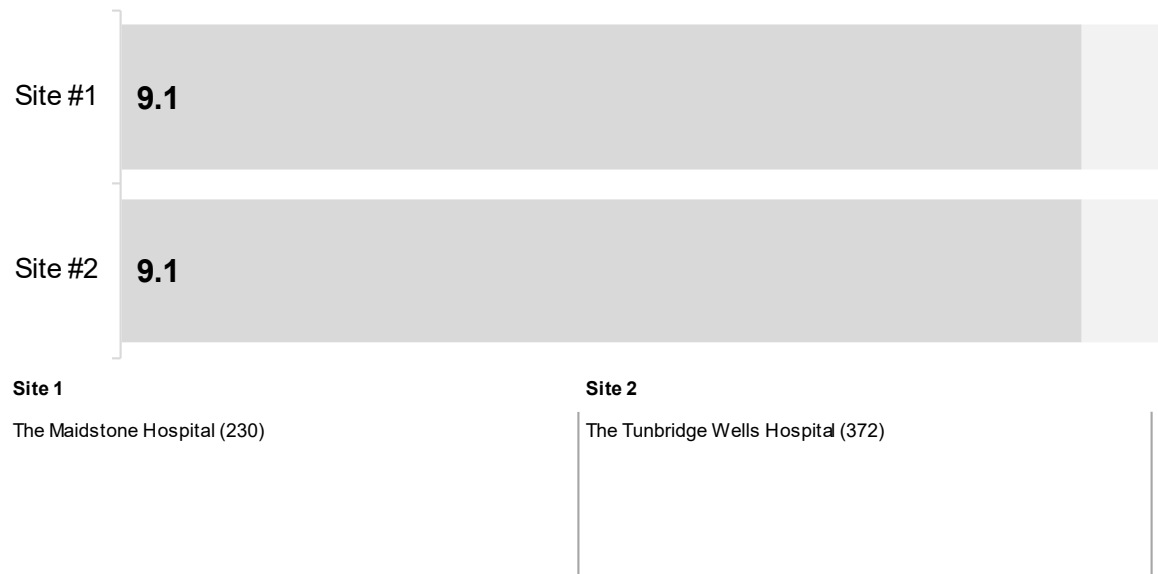
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Comparison with other trusts within your region

Top five trusts

Queen Victoria Hospital NHS Foundation Trust

9.7

Western Sussex Hospitals NHS Foundation Trust

9.4

University Hospital Southampton NHS Foundation Trust

9.3

Oxford University Hospitals NHS Foundation Trust

9.3

East Sussex Healthcare NHS Trust

9.3

Bottom five trusts

Medway NHS Foundation Trust

8.6

East Kent Hospitals University NHS Foundation Trust

8.8

Dartford and Gravesham NHS Trust

8.9

Ashford and St Peter's Hospitals NHS Foundation Trust

9.0

Isle of Wight NHS Trust

9.0

Nurses: Q20. When nurses spoke about your care in front of you, were you included in the conversation?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Comparison with other trusts within your region

Top five trusts

Queen Victoria Hospital NHS Foundation Trust

9.6

East Sussex Healthcare NHS Trust

9.1

University Hospital Southampton NHS Foundation Trust

9.0

Hampshire Hospitals NHS Foundation Trust

9.0

Oxford University Hospitals NHS Foundation Trust

8.9

Bottom five trusts

Dartford and Gravesham NHS Trust

8.3

Medway NHS Foundation Trust

8.3

Ashford and St Peter's Hospitals NHS Foundation Trust

8.5

Frimley Health NHS Foundation Trust

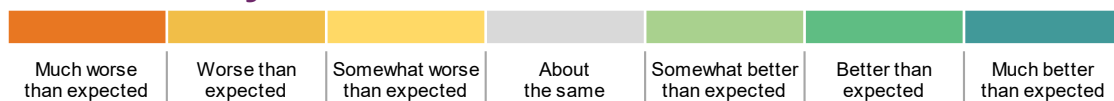
8.5

East Kent Hospitals University NHS Foundation Trust

8.5

Nurses: Q21. In your opinion, were there enough nurses on duty to care for you in hospital?

Results for your trust



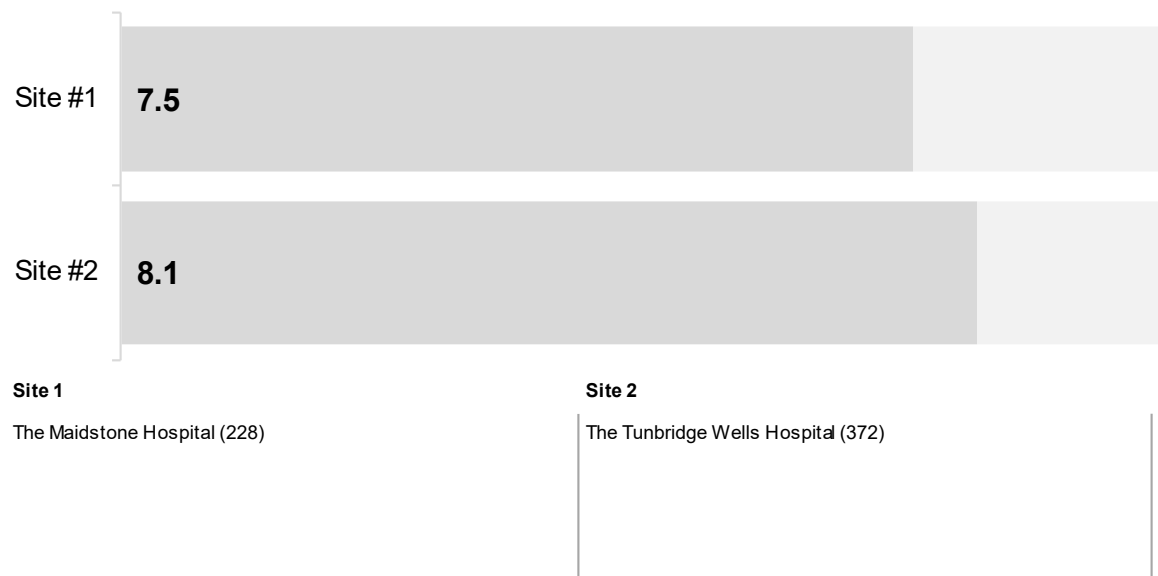
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

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Comparison with other trusts within your region

Top five trusts

Queen Victoria Hospital NHS Foundation Trust

9.3

Oxford University Hospitals NHS Foundation Trust

8.4

University Hospital Southampton NHS Foundation Trust

8.4

Royal Surrey NHS Foundation Trust

8.4

Royal Berkshire NHS Foundation Trust

8.3

Bottom five trusts

Medway NHS Foundation Trust

6.5

East Kent Hospitals University NHS Foundation Trust

7.3

Dartford and Gravesham NHS Trust

7.5

Isle of Wight NHS Trust

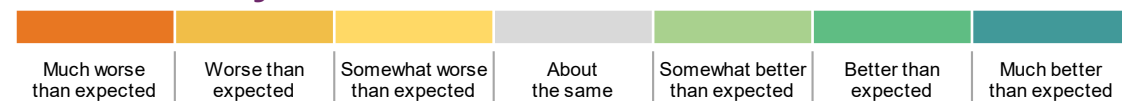
7.6

Ashford and St Peter's Hospitals NHS Foundation Trust

7.7

Your care and treatment: Q22. Thinking about your care and treatment, were you told something by a member of staff that was different to what you had been told by another member of staff?

Results for your trust



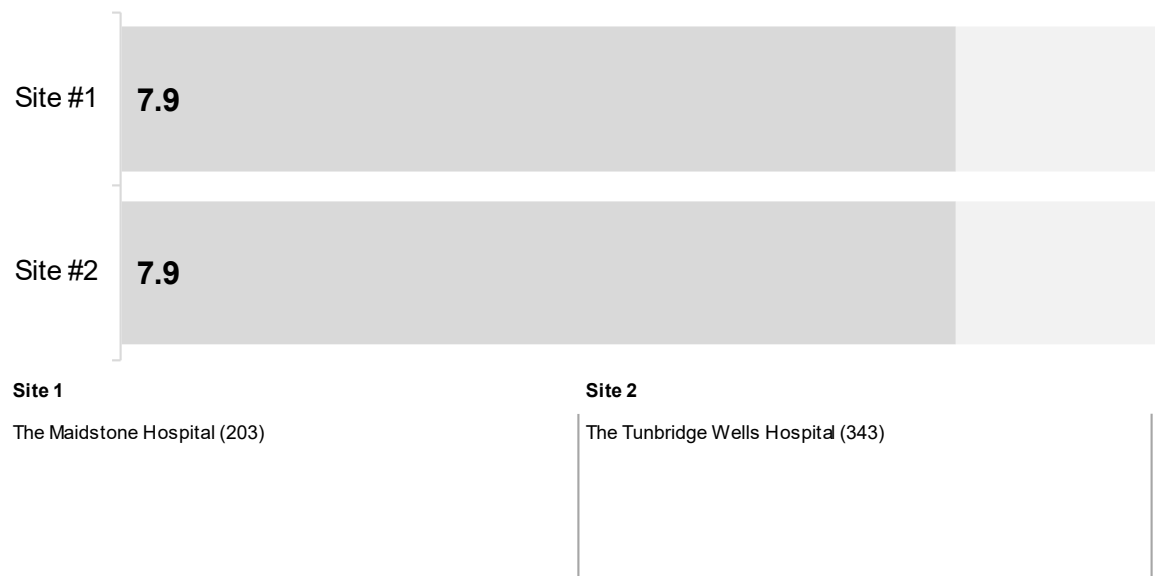
Your trust score compared with all other trusts:

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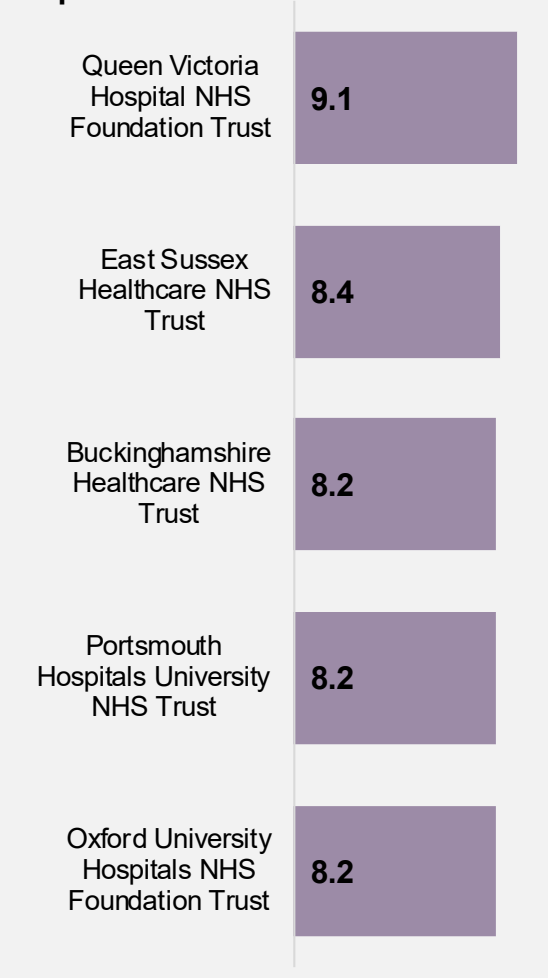
Breakdown of scores for sites within your trust:

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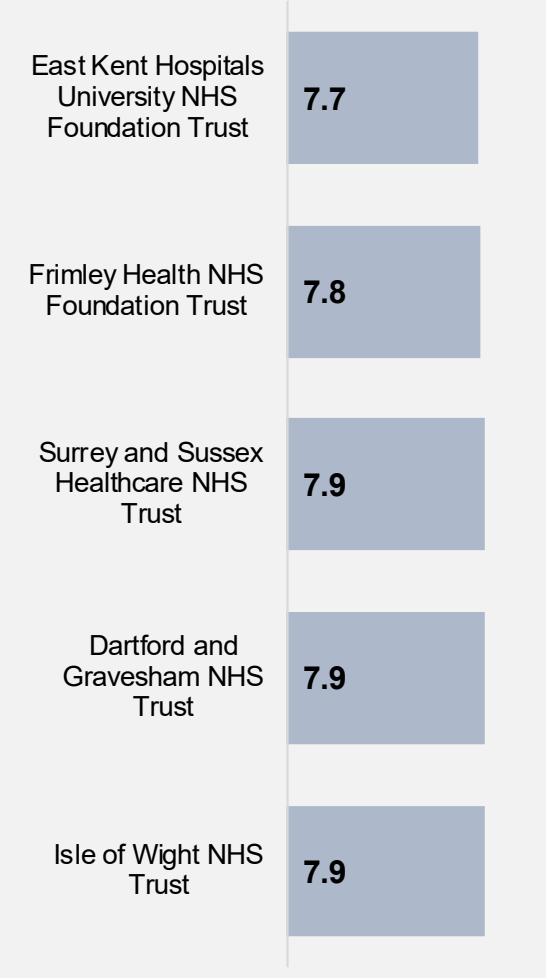


Comparison with other trusts within your region

Top five trusts



Bottom five trusts



Your care and treatment: Q23. To what extent did staff looking after you involve you in decisions about your care and treatment?

Results for your trust



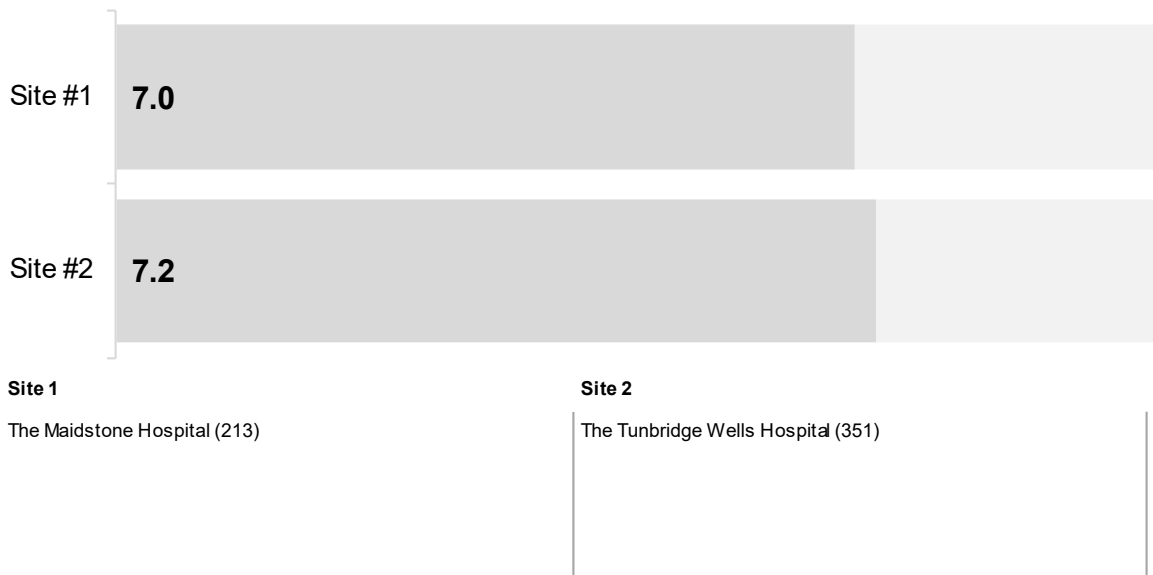
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Breakdown of scores for sites within your trust:

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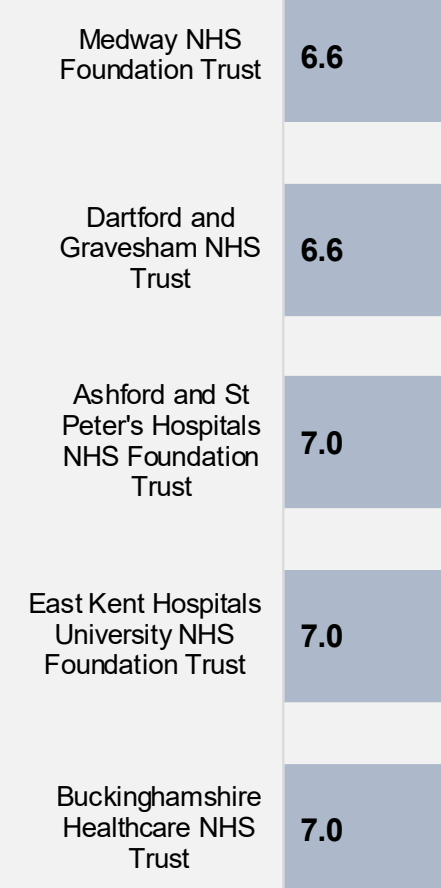


Comparison with other trusts within your region

Top five trusts

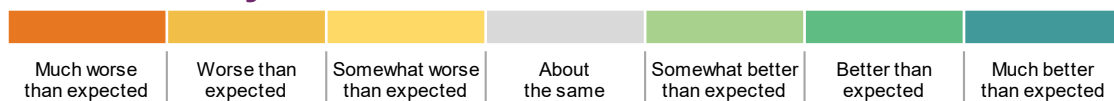


Bottom five trusts



Your care and treatment: Q24. How much information about your condition or treatment was given to you?

Results for your trust



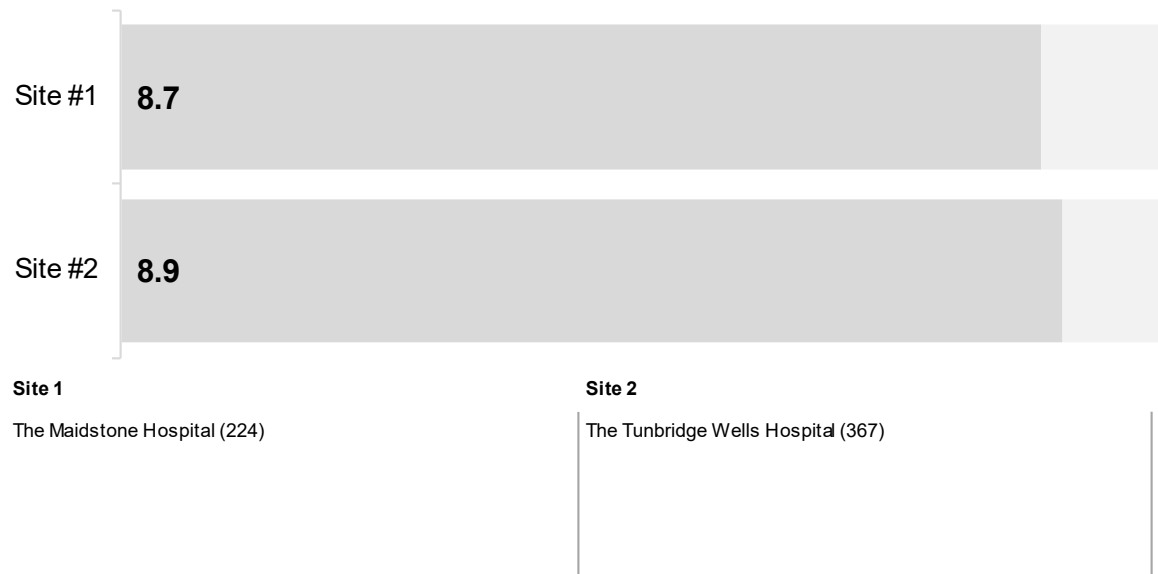
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Comparison with other trusts within your region

Top five trusts

Queen Victoria Hospital NHS Foundation Trust

9.8

Oxford University Hospitals NHS Foundation Trust

9.2

Royal Surrey NHS Foundation Trust

9.1

University Hospital Southampton NHS Foundation Trust

9.1

Hampshire Hospitals NHS Foundation Trust

9.0

Bottom five trusts

Medway NHS Foundation Trust

8.5

Isle of Wight NHS Trust

8.6

Dartford and Gravesham NHS Trust

8.6

East Kent Hospitals University NHS Foundation Trust

8.7

Ashford and St Peter's Hospitals NHS Foundation Trust

8.7

Your care and treatment: Q25. Did you feel able to talk to members of hospital staff about your worries and fears?

Results for your trust



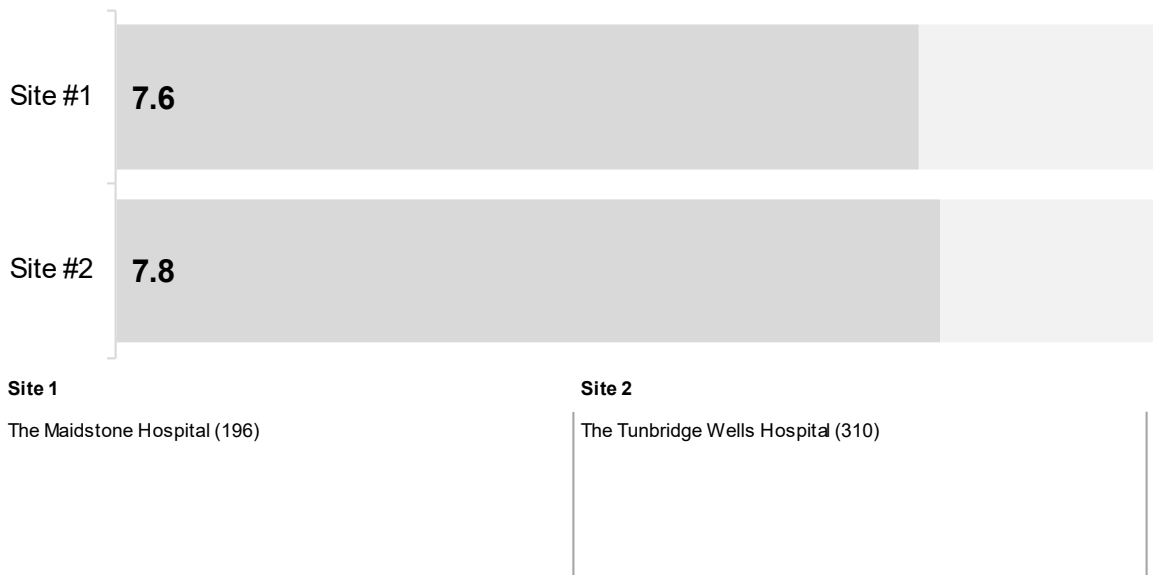
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



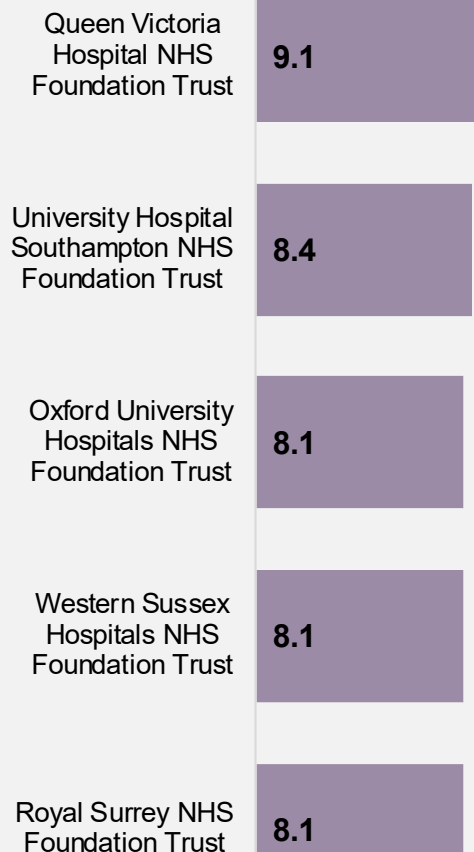
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

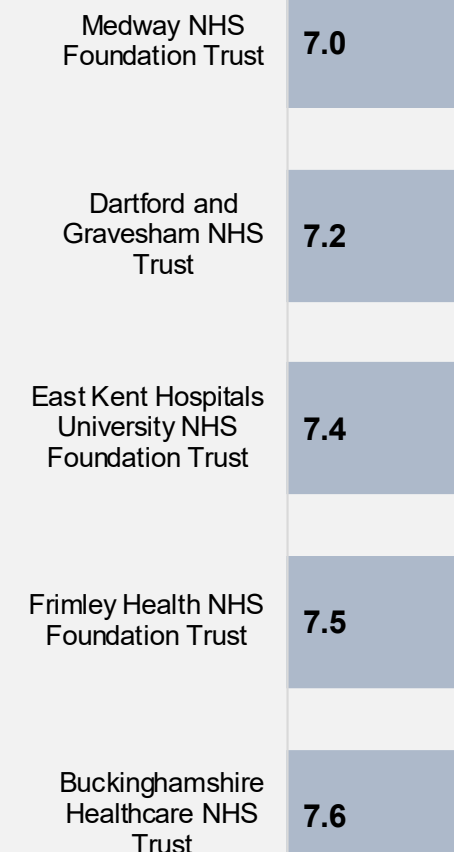


Comparison with other trusts within your region

Top five trusts

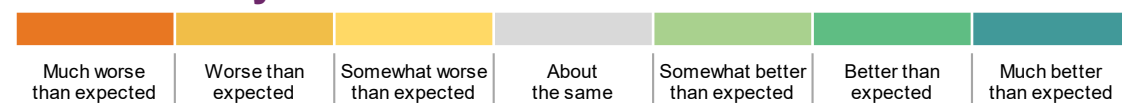


Bottom five trusts



Your care and treatment: Q26. Were you able to discuss your condition or treatment with hospital staff without being overheard?

Results for your trust



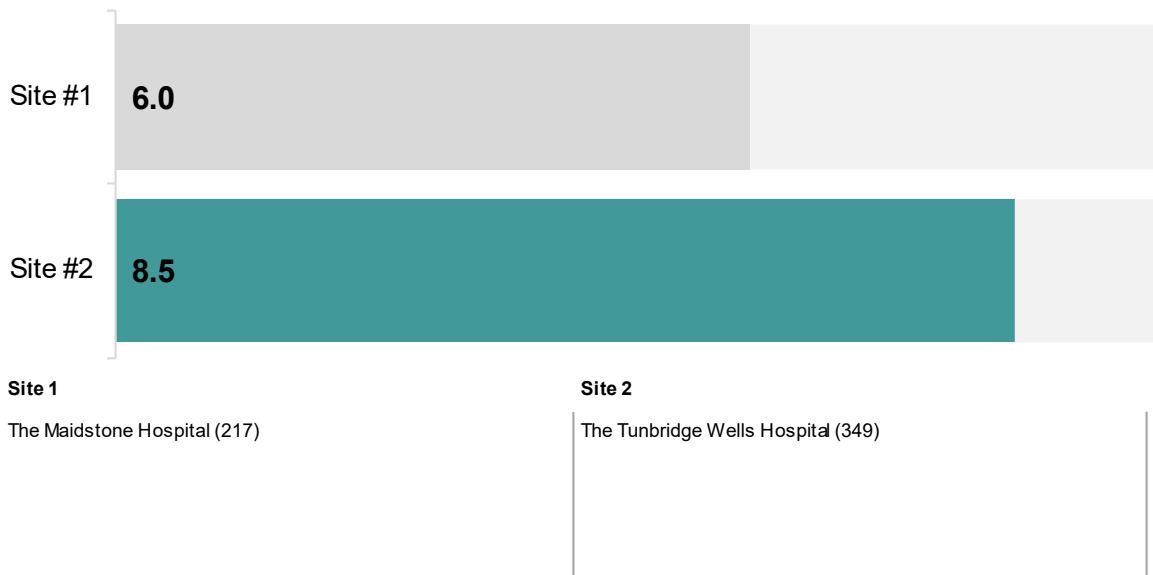
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Comparison with other trusts within your region

Top five trusts

Queen Victoria Hospital NHS Foundation Trust

8.3

Maidstone and Tunbridge Wells NHS Trust

7.6

Oxford University Hospitals NHS Foundation Trust

6.7

Royal Surrey NHS Foundation Trust

6.6

Hampshire Hospitals NHS Foundation Trust

6.5

Bottom five trusts

Medway NHS Foundation Trust

5.5

East Kent Hospitals University NHS Foundation Trust

5.6

Buckinghamshire Healthcare NHS Trust

5.8

Dartford and Gravesham NHS Trust

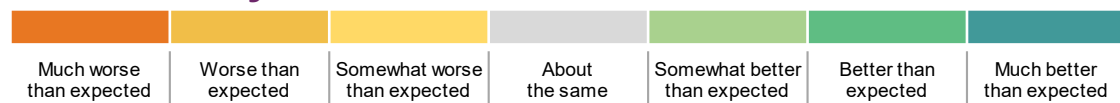
5.9

Brighton and Sussex University Hospitals NHS Trust

6.1

Your care and treatment: Q27. Were you given enough privacy when being examined or treated?

Results for your trust



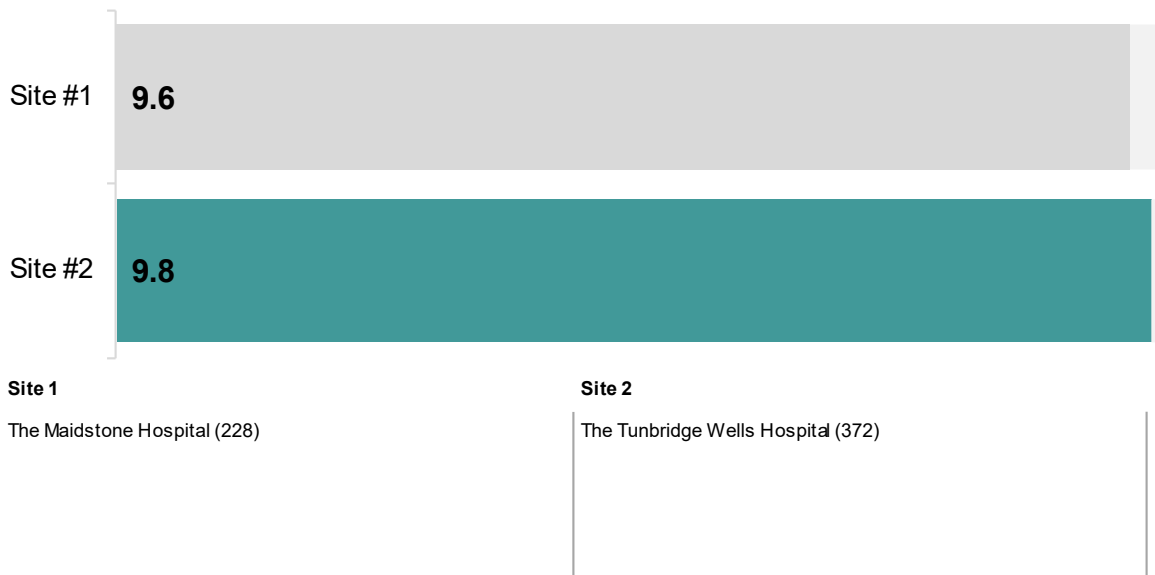
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



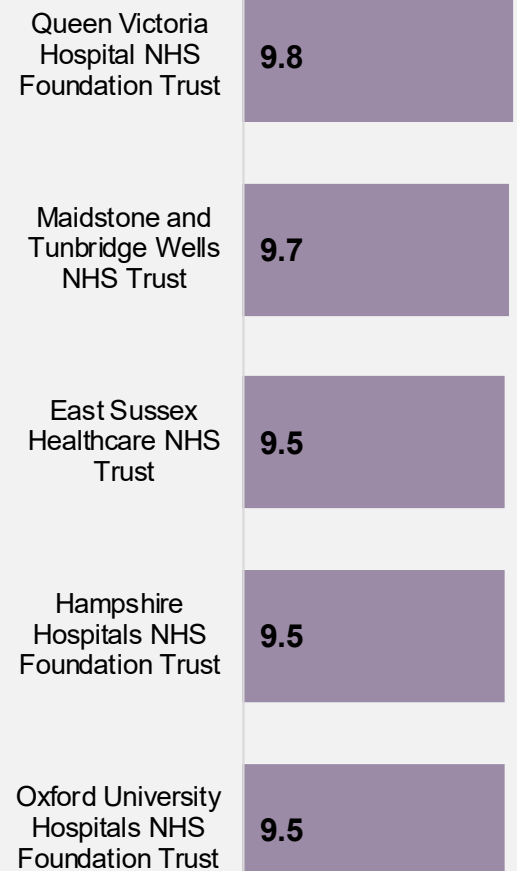
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

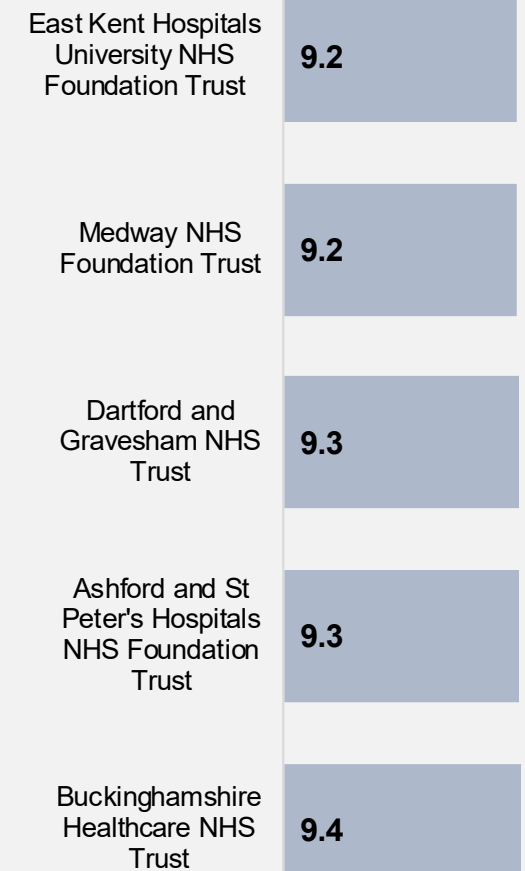


Comparison with other trusts within your region

Top five trusts

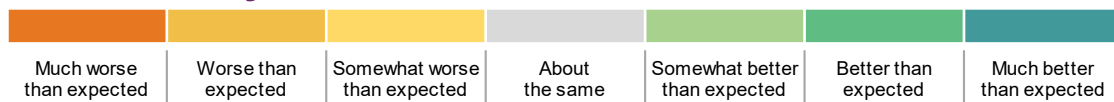


Bottom five trusts



Your care and treatment: Q28. Do you think the hospital staff did everything they could to help control your pain?

Results for your trust



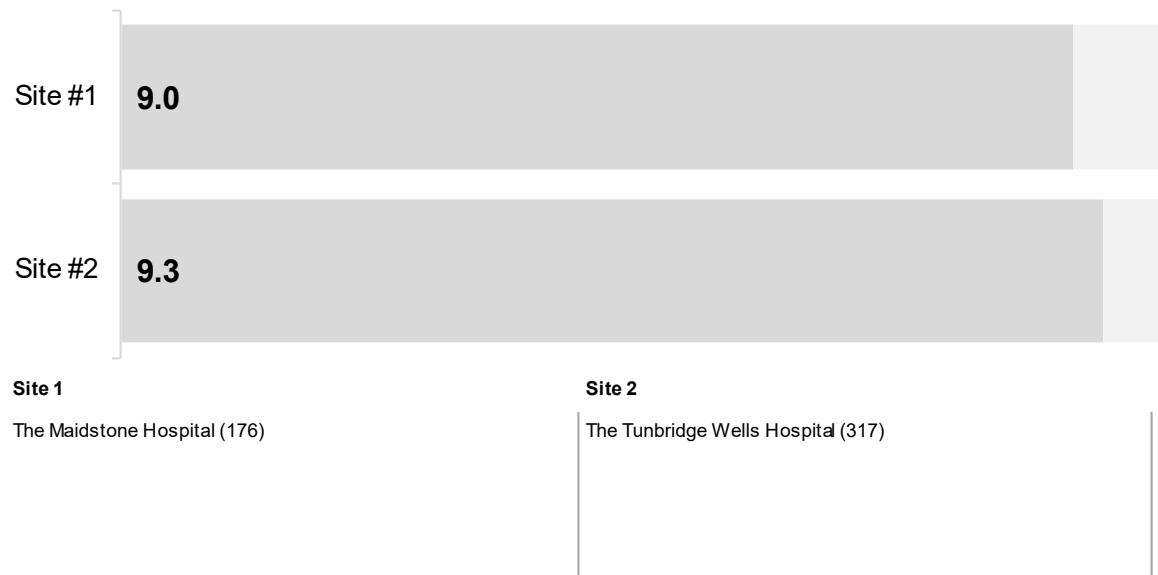
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Comparison with other trusts within your region

Top five trusts

Queen Victoria Hospital NHS Foundation Trust

9.7

Western Sussex Hospitals NHS Foundation Trust

9.3

East Sussex Healthcare NHS Trust

9.3

Maidstone and Tunbridge Wells NHS Trust

9.2

Oxford University Hospitals NHS Foundation Trust

9.2

Bottom five trusts

Medway NHS Foundation Trust

8.5

East Kent Hospitals University NHS Foundation Trust

8.6

Dartford and Gravesham NHS Trust

8.6

Isle of Wight NHS Trust

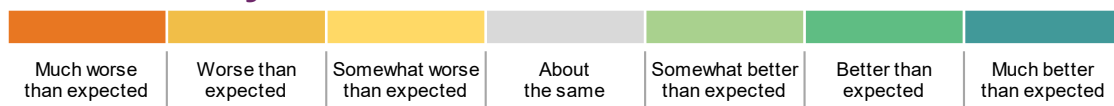
8.8

Portsmouth Hospitals University NHS Trust

8.9

Your care and treatment: Q29. Were you able to get a member of staff to help you when you needed attention?

Results for your trust



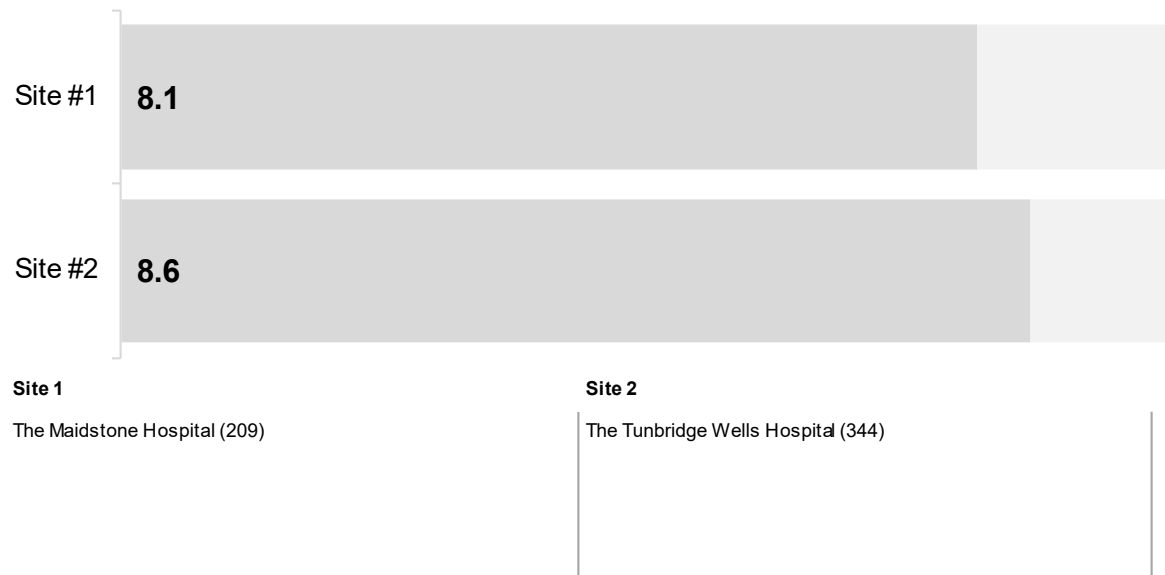
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Comparison with other trusts within your region

Top five trusts

Queen Victoria Hospital NHS Foundation Trust

9.5

University Hospital Southampton NHS Foundation Trust

8.8

East Sussex Healthcare NHS Trust

8.7

Oxford University Hospitals NHS Foundation Trust

8.7

Western Sussex Hospitals NHS Foundation Trust

8.6

Bottom five trusts

Dartford and Gravesham NHS Trust

7.7

East Kent Hospitals University NHS Foundation Trust

7.8

Medway NHS Foundation Trust

7.8

Portsmouth Hospitals University NHS Trust

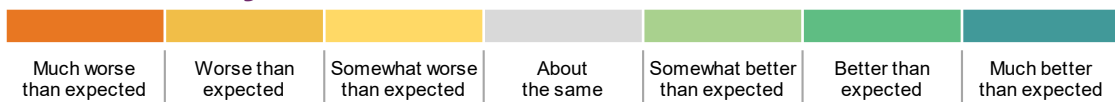
8.1

Buckinghamshire Healthcare NHS Trust

8.2

Operations and procedures: Q31. Beforehand, how well did hospital staff answer your questions about the operations or procedures?

Results for your trust



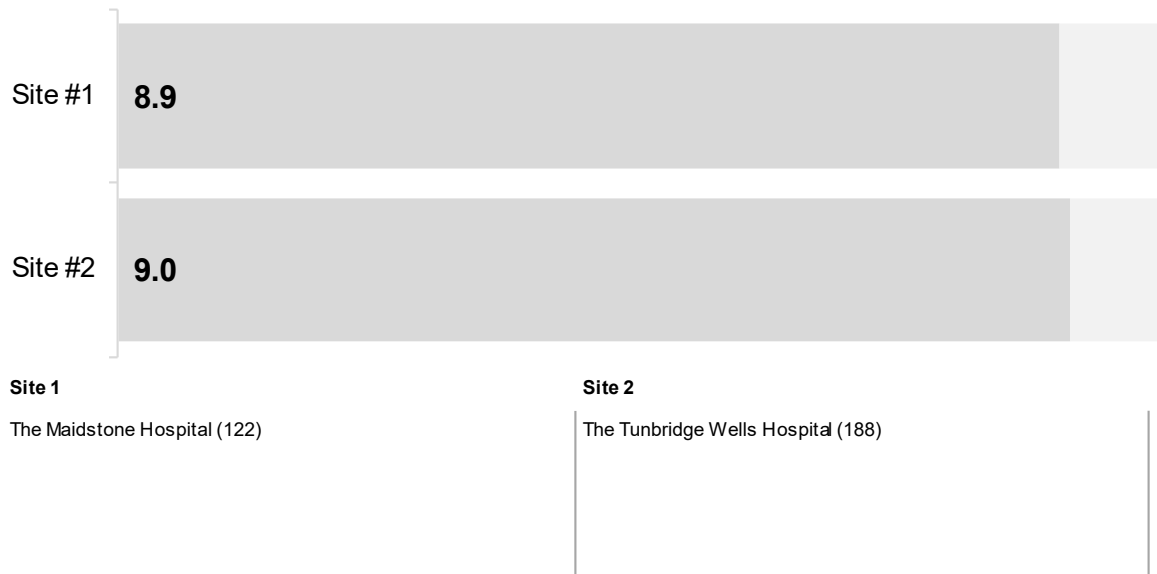
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



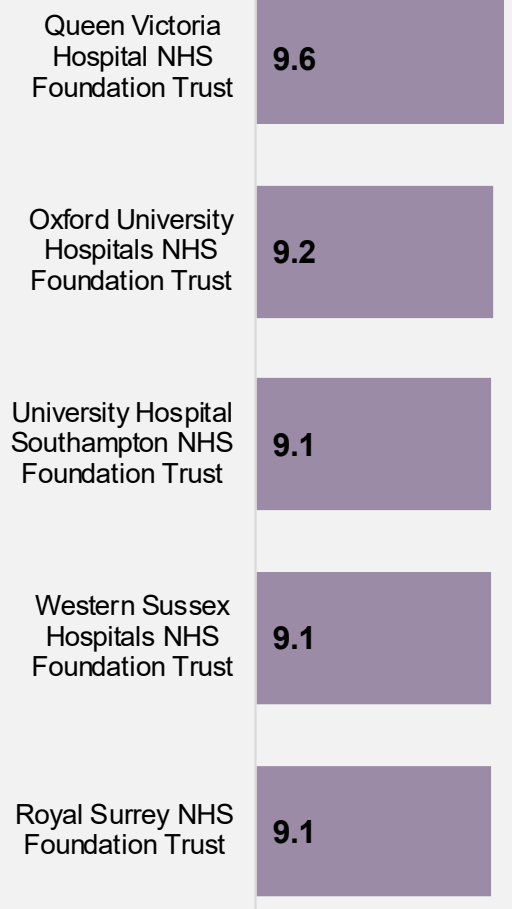
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

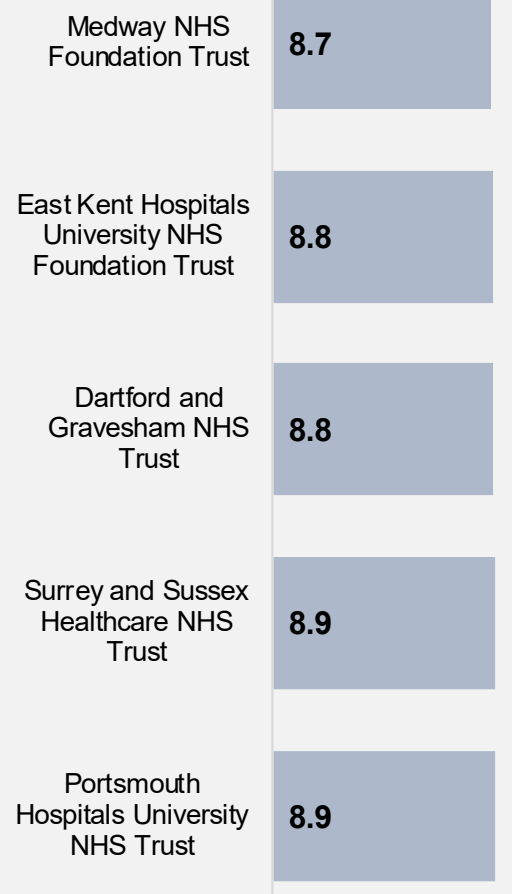


Comparison with other trusts within your region

Top five trusts

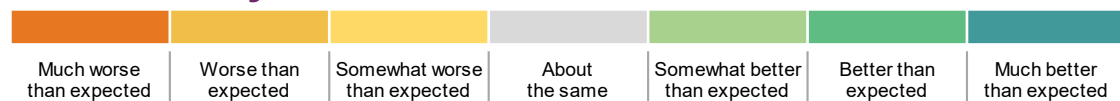


Bottom five trusts



Operations and procedures: Q32. Beforehand, how well did hospital staff explain how you might feel after you had the operations or procedures?

Results for your trust



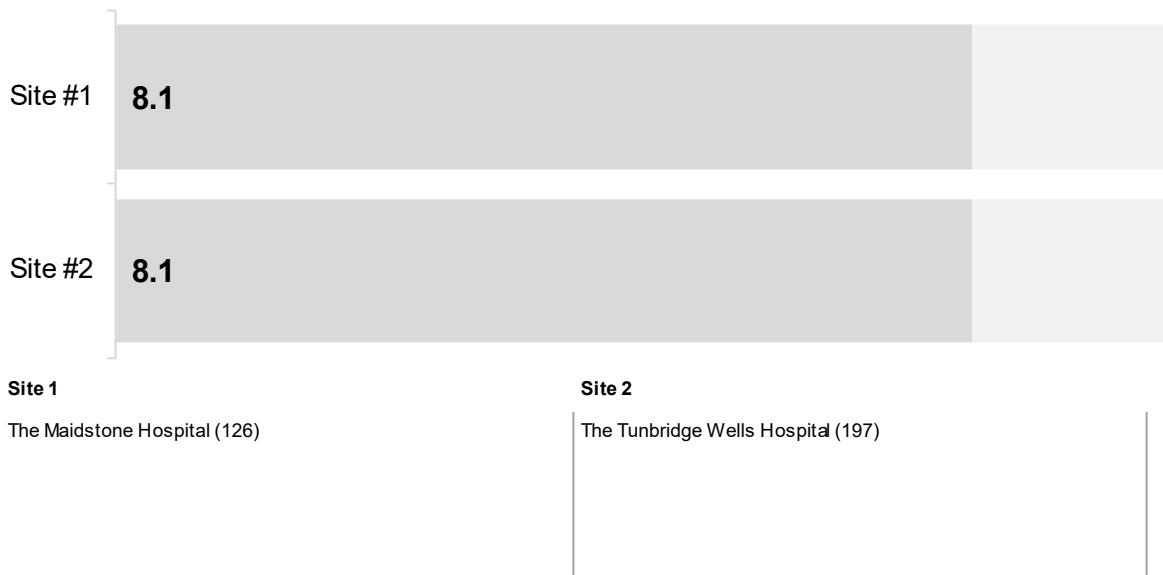
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



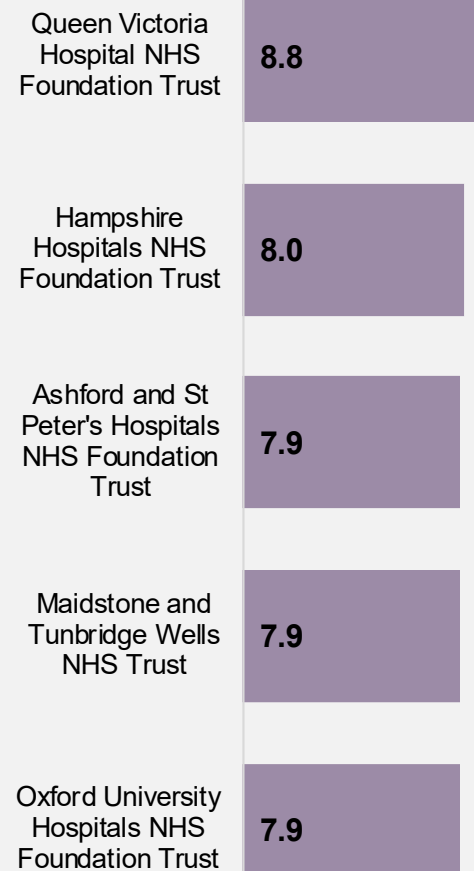
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

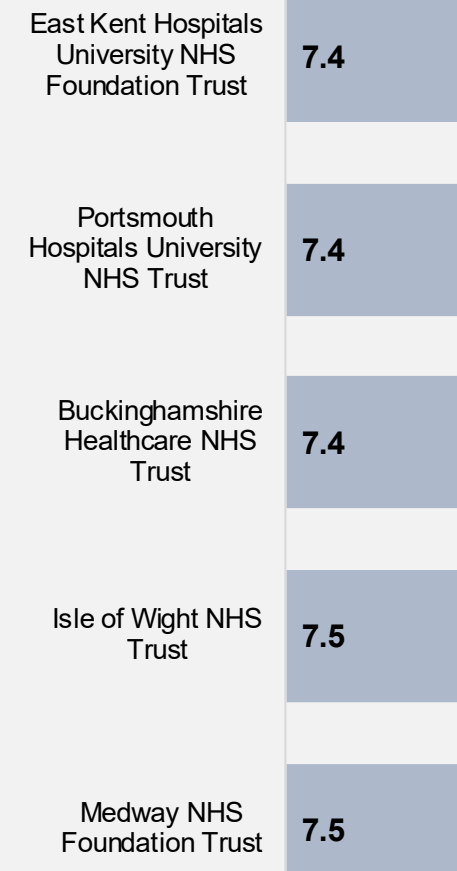


Comparison with other trusts within your region

Top five trusts

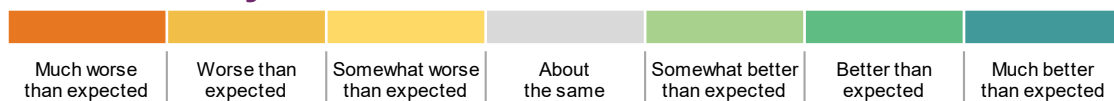


Bottom five trusts



Operations and procedures: Q33. After the operations or procedures, how well did hospital staff explain how the operation or procedure had gone?

Results for your trust



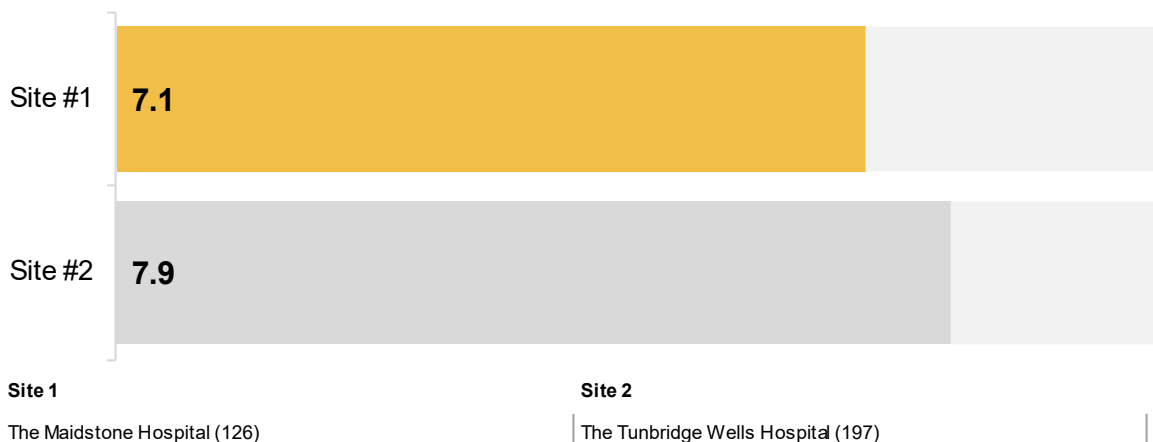
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Comparison with other trusts within your region

Top five trusts

Queen Victoria Hospital NHS Foundation Trust

8.9

Oxford University Hospitals NHS Foundation Trust

8.4

Western Sussex Hospitals NHS Foundation Trust

8.4

Hampshire Hospitals NHS Foundation Trust

8.3

Surrey and Sussex Healthcare NHS Trust

8.1

Bottom five trusts

Maidstone and Tunbridge Wells NHS Trust

7.6

Dartford and Gravesham NHS Trust

7.7

Portsmouth Hospitals University NHS Trust

7.8

Ashford and St Peter's Hospitals NHS Foundation Trust

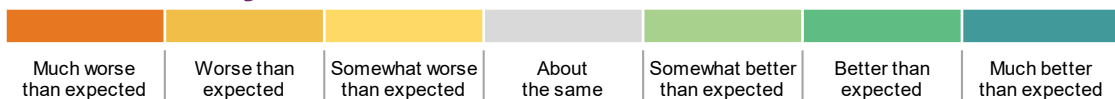
7.8

Buckinghamshire Healthcare NHS Trust

7.8

Leaving hospital: Q34. To what extent did staff involve you in decisions about you leaving hospital?

Results for your trust



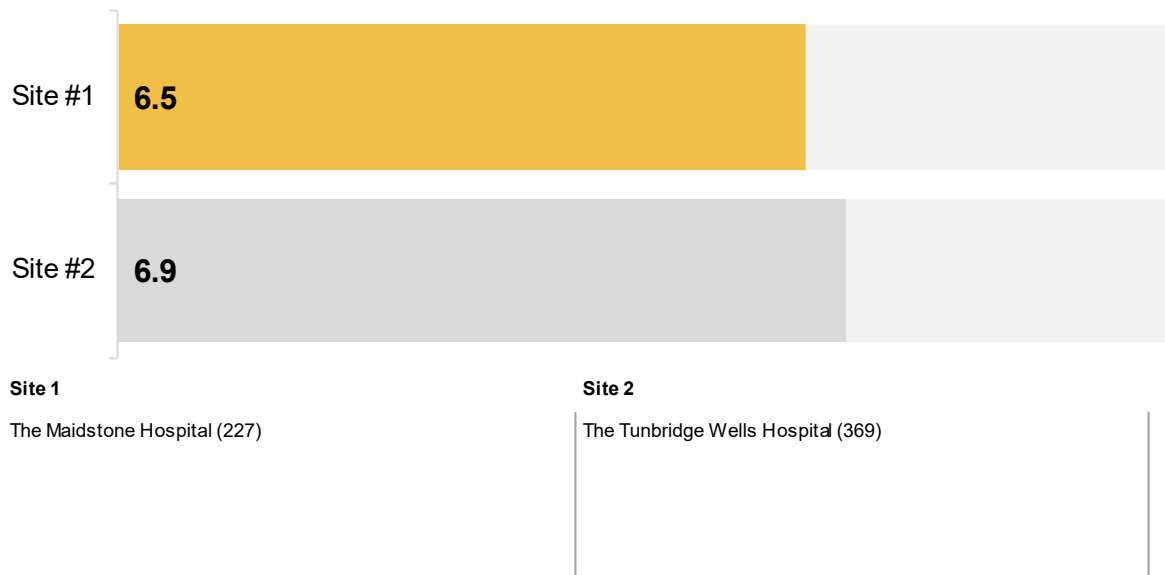
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



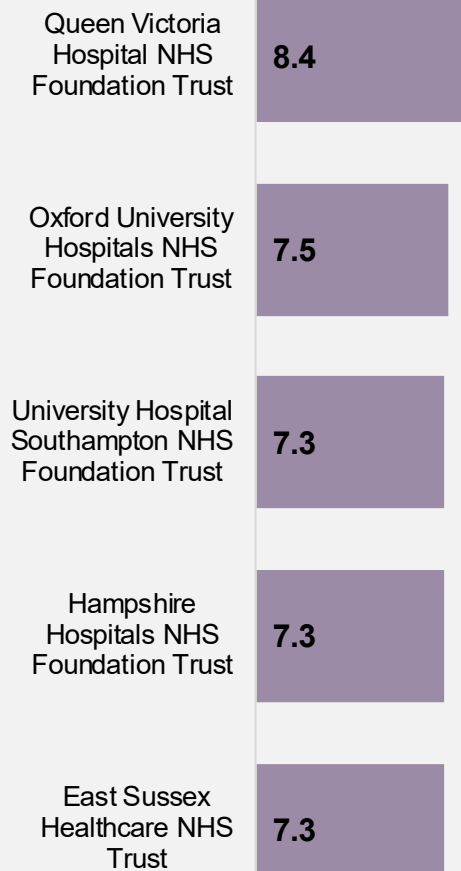
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

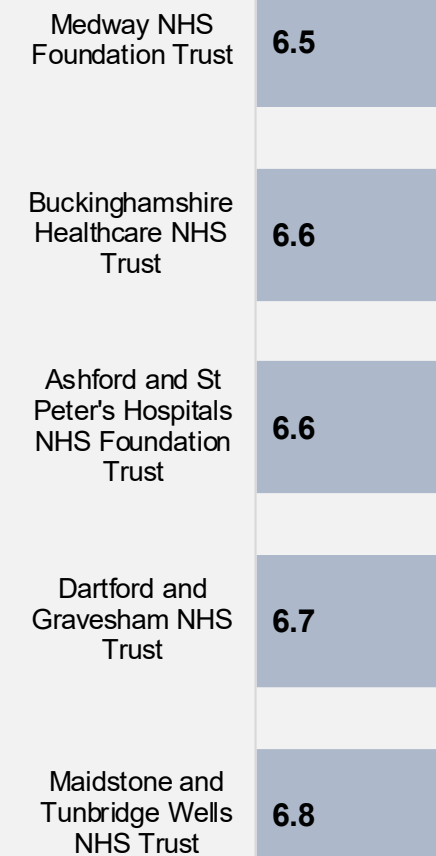


Comparison with other trusts within your region

Top five trusts

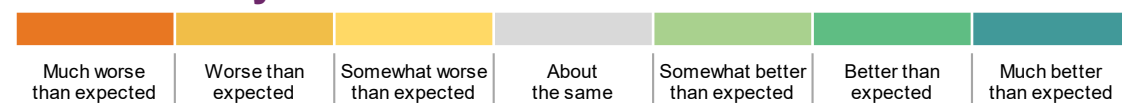


Bottom five trusts



Leaving hospital: Q35. To what extent did hospital staff take your family or home situation into account when planning for you to leave hospital?

Results for your trust



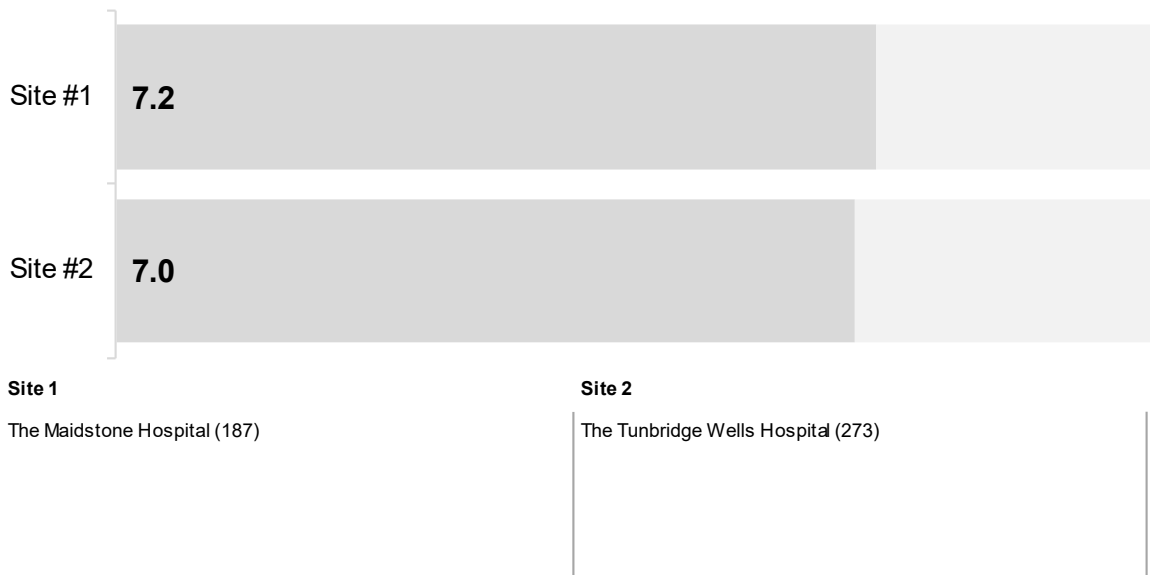
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Comparison with other trusts within your region

Top five trusts

Queen Victoria Hospital NHS Foundation Trust

8.4

Oxford University Hospitals NHS Foundation Trust

7.8

University Hospital Southampton NHS Foundation Trust

7.7

Hampshire Hospitals NHS Foundation Trust

7.6

Royal Surrey NHS Foundation Trust

7.6

Bottom five trusts

Dartford and Gravesham NHS Trust

6.7

Medway NHS Foundation Trust

6.8

Ashford and St Peter's Hospitals NHS Foundation Trust

7.0

Frimley Health NHS Foundation Trust

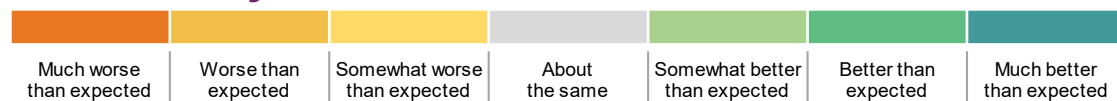
7.1

Maidstone and Tunbridge Wells NHS Trust

7.2

Leaving hospital: Q36. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?

Results for your trust



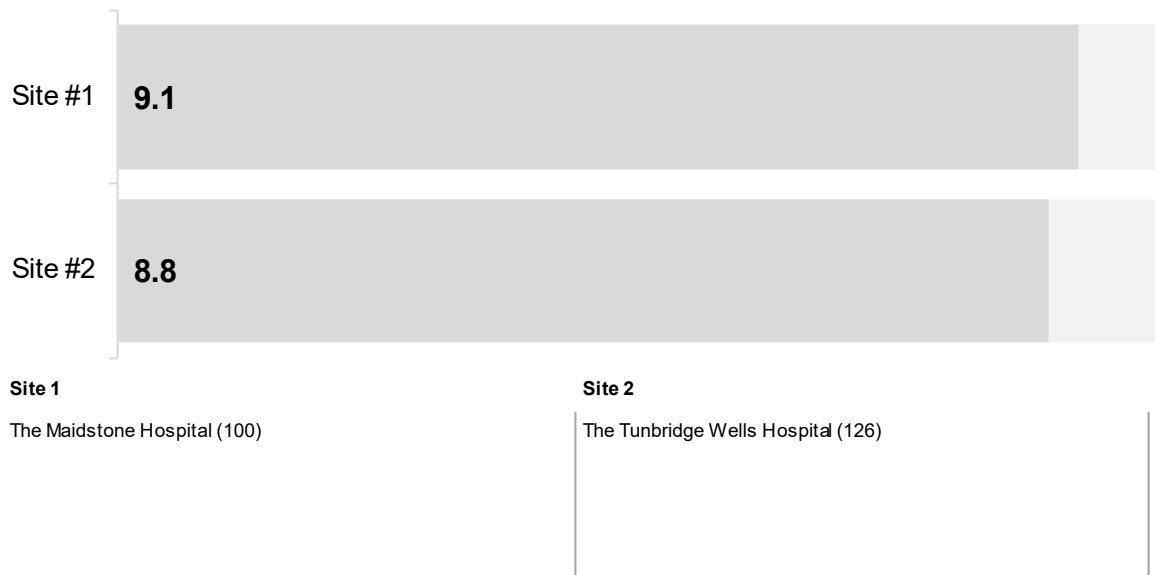
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Comparison with other trusts within your region

Top five trusts

Queen Victoria Hospital NHS Foundation Trust

9.4

Western Sussex Hospitals NHS Foundation Trust

9.2

Maidstone and Tunbridge Wells NHS Trust

9.0

East Sussex Healthcare NHS Trust

9.0

Ashford and St Peter's Hospitals NHS Foundation Trust

9.0

Bottom five trusts

Frimley Health NHS Foundation Trust

7.8

Medway NHS Foundation Trust

7.8

Dartford and Gravesham NHS Trust

7.9

Isle of Wight NHS Trust

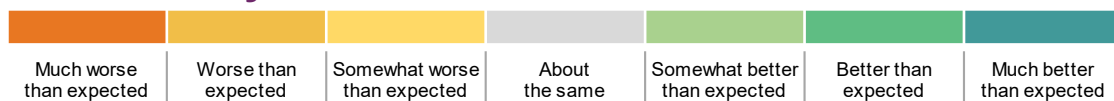
8.4

Royal Berkshire NHS Foundation Trust

8.4

Leaving hospital: Q37. Were you given enough notice about when you were going to leave hospital?

Results for your trust



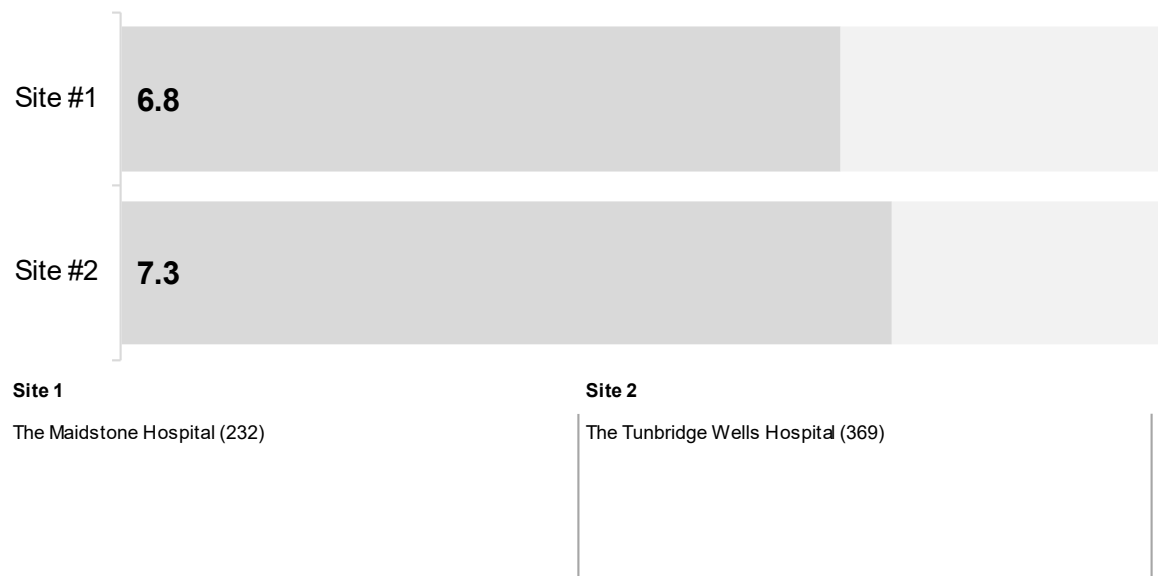
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Comparison with other trusts within your region

Top five trusts

Queen Victoria Hospital NHS Foundation Trust

8.4

Royal Berkshire NHS Foundation Trust

7.6

Oxford University Hospitals NHS Foundation Trust

7.5

Royal Surrey NHS Foundation Trust

7.5

Hampshire Hospitals NHS Foundation Trust

7.5

Bottom five trusts

Medway NHS Foundation Trust

6.4

East Kent Hospitals University NHS Foundation Trust

6.7

Buckinghamshire Healthcare NHS Trust

6.8

Isle of Wight NHS Trust

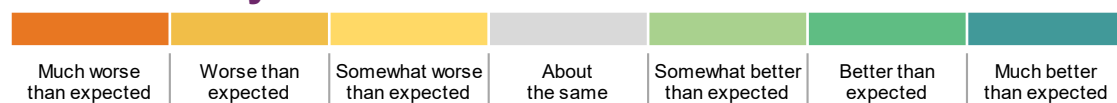
6.8

Portsmouth Hospitals University NHS Trust

6.9

Leaving hospital: Q38. Before you left hospital, were you given any written information about what you should or should not do after leaving hospital?

Results for your trust



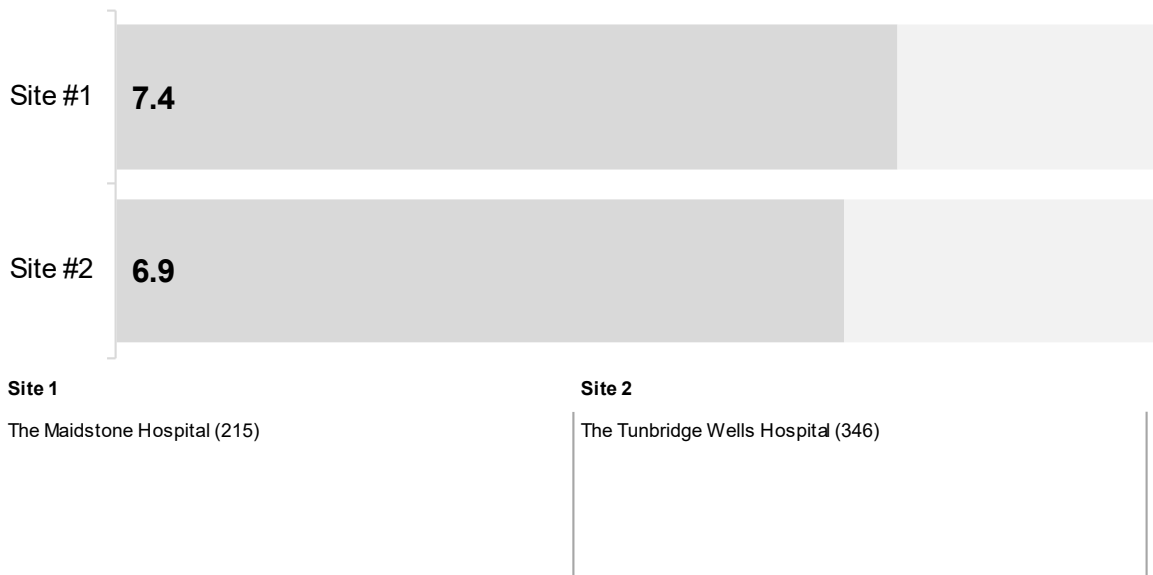
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



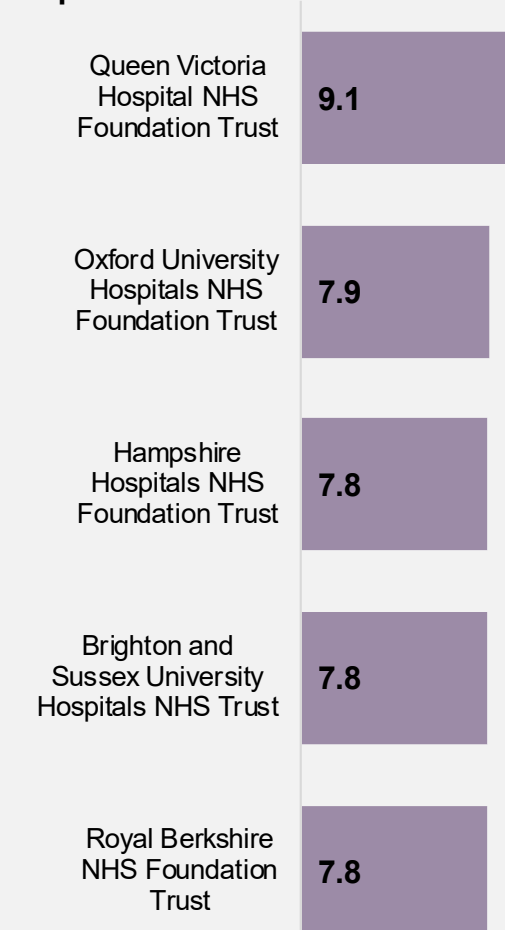
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

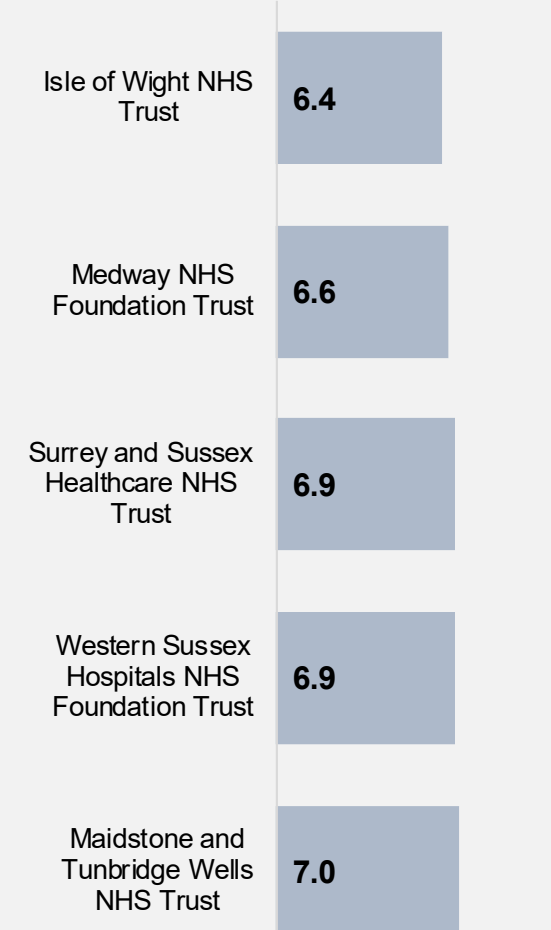


Comparison with other trusts within your region

Top five trusts

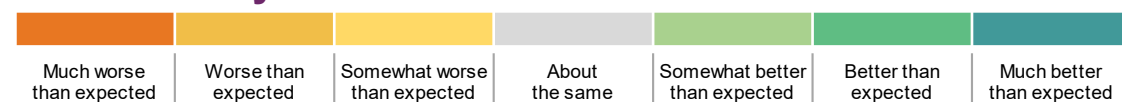


Bottom five trusts



Leaving hospital: Q39. Thinking about any medicine you were to take at home, were you given any of the following?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Site 1

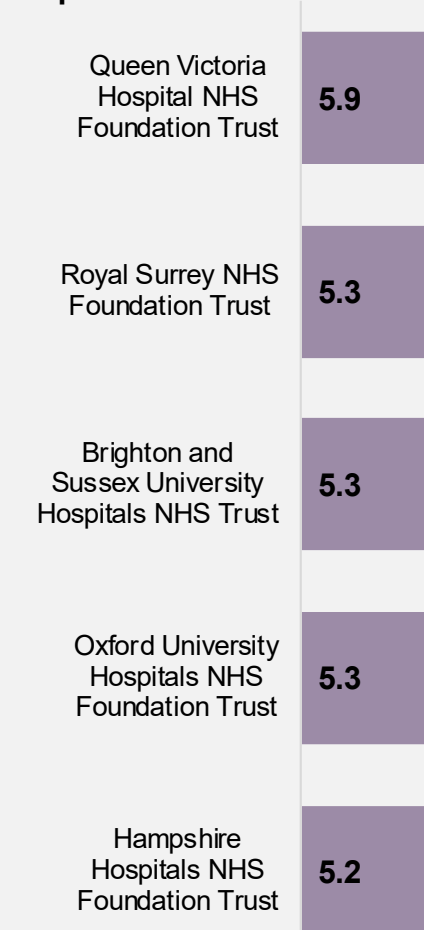
The Maidstone Hospital (165)

Site 2

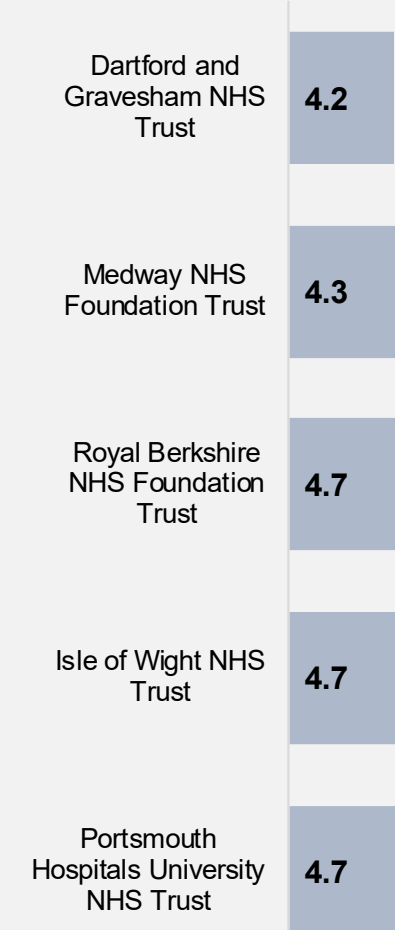
The Tunbridge Wells Hospital (267)

Comparison with other trusts within your region

Top five trusts



Bottom five trusts



Leaving hospital: Q40. Before you left hospital, did you know what would happen next with your care?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Comparison with other trusts within your region

Top five trusts

Queen Victoria Hospital NHS Foundation Trust

8.7

Oxford University Hospitals NHS Foundation Trust

7.2

Royal Surrey NHS Foundation Trust

7.1

Royal Berkshire NHS Foundation Trust

6.9

Hampshire Hospitals NHS Foundation Trust

6.9

Bottom five trusts

Medway NHS Foundation Trust

5.7

Dartford and Gravesham NHS Trust

6.2

Isle of Wight NHS Trust

6.3

East Kent Hospitals University NHS Foundation Trust

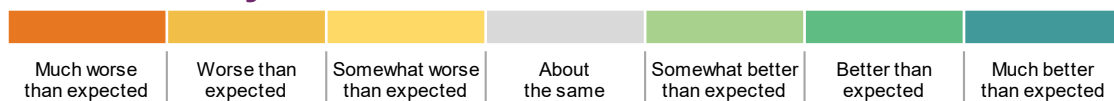
6.4

Frimley Health NHS Foundation Trust

6.5

Leaving hospital: Q41. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Results for your trust



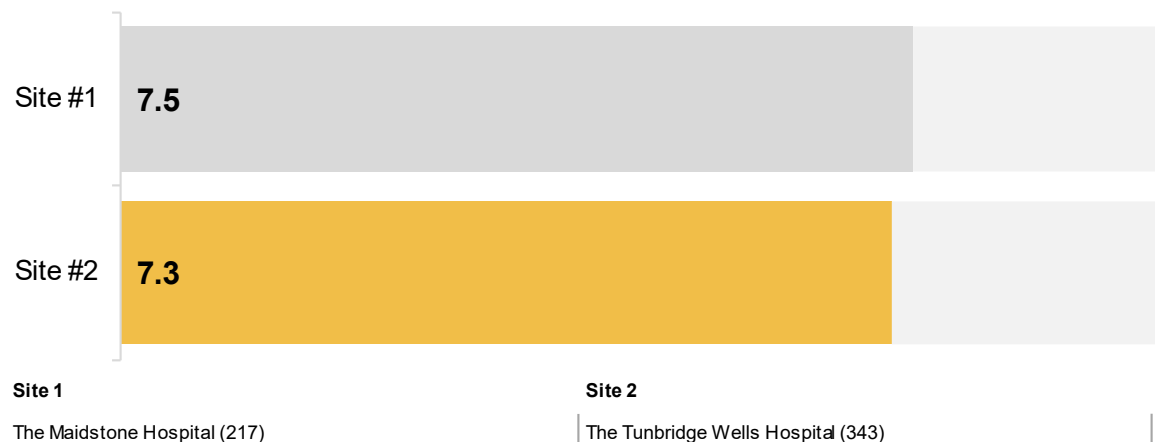
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Site 1

The Maidstone Hospital (217)

Site 2

The Tunbridge Wells Hospital (343)

Comparison with other trusts within your region

Top five trusts

Queen Victoria Hospital NHS Foundation Trust

9.7

Oxford University Hospitals NHS Foundation Trust

8.8

Hampshire Hospitals NHS Foundation Trust

8.3

University Hospital Southampton NHS Foundation Trust

8.3

Royal Berkshire NHS Foundation Trust

8.3

Bottom five trusts

Medway NHS Foundation Trust

6.6

Isle of Wight NHS Trust

7.2

Dartford and Gravesham NHS Trust

7.2

Maidstone and Tunbridge Wells NHS Trust

7.4

Ashford and St Peter's Hospitals NHS Foundation Trust

7.5

Leaving hospital: Q42. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?

Results for your trust



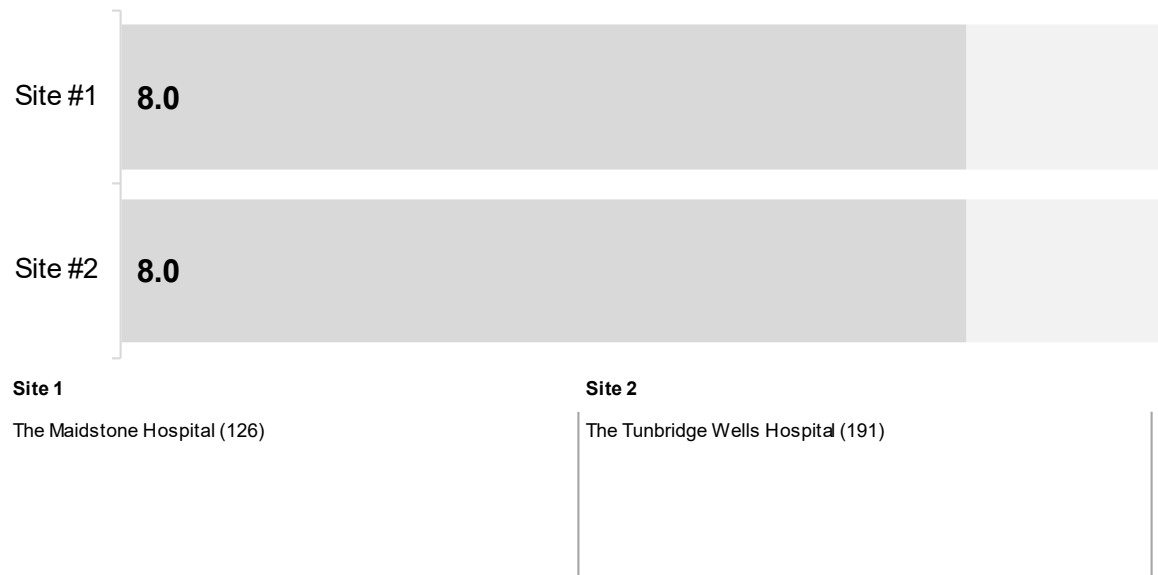
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Comparison with other trusts within your region

Top five trusts

Queen Victoria Hospital NHS Foundation Trust

9.6

Royal Surrey NHS Foundation Trust

8.7

Surrey and Sussex Healthcare NHS Trust

8.7

East Sussex Healthcare NHS Trust

8.5

Oxford University Hospitals NHS Foundation Trust

8.5

Bottom five trusts

Dartford and Gravesham NHS Trust

7.5

Medway NHS Foundation Trust

7.7

Portsmouth Hospitals University NHS Trust

8.0

Isle of Wight NHS Trust

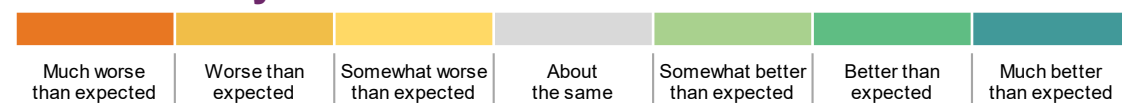
8.0

Maidstone and Tunbridge Wells NHS Trust

8.1

Leaving hospital: Q44. After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition?

Results for your trust



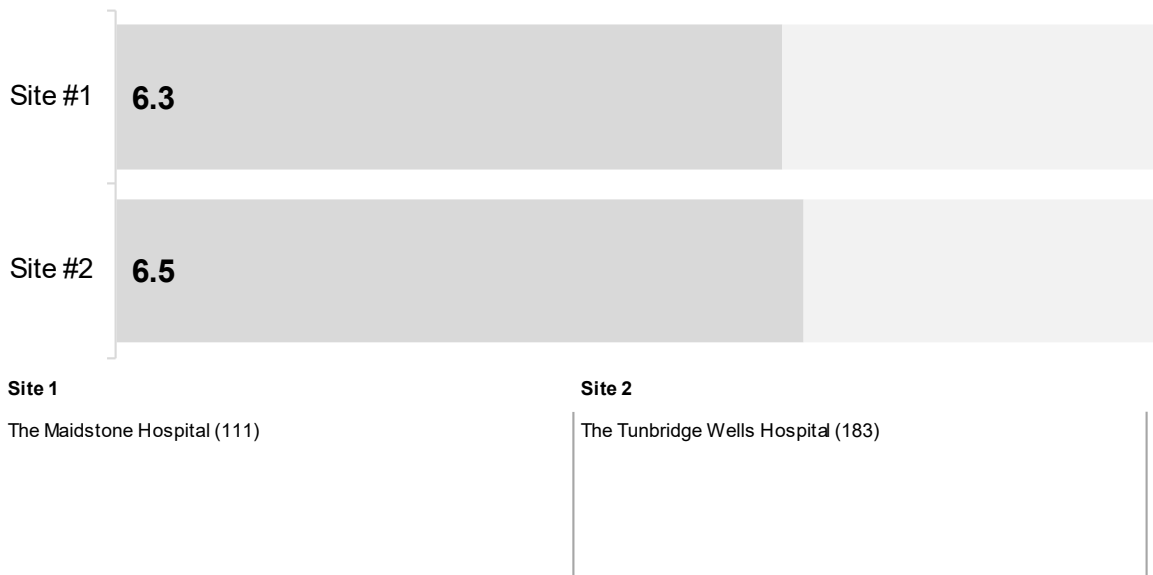
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Comparison with other trusts within your region

Top five trusts

Queen Victoria Hospital NHS Foundation Trust

8.0

Royal Surrey NHS Foundation Trust

7.4

East Sussex Healthcare NHS Trust

7.2

Oxford University Hospitals NHS Foundation Trust

7.1

University Hospital Southampton NHS Foundation Trust

6.9

Bottom five trusts

Dartford and Gravesham NHS Trust

5.9

Medway NHS Foundation Trust

6.0

Frimley Health NHS Foundation Trust

6.2

East Kent Hospitals University NHS Foundation Trust

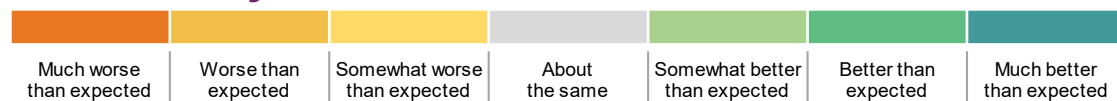
6.3

Isle of Wight NHS Trust

6.5

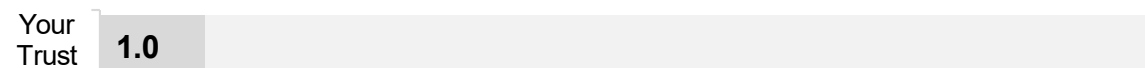
Feedback on care: Q47. During your hospital stay, were you ever asked to give your views on the quality of your care?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



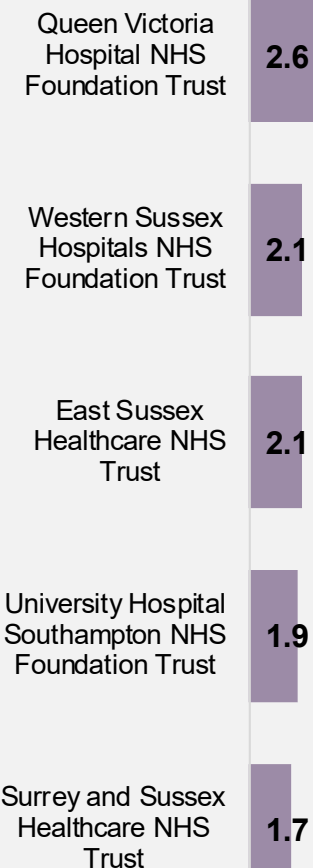
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

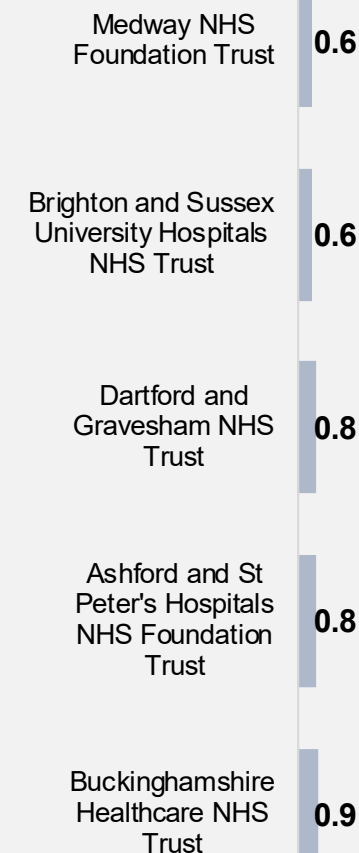


Comparison with other trusts within your region

Top five trusts

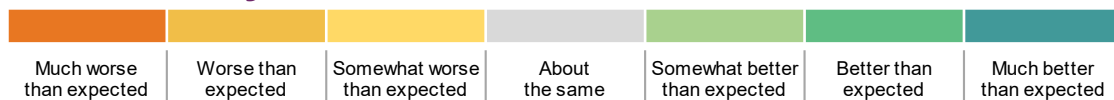


Bottom five trusts



Respect and dignity: Q45. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

Results for your trust



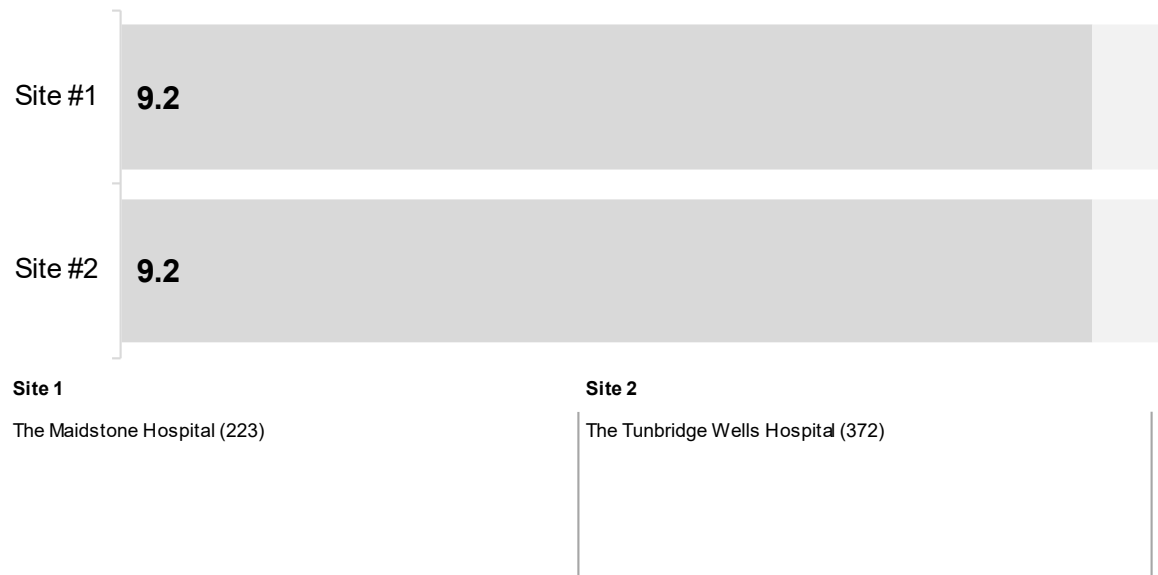
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Comparison with other trusts within your region

Top five trusts

Queen Victoria Hospital NHS Foundation Trust

9.8

University Hospital Southampton NHS Foundation Trust

9.6

Royal Surrey NHS Foundation Trust

9.5

East Sussex Healthcare NHS Trust

9.4

Oxford University Hospitals NHS Foundation Trust

9.4

Bottom five trusts

Medway NHS Foundation Trust

8.8

East Kent Hospitals University NHS Foundation Trust

8.8

Dartford and Gravesham NHS Trust

8.9

Isle of Wight NHS Trust

9.1

Ashford and St Peter's Hospitals NHS Foundation Trust

9.1

Overall: Q46. Overall, how was your experience while you were in the hospital?

Results for your trust



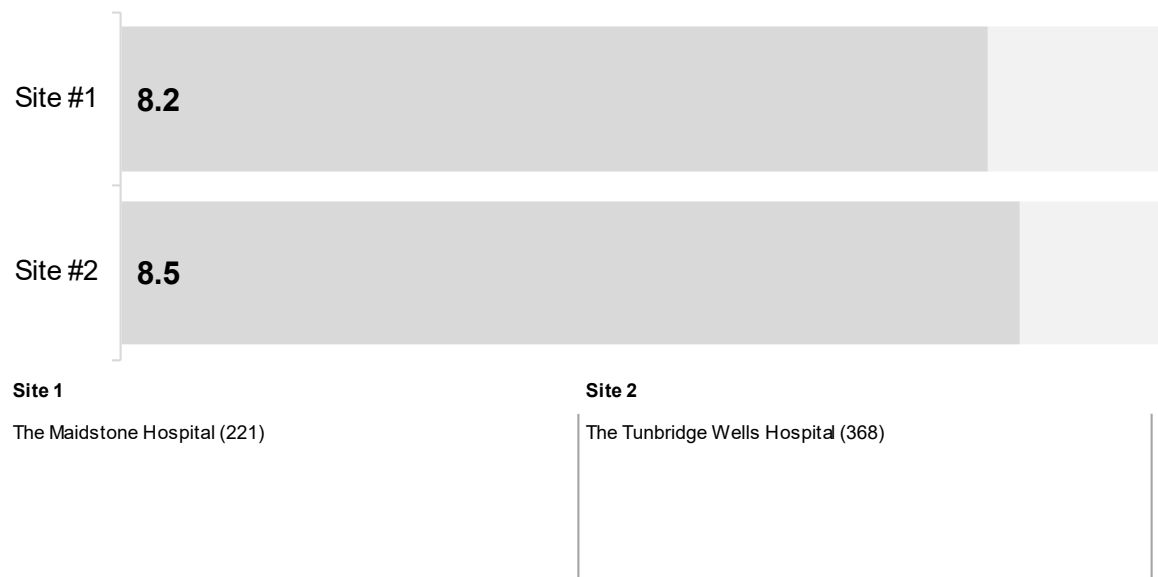
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Comparison with other trusts within your region

Top five trusts

Queen Victoria Hospital NHS Foundation Trust

9.4

University Hospital Southampton NHS Foundation Trust

8.7

Oxford University Hospitals NHS Foundation Trust

8.6

Royal Surrey NHS Foundation Trust

8.5

East Sussex Healthcare NHS Trust

8.5

Bottom five trusts

Medway NHS Foundation Trust

7.5

East Kent Hospitals University NHS Foundation Trust

7.9

Dartford and Gravesham NHS Trust

8.0

Buckinghamshire Healthcare NHS Trust

8.1

Isle of Wight NHS Trust

8.1

For further information

Please contact the Coordination Centre for Mixed Methods:
InpatientCoordination@ipsos-mori.com



Ipsos MORI



Appendix



Ipsos MORI



Comparison to other trusts

The questions at which your trust has performed much worse or worse compared with all other trusts are listed below. The questions where your trust has performed about the same compared with all other trusts have not been listed.

Much worse than expected

- Your trust has not performed "much worse than expected" for any questions.

Worse than expected

- Your trust has not performed "worse than expected" for any questions.

Comparison to other trusts

The questions at which your trust has performed somewhat worse or somewhat better compared with all other trusts are listed below. The questions where your trust has performed about the same compared with all other trusts have not been listed.

Somewhat worse than expected

- Q33. After the operations or procedures, how well did hospital staff explain how the operation or procedure had gone?

Somewhat better than expected

- Q10. If you brought medication with you to hospital, were you able to take it when you needed to?
- Q36. 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?

Comparison to other trusts

The questions at which your trust has performed better or much better compared with all other trusts are listed below. The questions where your trust has performed about the same compared with all other trusts have not been listed.

Better than expected

- Q5. Were you ever prevented from sleeping at night by noise from other patients?
- Q26. Were you able to discuss your condition or treatment with hospital staff without being overheard?
- Q27. Were you given enough privacy when being examined or treated?

Much better than expected

- Your trust has not performed "much better than expected" for any questions.

NHS Adult Inpatient Survey 2020

Results for Maidstone and Tunbridge Wells NHS Trust

Where patient experience **is best**

- ✓ Noise from other patients: patients not being bothered by noise at night from other patients
- ✓ Privacy for discussions: patients being able to discuss their condition or treatment with hospital staff without being overheard
- ✓ Equipment and adaptations in the home: hospital staff discussing if any equipment or home adaptations were needed when leaving hospital
- ✓ Taking medication: patients being able to take medication they brought to hospital when needed
- ✓ Noise from staff: patients not being bothered by noise at night from staff

Where patient experience **could improve**

- Contact: patients being given information about who to contact if they were worried about their condition or treatment after leaving hospital
- After the operation or procedure: patients being given an explanation from staff of how their operation or procedure went
- Involvement in decisions: patients being involved in decisions about leaving hospital, if they wanted to be
- Feedback on care: patients being asked to give their views on the quality of their care
- Dietary requirements: patients being offered food that met any dietary requirements they had

These topics are calculated by comparing your trust's results to the average of all trusts. "Where patient experience is best": These are the five results for your trust that are highest compared with the average of all trusts. "Where patient experience could improve": These are the five results for your trust that are lowest compared with the average of all trusts.

This survey looked at the experiences of people who were discharged from an NHS acute hospital in November 2020. Between January 2021 and May 2021, a questionnaire was sent to 1250 inpatients at Maidstone and Tunbridge Wells NHS Trust who had attended in late 2020. Responses were received from 607 patients at this trust. If you have any questions about the survey and our results, please contact [NHS TRUST TO INSERT CONTACT DETAILS].



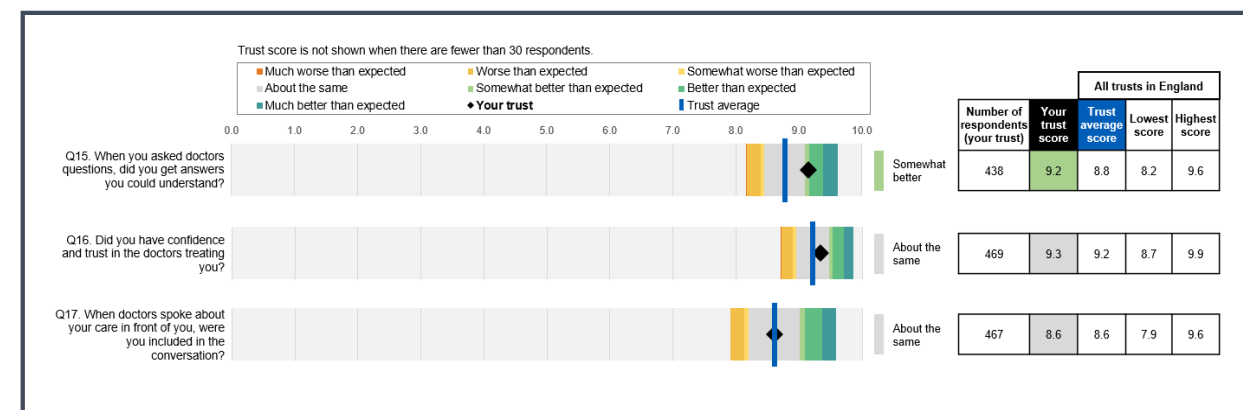
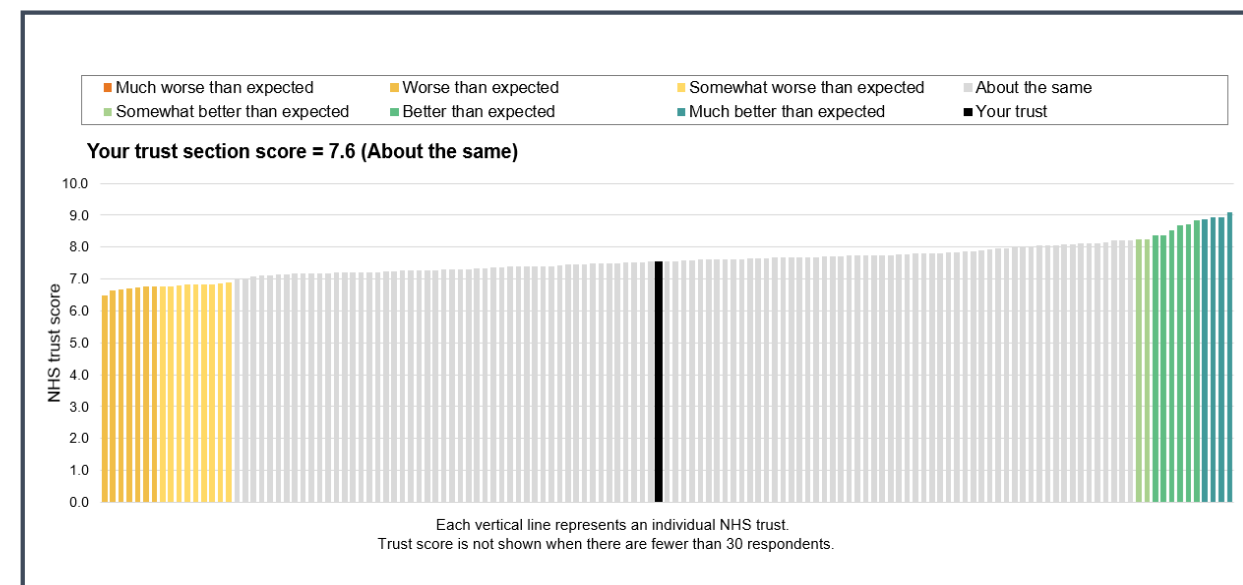
How to interpret benchmarking in this report

Trust level benchmarking

The charts in the 'benchmarking' section show how the score for your trust compares to the range of scores achieved by all trusts taking part in the survey. The black line shows the score for your trust. The graphs are divided into seven sections, comparing the score for your trust to most other trusts in the survey:

- If your trust's score lies in the **dark green section** of the graph, its result is 'Much better than expected'.
- If your trust's score lies in the **mid-green section** of the graph, its result is 'Better than expected'.
- If your trust's score lies in the **light green section** of the graph, its result is 'Somewhat better than expected'.
- If your trust's score lies in the **grey section** of the graph, its result is 'About the same'.
- If your trust's score lies in the **yellow section** of the graph, its result is 'Somewhat worse than expected'.
- If your trust's score lies in the **light orange section** of the graph, its result is 'Worse than expected'.
- If your trust's score lies in the **dark orange section** of the graph, its result is 'Much worse than expected'.

These groupings are based on a rigorous statistical analysis of the data termed the 'expected range' technique.



How to interpret benchmarking in this report (continued)

Trust level benchmarking

The 'much better than expected,' 'better than expected', 'somewhat better than expected', 'about the same', 'somewhat worse than expected', 'worse than expected' and 'much worse than expected' categories are based on an analysis technique called the 'expected range'. Expected range determines the range within which a trust's score could fall without differing significantly from the average, taking into account the number of respondents for each trust, to indicate whether the trust has performed significantly above or below what would be expected.

If it is within this expected range, we say that the trust's performance is 'about the same' as other trusts. Where a trust is identified as performing 'better' or 'worse' than the majority of other trusts, the result is unlikely to have occurred by chance.

The question score charts show the trust scores compared to the minimum and maximum scores achieved by any trust. In some cases this minimum or maximum limit will mean that one or more of the bands are not visible – because the range of other bands is broad enough to include the highest or lowest score achieved by a trust this year. This could be because there were few respondents, meaning the confidence intervals around your data are slightly larger, or because there was limited variation between trusts for this question this year.

In some cases, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust. This occurs as the bandings are calculated through standard error rather than standard deviation. Standard error takes into account the number of responses achieved by a trust, and therefore the banding may differ for a trust with a low numbers of responses.

Site level benchmarking

The charts in the 'trust results' section present site level benchmarking. This allows you to compare the results for sites within your trust with all other sites across trusts. It is important to note that there may be differences between the average score of the sites provided and the overall score for the trust. This may be related to the size of the sites, results for suppressed sites or weighting, as sites and trusts are weighted separately. In addition, if a single site result is presented for a trust, the 'expected range' category may differ: although the score achieved will be the same for both the site and for the trust, the upper and lower boundary levels will differ between the two due to them being calculated differently in each case.

Additional information on the 'expected range' analysis technique can be found in the survey technical report on the [NHS Surveys website](#).

An example of scoring

Each evaluative question is scored on a scale from 0 to 10. The scores represent the extent to which the patient's experience could be improved. A score of 0 is assigned to all responses that reflect considerable scope for improvement, whereas a score of 10 refers to the most positive patient experience possible. Where a number of options lay between the negative and positive responses, they are placed at equal intervals along the scale. Where options were provided that did not have any bearing on the trust's performance in terms of patient experience, the responses are classified as "not applicable" and a score is not given. Similarly, where respondents stated they could not remember or did not know the answer to a question, a score is not given.

Calculating an individual respondent's score

The following provides an example for the scoring system applied for each respondent. For question 15 "When you asked doctors questions, did you get answers you could understand":

- The answer code "Yes, always" would be given a score of 10, as this refers to the most positive patient experience possible.
- The answer code "Sometimes" would be given a score of 5, as it is placed at an equal interval along the scale.
- The answer code "No, never" would be given a score of 0, as this response reflects considerable scope for improvement.
- The answer codes "I did not have any questions" and "I did not feel able to ask questions" would not be scored, as they do not have a clear bearing on the trust's performance in terms of patient experience.

Calculating the trust score for each question

The weighted mean score for each trust, for each question, is calculated by dividing the sum of the weighted scores for a question by the weighted sum of all eligible respondents to the question for each trust. An example of this is provided in the [survey technical document](#).

Calculating the section score

An arithmetic mean of each trust's question scores is taken to provide a score for each section.

Quarterly maternity services report	Chief Nurse
<p>The enclosed report provides information about safety issues in Maternity, the themes and trends and the identified learning and action plans, including:</p> <ul style="list-style-type: none"> ▪ The number and summary of Serious Incidents declared for Maternity Services ** ▪ The number of Healthcare Safety Investigation Branch (HSIB) cases reported ** ▪ The number of Perinatal Mortality Review Tool (PMRT) case reviews* ▪ The key themes ▪ The recommendations and actions ▪ The progress in implementing Saving Babies Lives Care Bundle v2* ▪ A Maternity staffing review summary <p>The report also provides assurance of progress in meeting the requirements of the Ockenden Report and Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 4 which each recommend that this information is shared with the Trust Board on at least a quarterly basis</p> <p>*CNST - Maternity Incentive Scheme Year 4 requirement **Ockenden Report recommendation requirement</p>	
<p>Which Committees have reviewed the information prior to Board submission?</p> <ul style="list-style-type: none"> ▪ Maternity Safety Board 	
<p>Reason for submission to the Board (decision, discussion, information, assurance etc.) ¹</p> <p>Information and assurance</p>	

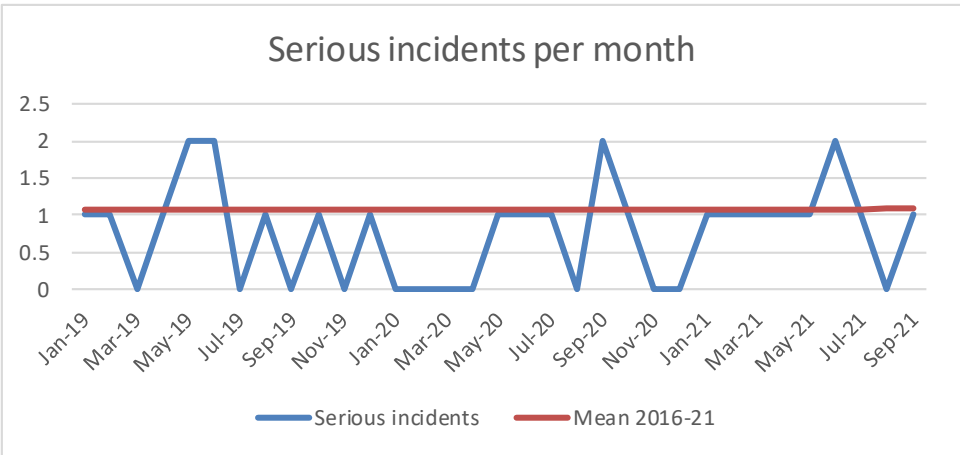
¹ All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making;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

Report to: Trust Board

Report from: Maternity Services

Date: October 2021 (reporting period July 2021 to September 2021)

Subject: Maternity Services Quarterly Update Report (Please note this report has not been previously submitted to Quality Committee, as this is a working prototype)

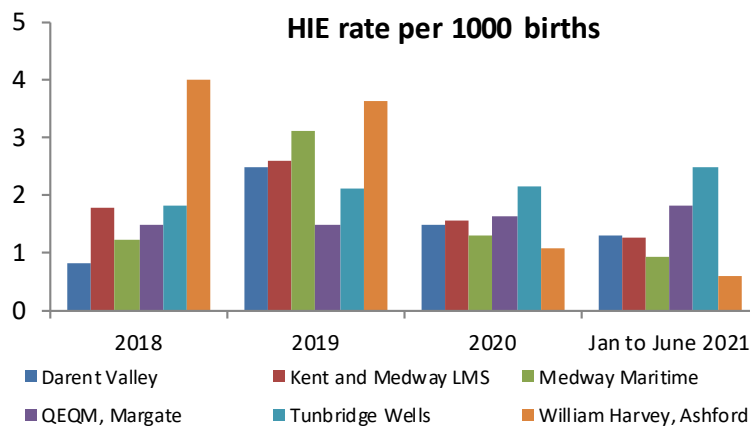
<p>Summary</p>	<p>This report provides an overview of the following for July to September 2021:</p> <ul style="list-style-type: none"> • Number and summary of SIs declared for Maternity Services ** • Number of HSIB cases reported ** • Number of PMRT case reviews* • Key themes • Learning • Recommendations and actions • Progress in implementing Saving Babies Lives Care Bundle v2* • Staffing review summary* <p>*CNST requirement **Ockenden recommendation requirement</p>									
<p>Number of Internal SI's Declared</p>	<p>2 - see summary in the table below:</p> <table border="1" data-bbox="459 1003 1407 1330"> <thead> <tr> <th>STEIS Ref</th> <th>Clinical Area</th> <th>Synopsis</th> </tr> </thead> <tbody> <tr> <td>2021/15654</td> <td>Delivery Suite, TWH</td> <td>HSIB investigation – see below</td> </tr> <tr> <td>2021/19844</td> <td>Delivery Suite, TWH</td> <td>HSIB investigation – see below</td> </tr> </tbody> </table> 	STEIS Ref	Clinical Area	Synopsis	2021/15654	Delivery Suite, TWH	HSIB investigation – see below	2021/19844	Delivery Suite, TWH	HSIB investigation – see below
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2021/15654	Delivery Suite, TWH	HSIB investigation – see below								
2021/19844	Delivery Suite, TWH	HSIB investigation – see below								

Number of HSIB Reported cases

2 – please see summary in the table below:

<i>Ref</i>	<i>Clinical Area</i>	<i>Synopsis</i>
2021/15654	Delivery Suite, TWH	G1 41+0wks gestation, Low risk pregnancy Spontaneous rupture of membranes pre-labour, attended Antenatal Ward for induction of labour, as planned, pathological CTG in labour, Cat 1 LSCS, born in poor condition Admitted to NNU and transferred to Medway for cooling HSIB investigation in progress
2021/19844	Delivery Suite, TWH	G2P1 40wks gestation. Low risk pregnancy. Admitted in advanced labour . Undiagnosed breech. Prepared for Cat 1 LSCS. Consultant decision Rapid labour, vaginal breech delivery Baby born in poor condition admitted to NNU sent to William Harvey for cooling HSIB investigation in progress

Comparative data for HIE rates across Kent and Medway LMNS:



In view of increasing rates at MTW, a task and finish thematic review, led by neonatologist Dr Park, has been planned

HSIB reports received – findings and actions	Ref	HSIB Recommendations	Trust Actions
	2021/7497	<p>1. The Trust to ensure that when a mother in maternity triage requires an obstetric review, that a comprehensive, holistic review is undertaken by a senior clinician.</p> <p>2. The Trust to ensure that staff in triage are able to recognise that when women attend the triage unit repeatedly or abnormal findings are identified a holistic review is obtained by the wider multidisciplinary team.</p> <p>3. The Trust to ensure that the local escalation policy enables sufficient staff to be available to give the expected level of care to women attending the triage unit.</p> <p>4. The Trust to ensure that when decisions are made as to the timing/ prioritization of IOL the full clinical information is available and the multidisciplinary team are involved</p>	<p>1 Every effort is made to provide senior obstetric cover in addition to the on call team who are available at all times during the 24 hr period. A dedicated Registrar is allocated to Triage if rota permits</p> <p>2 Triage SOP describes the process for multidisciplinary team review. SOP amended to clarify escalation process</p> <p>3 There is an escalation policy and staff are deployed appropriately according to activity and risk.</p> <p>Staffing levels are monitored continuously by the care pathway coordinators</p> <p>4 IOL process amended to include a proforma to include the details about the induction and patient's current condition. This information will be taken when the patient calls for time of attendance that day for IOL</p>
Number of PMRT case reviews	3 – please see summary in the table below:		
	PMRT ref	Clinical Area	Synopsis
	ID76081	Maternity Triage TWH	<p><i>Ante partum stillbirth at 37 weeks</i></p> <p><i>G1 High risk - smoking at booking, growth scans in pregnancy, normal growth</i></p> <p><i>Presented with first episode of reduced fetal movements – IUD diagnosed</i></p> <p><i>Cause of death not determined at post mortem</i></p>
	ID76395	Ultrasound scan department, TWH	<i>Ante partum stillbirth at 39 weeks</i>

			<p>G1 Gestational diabetes on insulin, high BMI, under care of diabetes MDT</p> <p>Presented for routine scan at 38 weeks – IUD diagnosed</p> <p>Placental insufficiency on post mortem</p>																																																				
	ID76714	Delivery Suite TWH	<p>Covid positive Mother at 22+1 weeks</p> <p>Attended Delivery Suite at 23/40 with reduced fetal movements. IUD diagnosed.</p> <p>Placental insufficiency on placental post mortem</p>																																																				
Trends in stillbirths since 2010:																																																							
<table border="1"> <caption>Stillbirth Rate MTW 2010-2021</caption> <thead> <tr> <th>Year</th> <th>SB/1000</th> <th>Mean</th> <th>National rate</th> </tr> </thead> <tbody> <tr><td>2010</td><td>4.0</td><td>3.5</td><td>3.5</td></tr> <tr><td>2011</td><td>5.5</td><td>3.5</td><td>3.5</td></tr> <tr><td>2012</td><td>3.5</td><td>3.5</td><td>3.5</td></tr> <tr><td>2013</td><td>3.8</td><td>3.5</td><td>4.2</td></tr> <tr><td>2014</td><td>3.0</td><td>3.5</td><td>4.1</td></tr> <tr><td>2015</td><td>3.8</td><td>3.5</td><td>3.8</td></tr> <tr><td>2016</td><td>4.2</td><td>3.5</td><td>3.8</td></tr> <tr><td>2017</td><td>3.5</td><td>3.5</td><td>3.8</td></tr> <tr><td>2018</td><td>1.5</td><td>3.5</td><td>3.5</td></tr> <tr><td>2019</td><td>2.5</td><td>3.5</td><td>3.3</td></tr> <tr><td>2020</td><td>2.5</td><td>3.5</td><td>3.3</td></tr> <tr><td>2021</td><td>3.0</td><td>3.5</td><td>3.3</td></tr> </tbody> </table>				Year	SB/1000	Mean	National rate	2010	4.0	3.5	3.5	2011	5.5	3.5	3.5	2012	3.5	3.5	3.5	2013	3.8	3.5	4.2	2014	3.0	3.5	4.1	2015	3.8	3.5	3.8	2016	4.2	3.5	3.8	2017	3.5	3.5	3.8	2018	1.5	3.5	3.5	2019	2.5	3.5	3.3	2020	2.5	3.5	3.3	2021	3.0	3.5	3.3
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Themes and Trends from investigations and case reviews	<ul style="list-style-type: none"> • Growth assessment protocol • Failure to follow guidelines • Failure to consider the whole picture • Communication - SBAR handover 																																																						
Recommendations and Actions	<ul style="list-style-type: none"> • Annual “deep-dives” – rolling programme of areas to review • Safety summit to be launched to share outcomes of deep dive • Thematic review of HIE cases, led by neonatologist Dr Park 																																																						
Progress with Implementation of Saving Babies Lives Care Bundle version 2	Element	Compliance data		Actions																																																			
	Smoking in pregnancy	CO monitoring at booking	94%	SiP midwife working with community and ANC teams to resolve issues																																																			
		CO monitoring at 36 weeks	69%																																																				
	Fetal growth restriction	Pregnancies where a risk status for fetal growth restriction is identified at booking and 20 week scan	100%																																																				
	Reduced fetal movements	Women who receive information about reduced FMs by 28 weeks	100%																																																				
Women attending with RFM who have a computerised CTG		94%																																																					
	Staff attended annual MDT fetal monitoring training	65%	Training programme under review																																																				

	Fetal monitoring	Lead midwife (0.4 wte) and Lead obstetrician (0.1 wte) are appointed	50%	Obstetrician appointed Midwife to be appointed
	Preterm births	Live births <34 weeks having full dose of steroids within 7 days of birth	45%	All cases reviewed to ensure steroids given appropriately
		Live births occurring more than 7 days after first course of steroids	25%	All cases reviewed to ensure steroids given appropriately
		Singleton live births < 30 weeks receiving MgSO4 within 24 hours before birth	100%	
		Women giving birth in an appropriate care setting for their gestation	92%	All cases reviewed to ensure transferred considered appropriately
Progress with clinical workforce planning	Workforce	Latest review	Progress with actions	
	Maternity workforce	Birthrate plus review October and December 2020 and Nursing and Midwifery Staffing Review April 2021 Senior management safety review October 2021	<i>Ockenden money is supporting some of the identified shortfall with a further business case being developed to support remaining shortfall</i> <i>Report being prepared</i>	
	Obstetric medical workforce	Review September 2021	<i>New consultants appointed and job plans reviewed to increase week end cover (Business case to be submitted)</i>	
	Anaesthetic medical workforce	Obstetric anaesthetic cover meets national recommendations		
	Neonatal medical workforce	Neonatal medical cover meets national recommendations		
	Neonatal nursing workforce	Nursing and Midwifery Staffing Review April 2021	<i>Business case for NNU BCP to meet BAPM recommendations</i>	
Perinatal Quality & Safety Dashboard	This is included as an Appendix in the monthly Trust-wide Integrated Performance Report (IPR).			
Related Regulatory Requirements	Response to the Ockenden Report, December 2020 CNST Maternity Incentive Scheme – year four, August 2021 Transforming perinatal safety, December 2020			
Author:	Sarah Blanchard-Stow, Divisional Director of Midwifery, Nursing and Quality Rachel Thomas, Deputy Head of Midwifery and Gynaecology			

Paper reviewed by:	Maternity Board (partial report)
Action Required by the Trust Board	N/A

Trust Board meeting – October 2021

Report on the Trust's COVID-19 response	Chief Operating Officer
Please find enclosed the report on the Trust's COVID-19 response.	
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

Freedom To Speak Up Guardian Board Report. July 2021

Maidstone and Tunbridge Wells NHS Trust COVID-19 Report



Maidstone and Tunbridge Wells NHS Trust COVID-19 Report.

Julie Elphick – Deputy Head Emergency Planning and Response (Tactical Advisor).
Darren Palmer – Tactical Commander.



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Foreword from the Chief Executive

The impact of COVID on the NHS over the 18 months has been unprecedented. At MTW the pandemic has touched every department and this report recognises the professionalism, dedication and team work shown by colleagues across the trust. It also highlights the work carried out in a number of key areas, reviewing the detailed planning our COVID response was built on and the valuable lessons we have learnt as we move forwards.



Colleagues should be proud of the care and services they delivered throughout the pandemic. They continued to provide urgent and emergency care while supporting patients, staff and local communities through comprehensive health and wellbeing schemes and testing programmes.

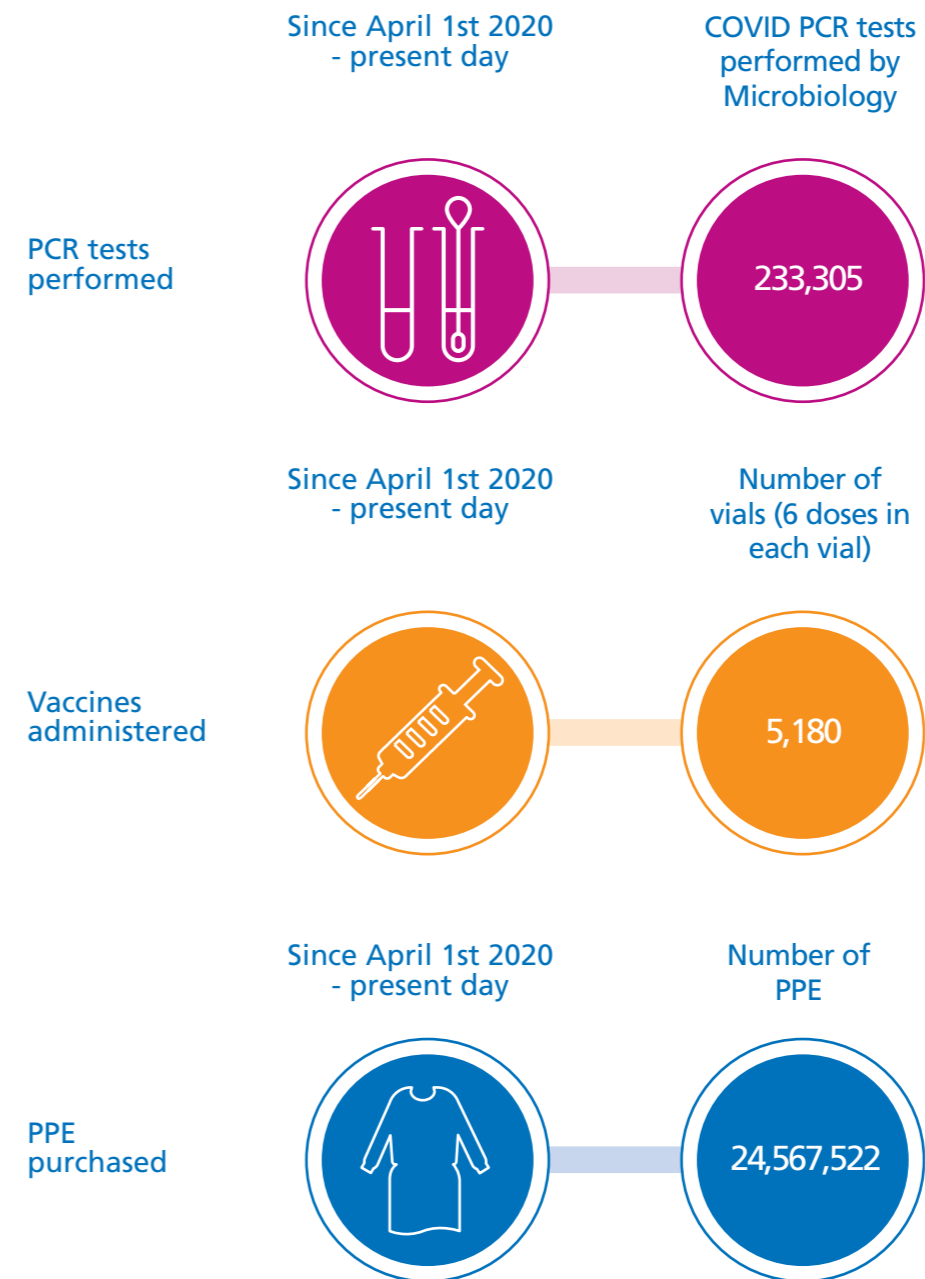
Our work on the hugely successful trust vaccination programme for both staff and partner organisations was recognised in Parliament and across MTW we have seen ambitious efforts to restore elective services quickly.

My thanks to everyone who provided the information for this report and to our post graduate colleagues who helped with the information gathering. As I read each page I was reminded of why I am so incredibly proud of our staff at MTW – they have truly been exceptional people providing outstanding care.

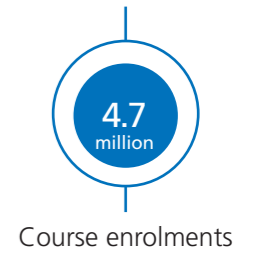
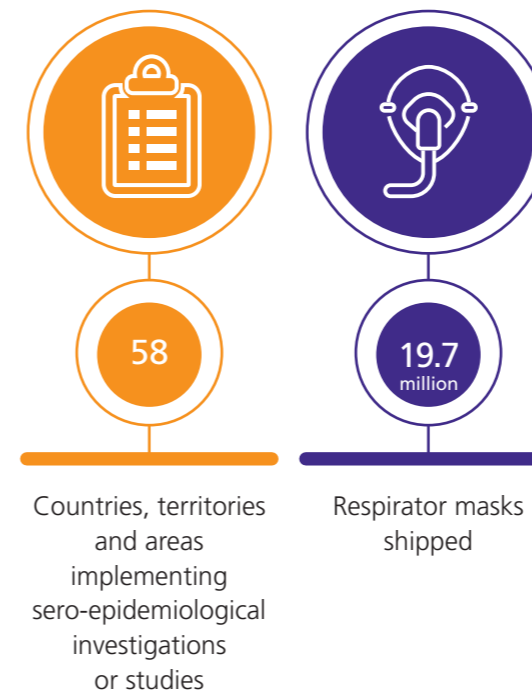
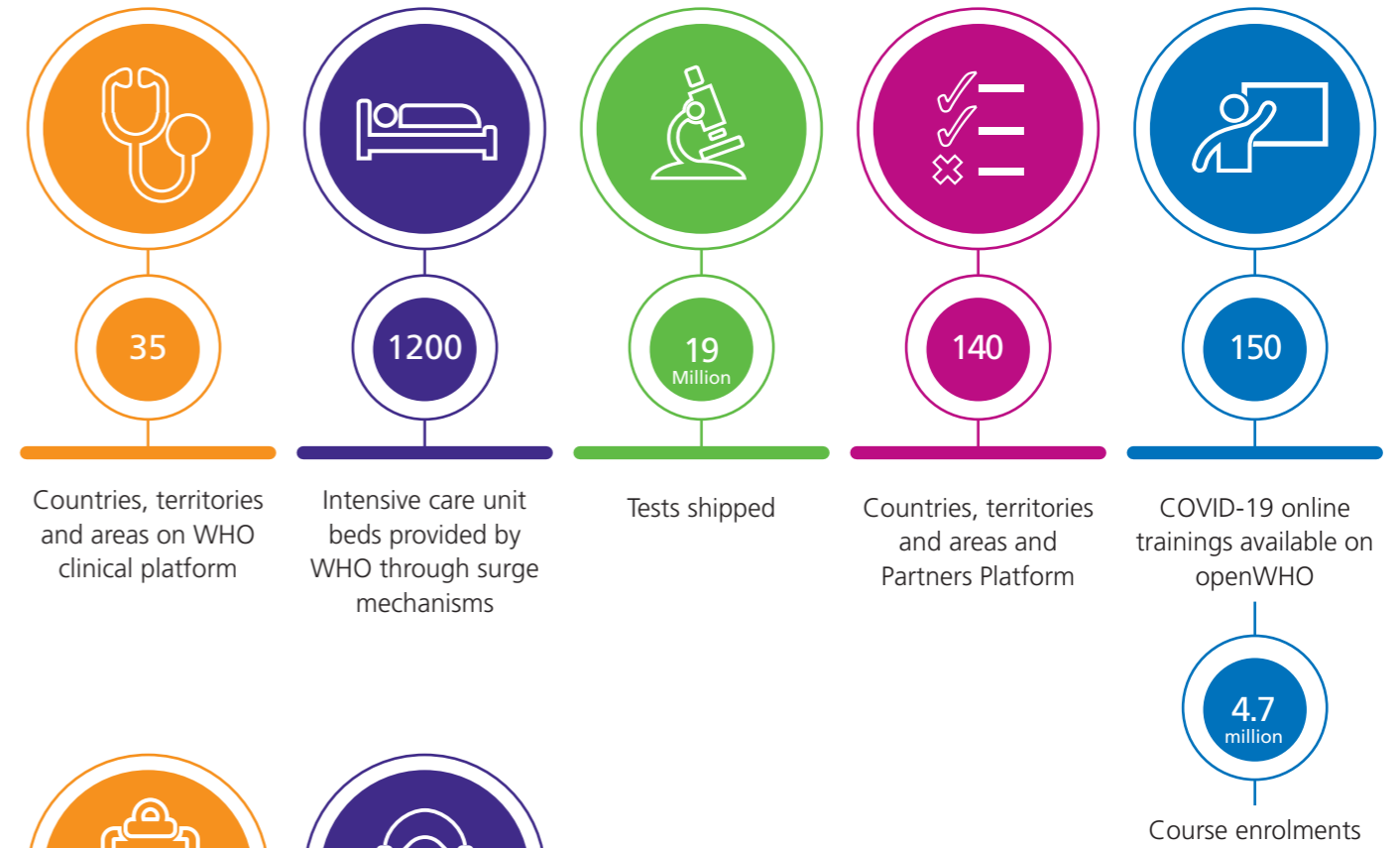
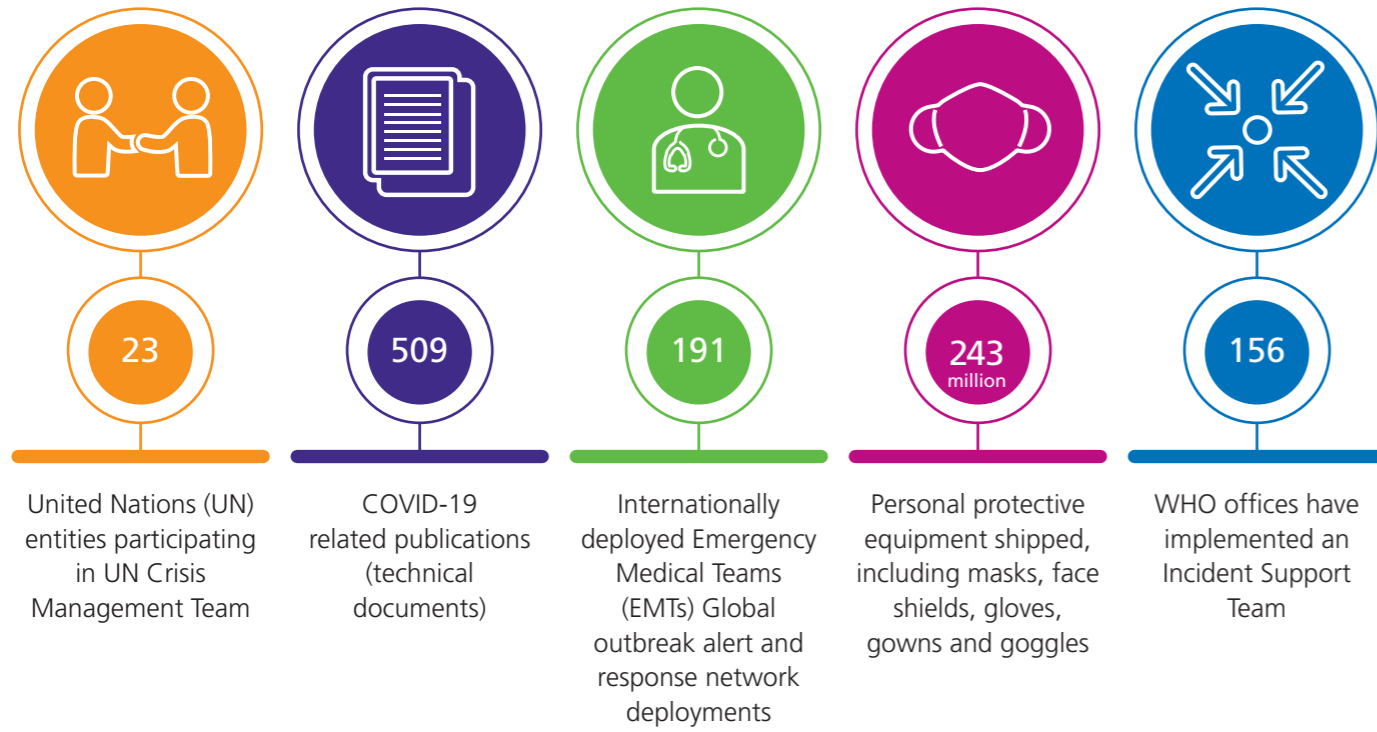
Best wishes
Miles Scott



MTW COVID-19 response overview



Worldwide overview of deployed resources



For financial year April 20 to March 21

Additional revenue spend of £32.8m to respond to COVID -19 (breakdown below)
 Additional capital spend of £3m on equipment, Information Communication Technology and Estates.

2.b COVID-19 expenditure and income Impact

Commentary

The Trust has identified the financial impact relating to COVID to be £36.1m, which includes £32.8m associated with additional expenditure and £3.3m due to lost income (mainly commercial income).

The main cost includes costs associated with virus testing, expansion of ITU capacity, purchase of PPE, staff welfare such as providing meals, purchase of IT equipment and software licences to enable staff working from home. Additional shifts required in ED, ITI areas sickness cover, additional on calls and extended opening hours for support teams.

The Trust has included £4.1m income in the position to offset the costs of COVID swabbing, rapid testing and the vaccination programme. NHSE/I have confirmed funding to the month 11 of forecast value of £3.9m, the remainder £0.2m (increase and forecast spend) is still to be validated by NHSE/I.

2020/21 Summary of cost reimbursement

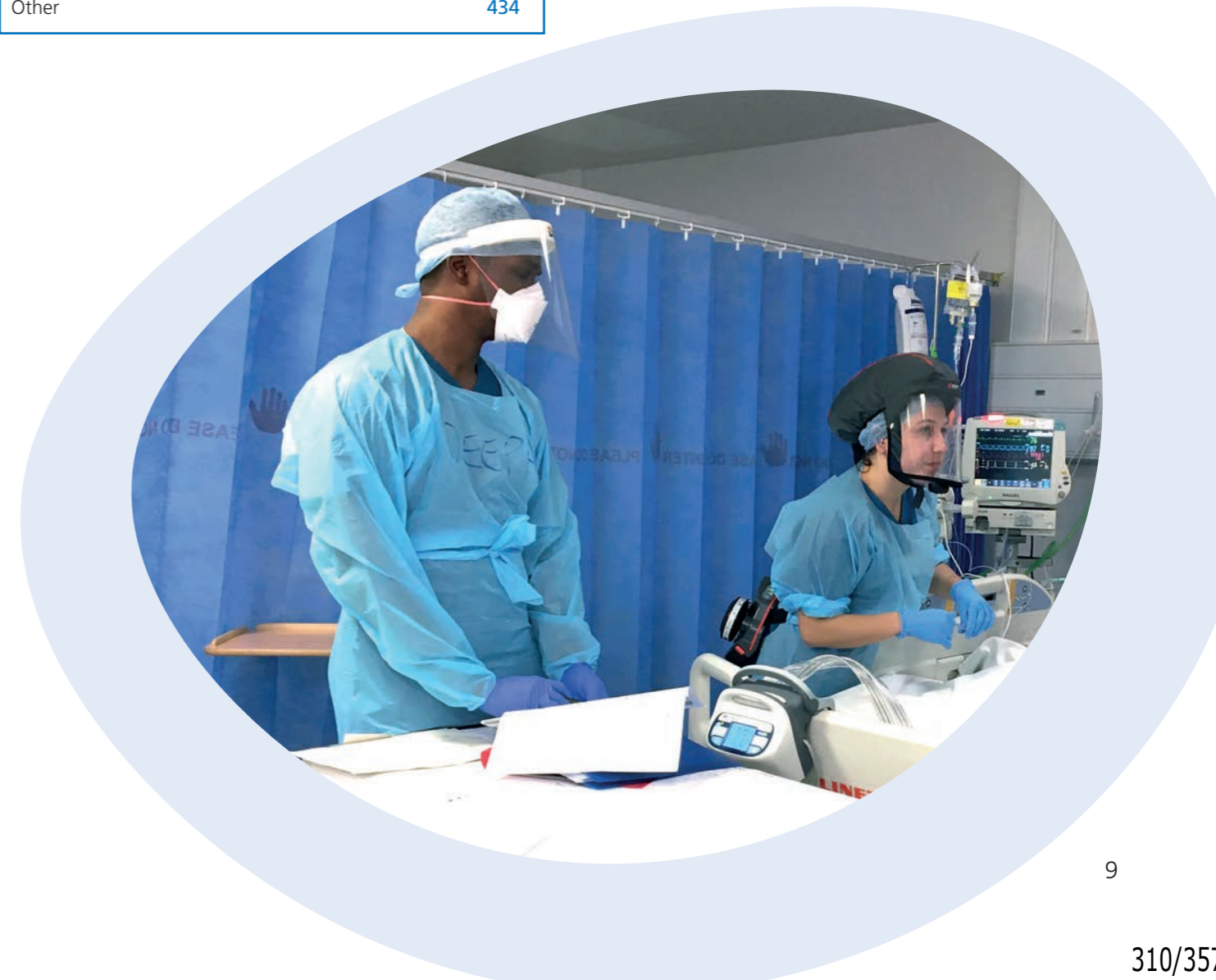
Total revenue (£000s)	32,815
Breakdown by allowable cost type	
£000s	
Expanding medical / nursing / other workforce	4,096
Sick pay at full pay (all staff types)	447
COVID-19 virus testing (NHS laboratories)	2,507
Remote management of patients	45
Support for stay at home models	99
Direct provision of isolation pod	7
Plans to release bed capacity	0
Increase ITU capacity (incl increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	2,770
Segregation of patient pathways	11,546
Enhanced PTS	0
Business Case (SDF) - Ageing Well - Urgent Response Accelerator	0
Existing workforce additional shifts	1,282
Decontamination	287
Backfill for higher sickness absence	2,502
NHS 111 additional capacity	0
Remote working for non patient activities	373
National procurement areas	1,970
Other	750
COVID-19 virus testing - rt-PCR virus testing	3,926
COVID-19 vaccination programme	92
COVID-19 virus testing - rapid / point of care testing	115

Summary: loss of income

Total (£000s)	3,272
Breakdown by income type	
£s	
Car parking income	1,353
Catering	218
Pathology trade income	120
Private patient income	946
Research and development	200
Other	434

Overall total

Total (£000s)	36,087
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Introduction

About this report

The year March 2020 to March 2021 has been an extremely complex and challenging year for the world, the global healthcare community and Maidstone and Tunbridge Wells NHS Trust (MTW).

In this report we will give some background to the pandemic planning and guidance and how prepared we as an organisation were. It will review, by looking back at how the whole organisation has risen to the COVID-19 pandemic challenge, and discuss the organisational learning going forward.

Background

During the H1N1 pandemic in 2009 central government's crisis management arrangements effectively supported and facilitated decision-making in an atmosphere of considerable uncertainty and pressure. The willingness of the devolved administrations and the Department of Health (DH) to work closely together within a common UK framework was fundamental to the overall success of the response.

MTW spent a year planning with multi-agency partners developing a pandemic flu plan that was used during 2009 but not to the intensity that the revised plan has been used during the COVID -19 pandemic

This report comes after 18 months of a very different world for us all here at MTW, staff across the organisation have experienced challenges in having to change the way they work to ensure we deliver the care our patients require alongside keeping our patients, staff and their families safe.

Many of us never imagined experiencing a UK level four emergency incident let alone a global response in our careers, but we have, and we can be proud of what our efforts have achieved as individuals and as a trust.

This report aims to outline what a level 4 incident meant for the organisation and its staff. It will aim to identify not only the facts of what staff and the organisation have achieved but also some of the personal experiences and pressures staff across the board have found themselves faced with and how we pulled together and learnt as we progressed through waves 1,2 & 3.

MTW has established an Emergency Planning, Response and Recovery team who, working with partners across MTW and the wider Kent and Medway healthcare community, established and strengthened key platforms to prepare our organisation for any healthcare or business continuity emergency. In early March 2020 as COVID-19 related deaths in the UK started to be recorded the Trust undertook a 'Pandemic Response' exercise led by John Weeks, Director of Emergency Planning & Communications, to strengthen the foundations from which MTW would launch and coordinate the largest, most rapid, most

complex bioscience/medical incident in the Trust's history. As the pandemic has grown and evolved to touch every one of us both professionally and personally so has MTW's response evolved ensuring that we bring every facet of the 'Exceptional people, outstanding care' philosophy to strengthen our resilience and continue to protect those most dear to us – our staff and our patients.

It is important to recognise at this stage that this report reflects on MTW's role as an acute hospital trust in the centre of Kent and Medway's response that unfolds on a scale that has proven to dwarf anything previously undertaken in modern times. MTW is extremely proud of the role we have played in supporting our own staff and patients alongside those of our wider Integrated Care Service. We are proud to say that everything we did and every decision we took had a very clear objective; control COVID-19 transmission, protect the vulnerable staff and patients and save every life possible for those in our care. It is important to recognise here that we strongly believe that these accomplishments belong to us all at MTW. Our actions first and foremost belong to us all here within the Trust that have been affected by COVID-19, and that we have taken collective and individual action to stop the spread of the virus and save lives. These actions belong to our healthcare teams who have bravely taken up the fight on the front line in the defence against the virus to keep our essential services running. These actions belong to MTW leaders who have shown the drive, innovation and resilience to tackle COVID-19, and who have given our clinical teams the tools, knowledge and protection to deliver the unimaginable. These actions belong to our partner organisations who have worked alongside MTW to ensure that no request for support was unheard and that no one was left behind when delivering their response. These actions belong to every individual who has contributed to MTW's response financially and materially and through their actions kept our vision of exceptional people outstanding care evident in everything we do.

The first section of this report will set out a brief history of the COVID-19 pandemic so far including some of the key global, UK and MTW milestones for context.

In the second section of the report we discuss how MTW responded to the developing situation and in the third section understand some of the individual divisions, directorates and teams perspectives on this.

The final, fourth section looks at some of the key learning and recommendations that MTW has taken from the past 12 months and looks ahead with cautious optimism to the challenges of 2021/22 as every pillar of our healthcare community looks to adapt the urgent need to prepare and strengthen existing healthcare systems in advance of new variants, vaccines and backlog of procedures.

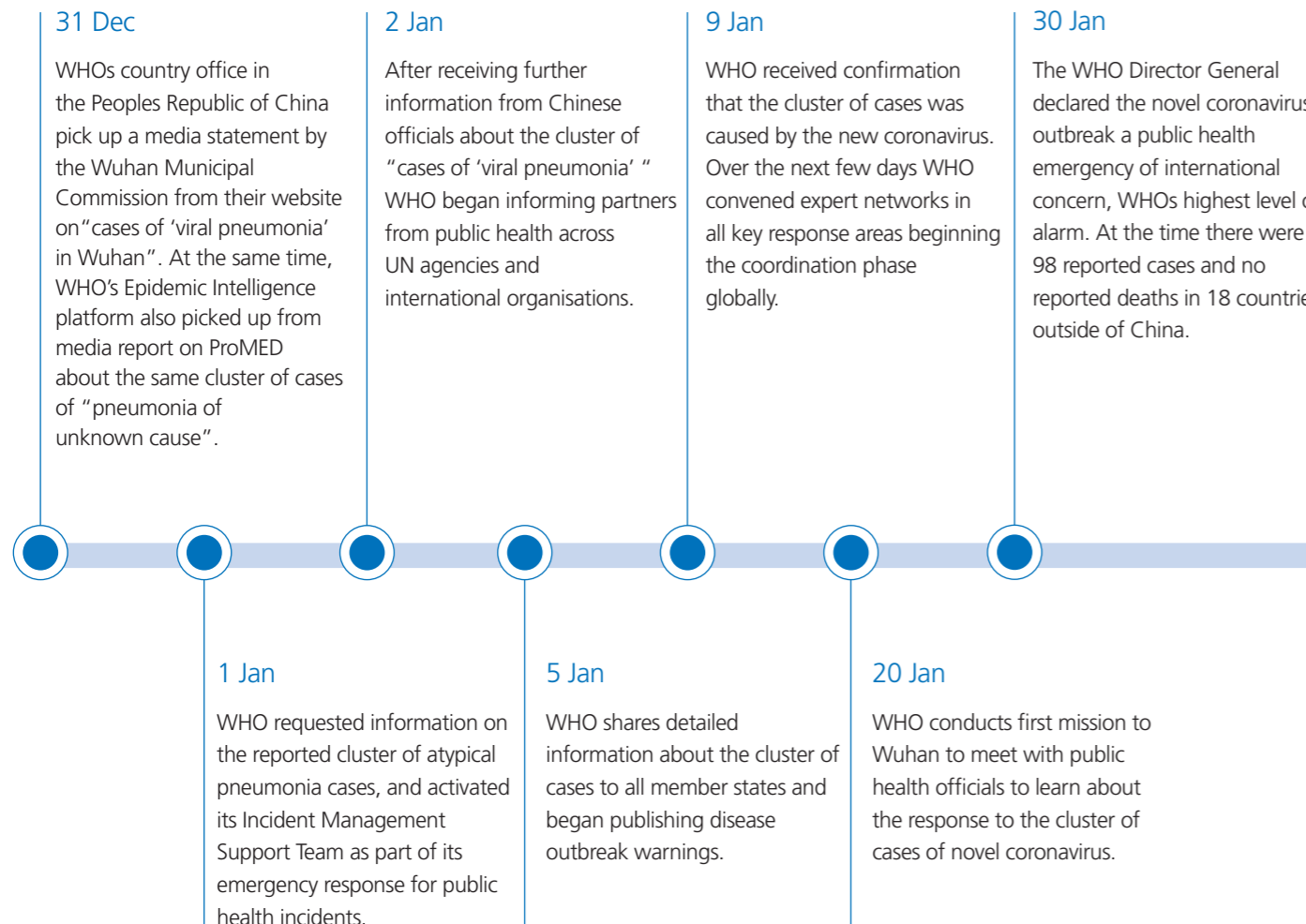


World Health Organisation epidemiological overview: January 2020 to December 2020

The first suggestion the World Health Organisation (WHO) noted of the emergence of COVID-19 was detected on 31st December 2019. Figure 1. is the beginning of the timeline where the WHO

country office in the Peoples Republic of China picked up a media statement by the Wuhan Municipal Health Commission that was referring to a 'cluster of cases of viral pneumonia'.

Figure 1: the first 30 days - timeline of WHO's early response.



As the virus continued to spread rapidly global lives and livelihoods began to change. In the first 3 months 1 million cases had been reported from everyone of the WHO regions shown in figure 2. By the end of 2020 only a very small handful of countries were still to report a case of COVID-19.

Evidence has shown that COVID-19 has the capacity to rapidly spread and evolve which at times has overwhelmed even the most resilient and advanced healthcare systems. By February 2021 more than 105 million cases had been reported worldwide with more than 2.2 million deaths reported due to coronavirus. Additionally, at a global level, we can see increasing indirect mortality being documented as disruptions to established healthcare systems associated with the pandemic. As the pandemic continues to evolve and the number of cases and deaths continue to increase the Trust turned its thoughts in Spring 2021 to India and the images of an overwhelmed healthcare setting which is particularly close to home to MTW as we reach out to support our Indian staff and their families. It is not surprising to see reports from WHO describing how trends in incidence and mortality are downwards or stable in

many countries, but these trends may not reflect the real evolution of the epidemic in countries where testing and reporting capacity is non-existent or limited.

As the global evidence base expands our knowledge we are starting to see some clear divides around how the world has been affected by coronavirus over the last year. Males are currently accounting for a higher proportion of deaths than females (57% of deaths but only 51% of cases) for reasons that are not understood yet. Women seem to be disproportionately affected by the social and economic implications of the healthcare response. These include but not exclusively limited to, a loss of sexual and reproductive health services, increased expectations to deliver care in the home and community environment and a significant rise in the incidence of gender-based violence. In countries that are capable of reporting to WHO data disaggregated by social determinants of health such as age, ethnicity, occupation, social and educational circumstances, living conditions and income there are notable disparities in terms of access to health services and health outcomes.



United Kingdom epidemiological overview

The first known UK cases were discovered on the 29th January 2020 in two Chinese nationals staying in a hotel in York in the North of England and were treated as a High Consequence Infections Disease (HCID). The 11th February saw the UK's first outbreak, in Brighton and Hove with 11 cases linked to a returning business traveller which had an impact on GPs in Brighton and A&E staff in Worthing Hospital.

To enable the national coordination of the NHS response, on 30th January 2020 NHS England and Improvement declared a Level 4 Incident. The first known (at the time) COVID-19 death in UK was 5th March 2020 in Royal Berkshire Hospital and the peak of first wave in the South East was 16 April 2020 with 2,239 COVID-19 positive cases in hospital, 373 in ITU/HDU and

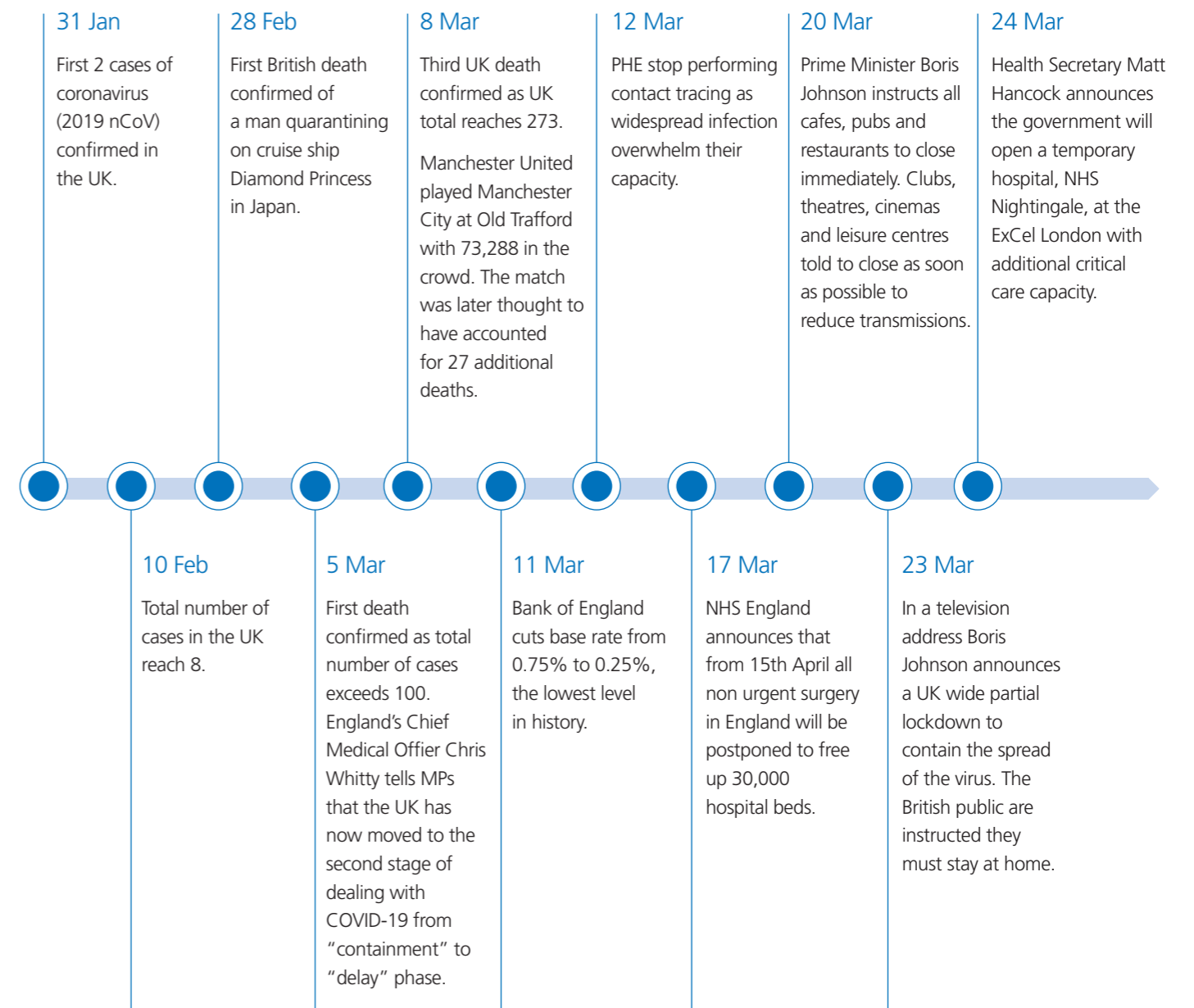
10,195 staff off with COVID-19 related illness. Case numbers declined over the summer months until increasing in the autumn with a second wave from November 2020. In the South East that second wave peaked on 11 and 12 January 2021 with 5,645 COVID positive and suspected inpatients (11 January), 528 COVID positive patients in critical care (12 January) and 6,186 staff off with COVID-19 related illness in the middle of the month. The UK is currently in the middle of wave 3 with hospital admissions and community prevalence rates continuing to rise.

The NHS England and Improvement incident response level changed between levels three and four to reflect whether coordination of the response was led regionally or nationally as shown in the table below:

Table 3: NHS England and NHS improvement incident levels incident level date declared



Figure 3: The first 60 days / timeline of UK's early response



Nightingale Hospitals

On 24th March the Secretary for Health and Social Care Matt Hancock announced the 'Nightingale Hospitals' initiative in response to ongoing concerns that the UK healthcare system could become overwhelmed by the pandemic. In April 2020 the British army at the request of the UK government set about establishing Nightingale Hospitals across the country to meet the increasing demand for critical care capacity and for recovering COVID patients to free up acute hospital beds. Maidstone and Tunbridge Wells NHS Trust was tasked with supporting a

potential site in Kent at Detling Showground. In early April MTW Estates and Emergency Planning teams met with the owners of the site and the army to scope out the practicalities should there be the decision to go ahead with a site in Kent. While the site was deemed practical for the use it was never developed further. It was a huge accolade for the Trust to have been asked to be part of the potential development should the need have arisen.

MTW COVID-19 Incident Coordination Centre

MTWs COVID-19 Incident Coordination Centre (ICC) was established in early March 2020 in response to the NHS level 4 national declaration.

The Trust's investment in incident command training for all senior on call managers and Loggists over recent years was very evident when the ICC was established with staff being familiar with processes of situational awareness, logging decisions and keeping action logs. Staff from departments including Business Information, Human Resources, Procurement and Infection Prevention and Control, who also had a seat at the table in the ICC, very quickly picked up the battle rhythm of the room and the requirement for using message logs and record all interactions. The biggest obstacle in the early stages was the need for an appropriate size room in an appropriate location, having assessed that the dedicated control centre was not the appropriate place to run the command and control of the pandemic from due to its dual use and its size. Once an appropriate room was identified the existing staff quickly packed up and relocated allowing the information technology teams to do what they do best, setting up computers, phones and extra internet points very swiftly.

The role of the tactical commander within the COVID-19 ICC needed to be one that could be sustained for a long period of time so an Executive decision was made about who could best be freed up in wave one. This role was supported by a tactical advisor which the Emergency Planning team took up the role of alongside a loggist rota with all trained loggists from across the organisation being freed up by their managers to take on their allocated shifts. The tactical commander was supported

throughout by a selection of senior managers on a rota to allow 7/7 cover.

Initially the ICC was operational 24/7 seven days a week with a full membership present on site. This was reviewed regularly as the situation across the country and within the organisation flexed over the last 18 months, allowing staff to be stood down or work shorter hours on site and remaining remote for periods of time. This was essential as staff exhaustion in the ICC needed to be managed to ensure their welfare was maintained.

The tactical commander set up and agreed the battle rhythm to ensure all calls with both external and internal partners could be facilitated. This changed on a regular basis in the early months as external health partners required different and more information on a regular basis as the pandemic evolved. Internal meetings with the Executive Divisions and ICC members remained more constant allowing attendees to build these into their busy days.

The Business Information team became an integral part of the ICC to enable them to facilitate the ever growing demand of SITREPS on a daily bases while in the background systems were being updated and altered to allow more information to become automated, reducing staff time and the need for handwritten records to be inputted for final data submissions, work that has been long overdue but that has improved our monitoring processes which will only hold us in good stead going forward. Presently all submissions are done remotely on a daily basis from existing platforms and electronic reports.

Infection Prevention Control & laboratories and diagnostics

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

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

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

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

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

Wave 2 of the pandemic increased pressure on the organisation and brought further challenges for IPC. Due to the increased infectivity of the Kent variant outbreaks were seen on many wards and processes were put in place to contain outbreaks rapidly and reduce patient to patient spread. By the end of 2020 the effect of the Kent variant on staff was so severe that the Trust implemented FFP3 masks for all staff caring for COVID patients to further protect them.

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

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

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

Swabbing and 'Swabulance'

MTW led the way locally with setting up swabbing units off site alongside a mobile 'swabulance' which was the first of its kind in the south east of England with full multi agency collaboration. The service was supported by SECAMB and Kent Community Health NHS Foundation Trust. This collaborative approach meant all staff and potential patients being admitted for elective

procedures had access to getting a swab. This partnership working approach allowed for resources and skills to be utilised to enable us to open up urgent swab requests to other blue light services facilitating the quick turnaround of suspected health staff with negative swabs returning to work.



Microbiology COVID experiences

The microbiology laboratory was as you can imagine a hive of activity throughout the COVID response and continues that way to the present day.

In January 2020 they had an establishment of 12.1 WTE made up of specialist biomedical scientists (BMS), support medical lab assistants, admin support staff and trainee biomedical scientists working a rota that covered Monday to Friday 8.30-18:00 and overtime weekend cover 08.00-13.30.

There was no provision for COVID-19 testing and limited experience and equipment with respiratory PCR testing, the capacity for influenza testing was 12 tests in 6 hrs. As you can imagine this was a steep learning curve for all the staff with the arrival of new equipment and new skills alongside the need to look at increasing supplies specifically around viral transport medium.

By March 2020 one additional low volume PCR instrument had been obtained allowing verification of COVID-19 testing on site with two staff completing training. This meant capacity increased to 24 tests in 6 hrs which unfortunately still didn't cover the number of swabs coming in which had to be sent to PHE reference lab for testing.

Further limited equipment was obtained and 10 BMS staff trained over the next three months increasing testing capacity to 48 tests in 6 hrs across four pieces of kit. With the support of 4 staff seconded from Blood Sciences and 2 from cellular pathology alongside some clerical support from GUMD, COVID testing was expanded to 15hrs a day 7 days a week.

Microbiology staffing levels remained the same with every member of staff undertaking extra hours to cover the requirements of the service. COVID-19 testing capacity increased to 500 per day with additional transport runs supported by the Transport department.

Bacteriology/serology workload was also being covered by the same staff. Although significantly decreased during this time frame, contingency was not required and we continued to offer a full service, including TB work for EKHUFT.

As the effects of the first wave began to reduce the team reduced its staff levels in line with demand to allow staff to get back to some level of normality, replacing some seconded clerical staff with bank staff. The challenges as with so many other areas of the organisation only changed, they did not go away. Many staff had children who would normally have been at school and they were juggling child care with work commitments. The easiest way to manage demand was a 12 on 2 off rota for staff which was exhausting but required. As the rest and recovery work began the workload significantly increased due to pre-assessment requirements.

New instrumentation provided by NHSE/I was slow to arrive so the Trust purchased one new piece of equipment which allowed, Testing capacity to increase to 700 tests per day by September 2020, allowing testing to be provided to private providers who were providing surgical services to MTW patients.

NHSE/I amended the requirements for 'care home' testing and we were required to test out break specimens for a large number of care homes in the area. Results were integrated to the EK portal already use by the Trust.

Bacteriology increased as BAU was slowly re-introduced across the Trust with the team also undertaking other tests as part of the Trust COVID-19 response. This included antibody testing for staff and the samples from the Siren study being undertaken by research and development.

13,113 COVID 'n' protein antibody tests have been carried out in a year from August 2020-2021.

As the Trust began to experience the effects of the second wave of the pandemic a recruitment drive helped to fill some of the essential roles. Unable to recruit at B6 (Specialist) level but managed to acquire 2 newly HCPC registered band 5 staff and 6 trainee BMS, 6 MLA support staff and 3.2 clerical officers. This led to a rapidly adapted training programme to be able to utilise the new staff to the fullest extent with Specialist staff required to work each shift as trainees cannot interpret and report results. The team continued through the second wave to work the same shift pattern and some more to ensure the work was done. Capacity increased to 1,000 swabs per day to accommodate wave 2 the 'Kent variant' outbreak and staff screening.

To manage the increase 3 workstreams were established, using new equipment provided by NHSE/I which allow continual testing in batches throughout the day. With different flow for urgent and staff screening and additional porters to keep the service flowing.



Jan 2021-to present day

Introduction of lateral flow staff screening and the end of 'care home' testing responsibilities allowed staff to 'drop' one overtime 'weekend shift' per month. This allowed full time staff to have 5 days a month when they are not at work. Support on shift for trainees remains with the trainees progressing well.

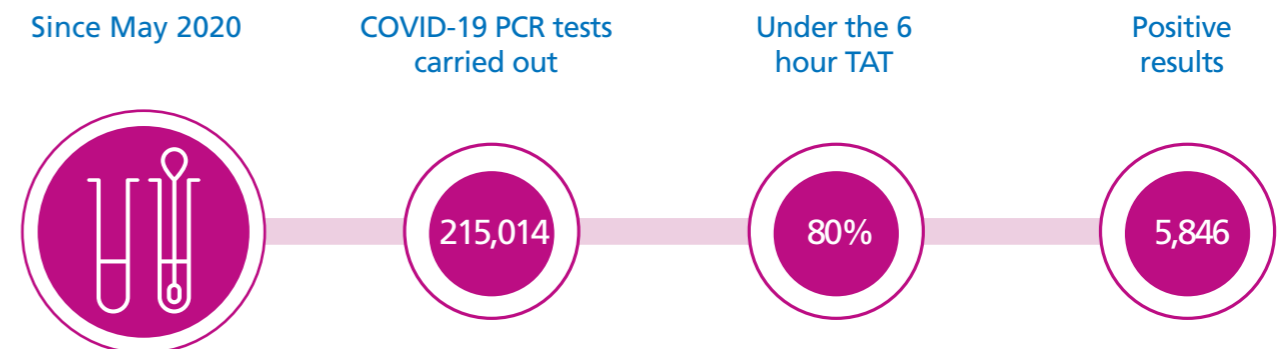
Capacity demand has dropped and the service to the independent sectors has been picked up locally in most cases although demand varies day to day due to uneven requests from pre assessment. Capacity remains at 700 per day and could be stepped back to 1000 with minor changes to workflow should it be required.

Laboratory hours reduced by one hr to 08.00 – 22.00hrs per day, with substantive staff still working overtime but at a much-reduced rate Monday – Friday.

Agreement has been given to extend fixed term contracts until 31/3/22. A business case is being developed to allow for the



introduction of 7 day working so that the overtime still being worked by substantive staff at weekends can be removed and a more robust service established for the future.



Once established COVID PCR testing has been conducted within the NHSE recommendations of 15 hour TAT on each day for 90% of specimens averaging 6 hours which is an amazing achievement.

The COVID service is available every day. Stock levels have been able to be maintained. The introduction of 3 testing workstreams has given robustness and continuity even when equipment has failed. This has been in the main due to the staff who have gone over and above to achieve the best for the patients and staff the Trust serves.

Alongside all the day to day activity the team have also been involved in research and development trials as well as any requests from NHSE/I for trials.

Preparation and packaging for the Novovax vaccine trial has been established within very short timeframe. Again staff

'stepped up' and worked additional weekends to accommodate this workload. Which will continue until March 2022. Three members of staff had to undertake five hours of e-learning to allow this to happen.

Future initiatives

The department is currently conducting a verification for COVID 'S' protein antibody to allow for NHSE recommendation of rollout of MAB testing. This will require a TAT of 24hrs.

Aim to establish NPEX IT links with other laboratories should contingency testing be required at any time. Unfortunately this is an NHSE/I expectation but has proved difficult to achieve throughout the past 12 months as the Trust does not have an HL7 link and alternate mechanisms have had to be sought to enable us to achieve what's required.

Expansion of mortuary facilities

The onset of COVID-19 in spring 2020 was mitigated by the presence of winter pressures temporary storage units (Nutwell units) already present at both sites (2 x 15 units TWH and 1 x 15 unit Maidstone). An additional external storage unit was sourced via the COVID budget and delivered in March 2020. The Mortuary managers also sourced and retained 25 spaces at a local funeral director for additional resilience.

The service retained all of this additional capacity throughout the summer and early autumn. Then just as the second wave being prepared for the works to expand existing capacity with a permanent solution was undertaken, the temporary winter capacity (Nutwell units) were returned in September 2020 to enable commencement of works to expand both mortuaries internal capacity to 20 additional spaces at Tunbridge Wells and 15 fridges plus five freezer spaces at Maidstone. Works were completed in November 2020 which was very timely.

In December 2020 the second wave of COVID-19 started to significantly impact the service. The Death Process Management Group (DPMG) for Kent had not sufficiently predicted the impact and the Kent solution of storage resilience at Aylesford Temporary Place of Rest (Aylesford TPoR) was not available to any service. The Trust secured an additional 58 spaces arranged locally at funeral directors in Kent to increase the available storage for MTW. Capacity was extended by a further 76 spaces in January 2021. This was an exceptionally difficult time as not

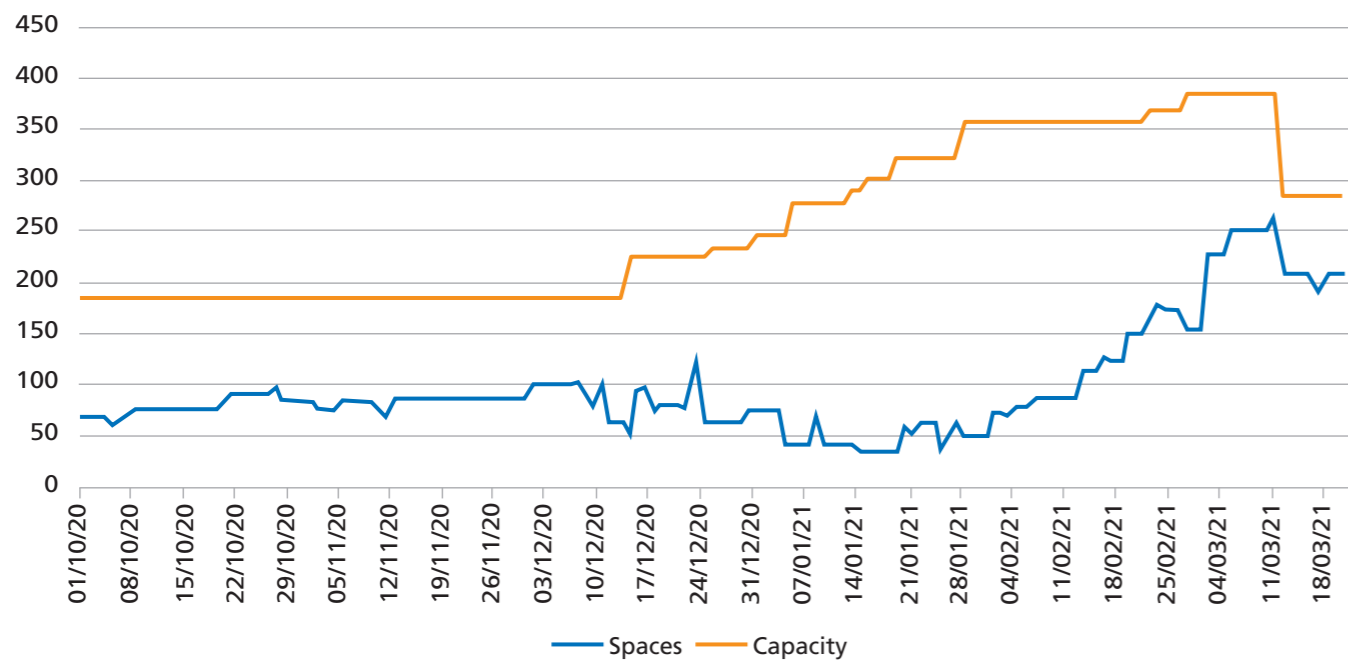
only did the number of deceased increase, the length of stay also increased significantly as funeral directors were not appointed by the deceased families amongst other reasons often COVID-19 related such as government guidance on number of attendees at funerals.

The Mortuary and Bereavement team ceased mortuary viewings on 7th January 2021 due to the Trust policy to reduce footfall on both sites and to protect the staff and families from possible infection. This had a significant effect on families and these viewings were not recommenced until 5th April 2021

The Aylesford TPoR opened on the 1st January but the requirements for transfer were very prescriptive and MTW struggled to meet them. A significant impact here was the Trust's adherence to new guidance and processes implemented in 2020 that caused significant delays to the production of MCCDs and consequent delays in referral to the coroners. Histopathology STRs were directed to support the production of MCCDs and alleviated some of the stressors which allowed some deceased transfer to Aylesford TPoR.

To conform to Human Tissue Authority regulations external refrigerated unit were converted to freezer capacity on the 7th April 2021 to accommodate the deceased that needed to be returned to local on site storage, some of who were with us for over a month.

Capacity versus availability Nov 2020 - April 2021

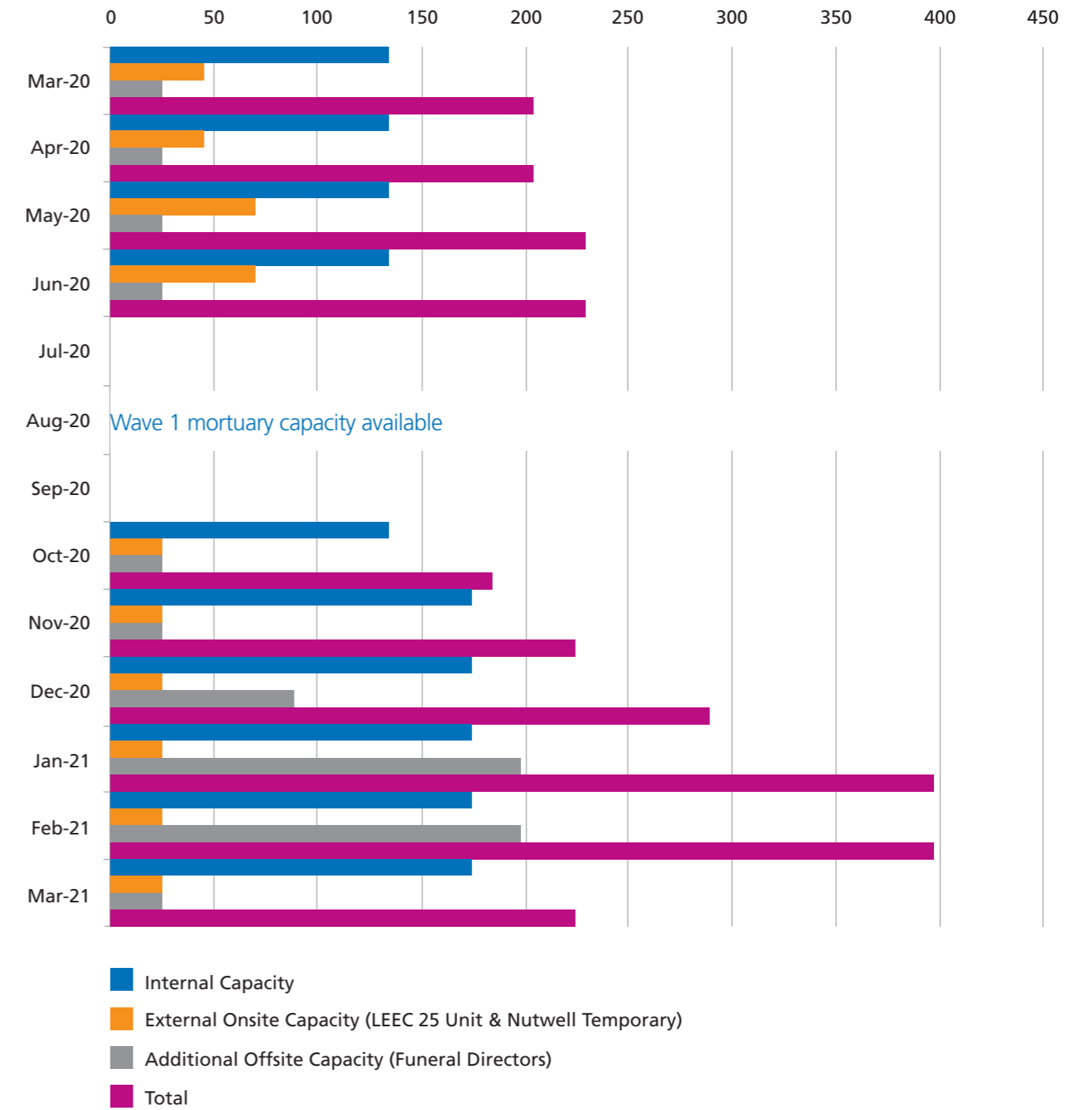


This graph demonstrates the spaces available versus capacity as the number counting always looked at spaces available rather than patients for reasons of ease and accuracy, Sitreps were asking for unoccupied capacity/available spaces.

The Maidstone freezer spaces were converted to fridges in mitigation. This was effective and provided the capacity required until the issue started to resolve in May 2021 (24th). The external storage unit remains on site as mortuary capacity remains challenged throughout the summer months.

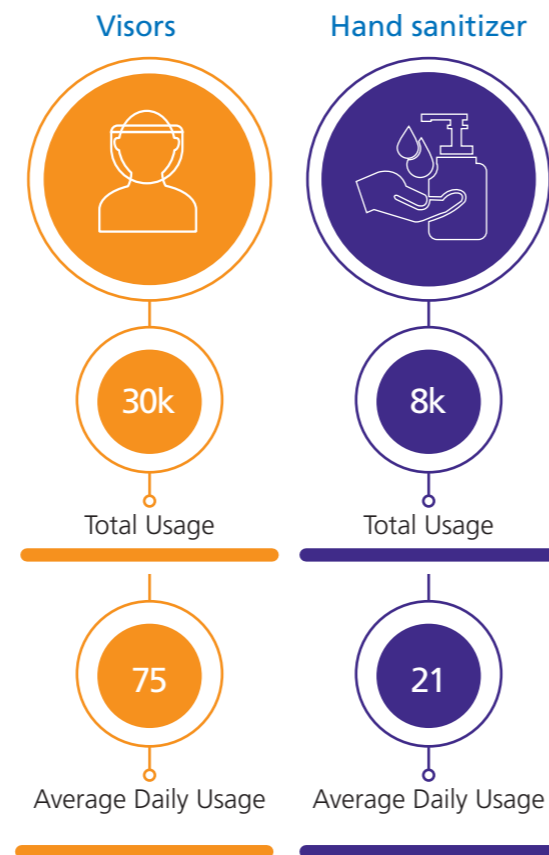
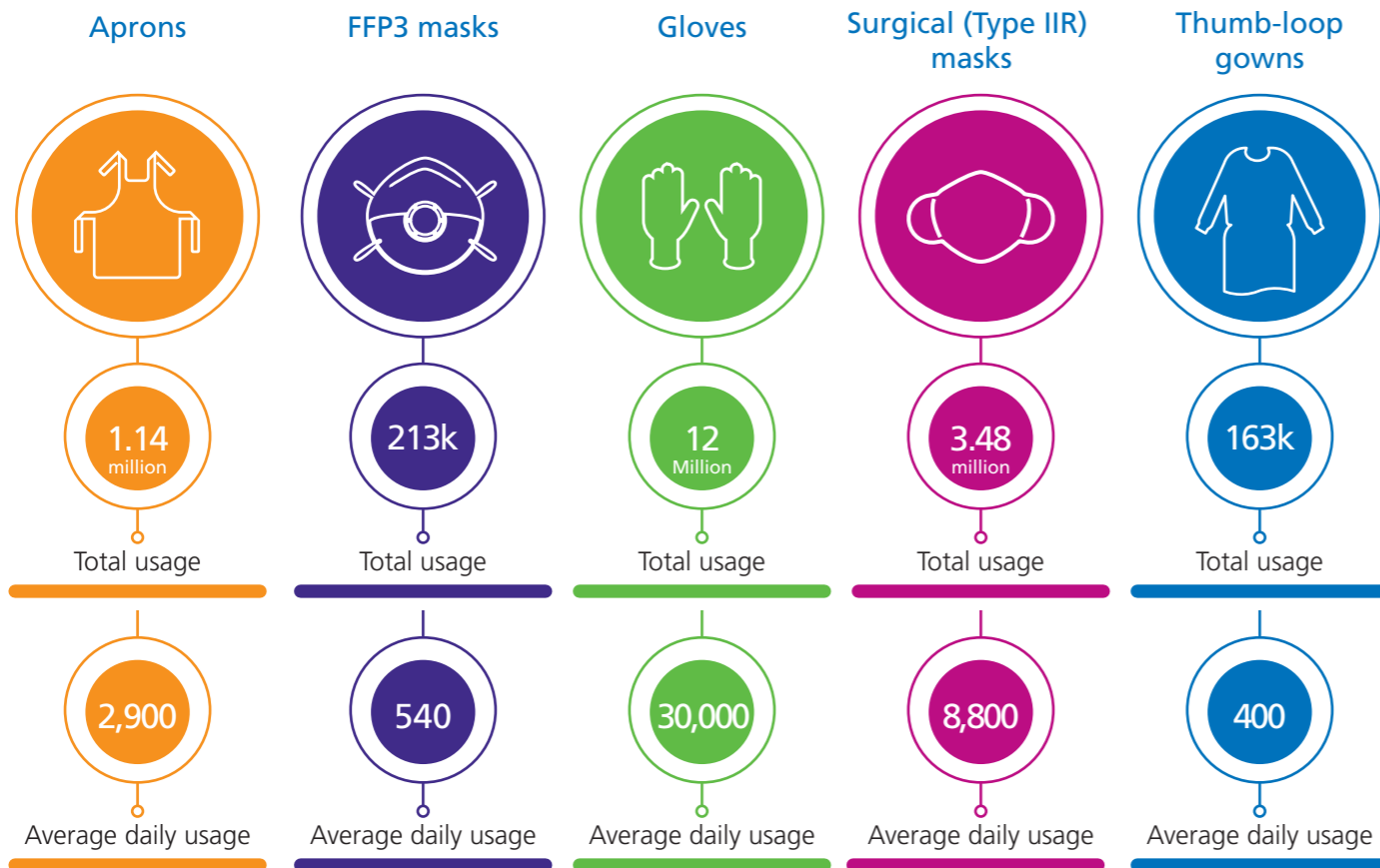
In March 2021 the situation had alleviated sufficiently to repatriate all externally stored deceased to the MTW mortuaries and to terminate all of the external off-site storage contracts. All of these contracts were terminated by 15th March 2021. The team had worked tirelessly up against the wall on many occasions to manage both capacity alongside the patients in their care.

Wave 1 mortuary capacity available



This graph identifies capacity but it is unable to include the Aylesford temporary place of rest due to the capacity there being shared across the whole of Kent and Medway and flexing as per demand.

Personal protective equipment usage (April to April)



Personal Protective Equipment (PPE)

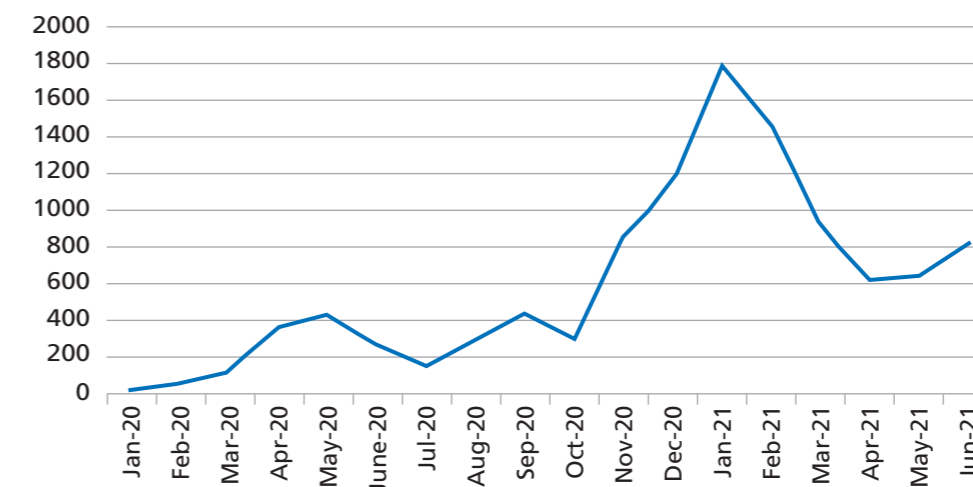
March 2020 brought the cold recognition that staff working within clinical areas were not automatically fit tested in FFP3 face masks. Some areas such as the Emergency Departments and Intensive Care Units had a percentage of staff fit tested but general compliance was nowhere near where it needed to be to keep staff safe across the board. In the initial months fit testing was undertaken locally by trained staff from wherever trained staff were, while a working group was set up to form a fit testing team. The responsibility came to the respiratory nurses from the Medicine and Emergency Care Division who took on the challenge and began fit testing as many staff as they could with "drop-in" sessions, but this was still a struggle as they too had other demands. The working group approached a clinical nurse specialist to join them and from here clinics were formed for staff to attend by appointment. These clinics were supported with re-deployed staff and two volunteers who soon re-joined the nursing register and worked bank with fit testing until March 2021. By the end of the summer 2020 there was a dedicated fit testing team with 5 staff members who took on the challenge to develop appropriate pathways, SOPs and undertook any further training to ensure best practice was followed and staff felt comfortable undertaking the role. Fit testing clinics were offered 7 days a week including 3 nights each week during the second wave.

All fit testing was initially undertaken using the qualitative (hood mask testing) we had used for years where staff wore a mask under a hood and either a sweet or bitter vapour was released into the hood to see if the staff member could detect any sweet or bitter taste in their throat. This identified they had either failed in the fitting of the mask due to incorrect fitting or the mask was not suitable for their face shape. This, alongside the need for an external aerated room and the difficulty with space meant prompt changes to the way we fit test was undertaken.

The ICC supported the investment into a 'Portacount' machine that had been recommended by Infection Prevention and Control the year before the pandemic, but due to cost, no clear plan of who would be trained to use the machine and no dedicated fit testing team it was put on hold. The pandemic and the development of a fit testing team allowed for the purchase to be escalated for such a valuable piece of kit. We were able to secure 2 Portacount machines (one for each site) which made fit testing going forward far more accurate and easier. So much so the Trust agreed to purchase another 2 totalling 4 for use across the Trust. After securing testing equipment the next challenge was to find space for the team to work and carry out fit testing in such large numbers. With Trust patient pathways developing quickly, the need for space continued to change almost daily at times. Eventually after moving 7 times at Maidstone Hospital and 4 times at Tunbridge Wells Hospital the team finally got permanent residence in a portable building at each site. The fit testing team has also been fortunate to receive support from the national team who have supported with fit testing since November 2020.

Fit testing was not only an essential role for staff safety but it was required continuously as the national supply of masks changed so each member of staff need to be re fit tested in the latest mask supplied. More recently The Department of Health and Social Care has created a set of new resilience principles for acute trusts to implement that all FFP3 users should be FIT Tested and use at least two different masks, ideally three. One of the masks should be from UK supply. This has seen steady requirement for fit testing across both sites. Figures for the number of tests carried out can be seen in appendix 2 – note in the early months of 2020 the records were not centralised due to departments with fit testers doing their own, so numbers are not a true reflection of the number of fit tests undertaken. Thanks to the amazing team of staff and the new Portacounts recording tests became easier and more reliable.

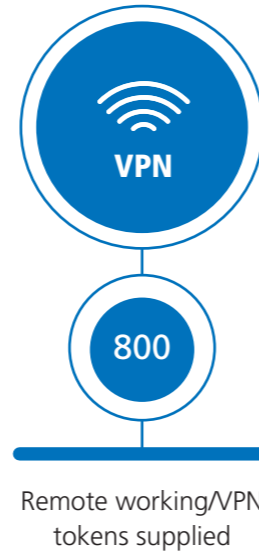
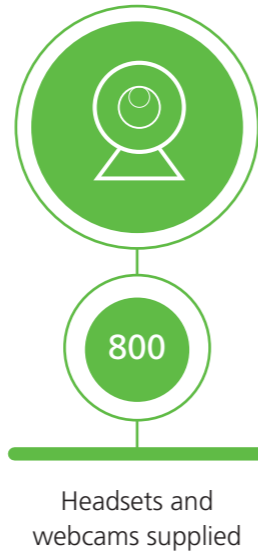
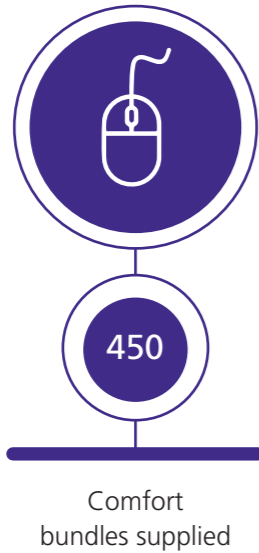
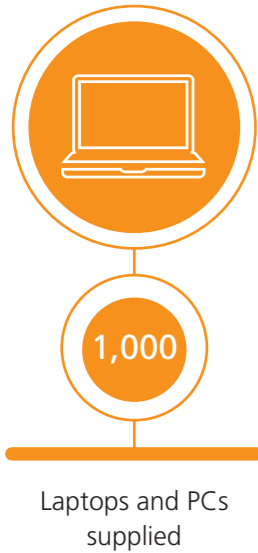
Fit Testing Data



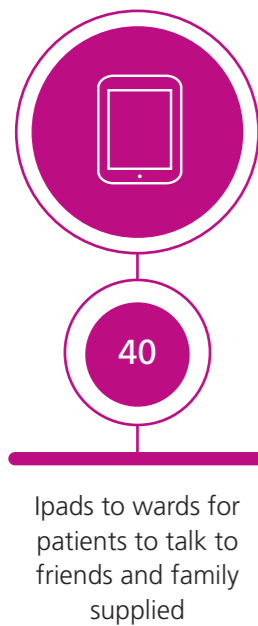
Information Technology

IT have worked tirelessly to support all the requirements of the organisation during the pandemic alongside all the requirements of the sunrise project and continue to do so.

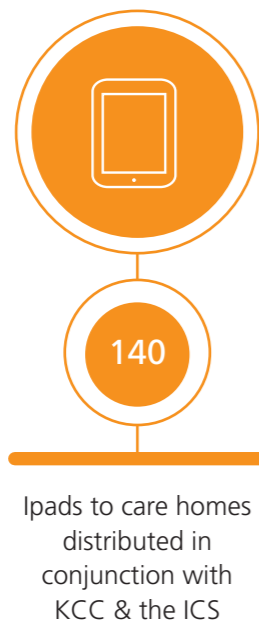
Summary for home working equipment April 1st 2020 - present day



Items distributed to wards



Items distributed to care homes April 1st 2020 - present day



Protecting essential health services

Within the Cancer Division a significant number of changes were made in line with the requirements of national guidance during the COVID-19 pandemic.

With this in mind the division have maintained business as usual for the majority of patients in Radiotherapy while looking at ways of reducing footfall in the department. The main change in practice was reducing activity for low-risk patients and non-essential surgery. However, despite reduced patient numbers, they were able to maintain both 62 and 31 day cancer wait targets, and continued to achieve these targets despite low staff numbers due to isolation requirements. This was no easy task and one the organisation is very proud of.

They also had to devise ways to reduce the number of staff in the department to enable social distancing. This included; creating a team A and a team B on the Radiotherapy machines to minimise staff numbers and avoid overlap; closing one machine at Maidstone per day for QA which extended the day on the others, enabling a shift system to be put in place to allow for the two teams to work independently of each other; recommending that all staff avoided walking between machines for queries use the telephone/email in these situations; and asking staff to leave the building once their clinical shift finished and to complete any CPD, mandatory training, or paperwork at home.

Furthermore, they introduced COVID testing for all patients required to come on site. All clinical staff are also tested regularly and vaccine uptake within the division has been very high.

All consultants engaged with virtual activity where possible, whether this was reviewing patients via telephone or video appointments, which significantly reduced their face-to-face appointments; some patient had all appointment virtually, which was safer for them. The Trust's objective was 80% of appointments to be transferred to virtual and we exceeded this, averaging at 90% virtual in April 2020, 89% in June 2020 and 84% in December 2020. Oncology was the lead in virtual clinical activity for the Trust for most of the pandemic.

The division was not without its challenges. The first being that due to post taking a significant amount of time to be delivered, every patient had to be directly contacted on the phone to tell them whether their appointment would be via telephone, video or face-to-face. This was extremely time consuming until we worked far enough in advance that we could be certain letters would be delivered to patients in time for their appointments. This was also a challenge as it meant a change in process on KOMS for admin staff to reflect new clinic appointment types.

What is incredibly important and something the Division are extremely proud of is that they have maintained chemotherapy and radiotherapy provisions throughout the COVID-19 pandemic, whilst consistently maintaining 'super green' status as a centre.



Procurement

Procurement team representation in the ICC was critical to the Trust response which has had positive outcomes for the Procurement department post waves 1&2 as they are seen more as an integral part of the Trust that delivers as and when required. Engagement with Divisional leads has improved significantly, and this can only be beneficial to the development of annual business plans and delivery of CIPs moving forward.

The availability of some lines of PPE became very challenging for the team. The development of strong links with the Infection Prevention Control team being established through the Trust COVID response enabled very difficult and innovative decisions to be made to ensure staff safety as all times.

Along with managing social distancing, shielding and sickness the teams provided 24/7 access to essential items of PPE and


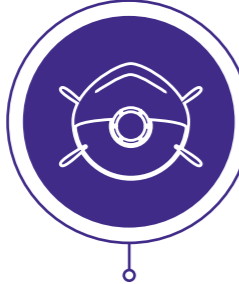






came up with solutions of creativity and sharing to help both external partners and teams on the frontline.

An overview of the amount of PPE the organisation use can be seen in Appendix 1. The tremendous task undertaken by Procurement in wave 1 gave us the resilience to get through all the requirements on PPE in wave 2

Supply chain issues were identified very early (NHSSC being a major single point of failure), and alternative direct supply routes from China were quickly established locally. Procurement said to execs "trust us and we will deliver", rather than hiding within a regional or national response which was not as effective, and they did.



Daily usage per month for PPE Items

Aprons	FFP3 mask (unit)	Gloves (unit)	Surgical mask (unit)	Tloop gown	Visor	Hand sanitizer (bottle)	Wipes (boxes)								
															
Apr 2020	402	Apr 2020	243	Apr 2020	71	Apr 2020	9953	Apr 2020	253	Apr 2020	12	Apr 2020	55	Apr 2020	37
May 2020	9	May 2020	600	May 2020	363	May 2020	15308	May 2020	966	May 2020	224	May 2020	37	May 2020	52
Jun 2020	574	Jun 2020	532	Jun 2020	4413	Jun 2020	17170	Jun 2020	612	Jun 2020	101	Jun 2020	55	Jun 2020	48
Jul 2020	6827	Jul 2020	380	Jul 2020	74958	Jul 2020	11203	Jul 2020	447	Jul 2020	63	Jul 2020	26	Jul 2020	57
Aug 2020	3027	Aug 2020	910	Aug 2020	54045	Aug 2020	13785	Aug 2020	444	Aug 2020	26	Aug 2020	22	Aug 2020	22
Sep 2020	3760	Sep 2020	221	Sep 2020	48647	Sep 2020	5248	Sep 2020	281	Sep 2020	74	Sep 2020	4	Sep 2020	4
Oct 2020	3313	Oct 2020	423	Oct 2020	53282	Oct 2020	8152	Oct 2020	421	Oct 2020	110	Oct 2020	51	Oct 2020	3
Nov 2020	2320	Nov 2020	266	Nov 2020	30737	Nov 2020	5938	Nov 2020	346	Nov 2020	65	Nov 2020	15	Nov 2020	8
Dec 2020	907	Dec 2020	438	Dec 2020	52256	Dec 2020	10583	Dec 2020	640	Dec 2020	104	Dec 2020	14	Dec 2020	6
Jan 2021	4363	Jan 2021	1668	Jan 2021	49497	Jan 2021	9556	Jan 2021	877	Jan 2021	149	Jan 2021	5	Jan 2021	19
Feb 2021	3100	Feb 2021	1034	Feb 2021	46921	Feb 2021	7220	Feb 2021	471	Feb 2021	111	Feb 2021	4	Feb 2021	5
Mar 2021	2716	Mar 2021	258	Mar 2021	37942	Mar 2021	7492	Mar 2021	123	Mar 2021	26	Mar 2021	4	Mar 2021	2
Apr 2021	4167	Apr 2021	632	Apr 2021	59660	Apr 2021	8657	Apr 2021	170	Apr 2021	28	Apr 2021	3	Apr 2021	3

Where did the challenge start for Estates and Facilities?

Estates and Facilities worked hand in hand with Mittie at TWH to manage their response across the trust. Structurally the TWH site leads itself to easier isolation due to all single rooms and has a more sophisticated oxygen circuit.

A Trust wide lockdown was probably the most significant action in the early stages that came from the decision in the ICC in early March 2020 requiring a rapid increase in security levels to facilitate secure sites with all those entering being required to show Trust ID. Security staffing levels increased rapidly from six guards 24/7 across both sites to 15 guards 24/7. This remained in place until June 2021 when it was reassessed, and numbers were reduced although presently remaining above pre COVID levels. This has enabled a continual presence at the front doors supporting the temperature checking teams and volunteers trying to make the patient experience as seamless and safe as possible.

As inpatient numbers increased over the coming months requests for more side rooms at Maidstone, ventilation systems, oxygen points, electrical supplies, and a constant number of requests to mend, build, repair or deliver on projects just kept rolling in like expanding ITUs on both sites. The amazing thing about all the staff is like others they pulled together and got the job done very quickly. Recognising that some challenges such as the oxygen supply that was under increasing demand up to 7 times our normal daily consumption on an already old system at MGH required senior involvement with external companies. Engineering suppliers were already in very difficult times across the country requiring creative and innovative solutions. The best resolution the Trust could ask for was a continuous supply of oxygen that met demand and this is what the team delivered on for our patients. The occasional low-pressure alarms going off were a concern for staff in some areas, however, the team immediately responded reassuring staff and sharing knowledge that the system was maintaining the level of supply being put upon it. The pre-wave 2 work with consultant anaesthetists, EME, Emergency Planning and E & F to work out maximum delivery levels for individual areas based on the diameter of the delivery pipes within that area helped on call managers to understand the infrastructure and make decisions

when dealing with bed and staff numbers alongside isolation restrictions. Due to the modern build of the TWH site the same problems did not arise there although decisions were made about best locations for high oxygen demand.

Social distancing requirements meant reshaping workplaces storage of furniture, erection of screens, floor stickers and signage to name but a few.

Facilities also delivered on many more elements for our staff including free food for all in several locations including outreach areas such as medical records. They also ensured the Wingman tents were kept clean and supplied with food for staff to take a well-earned break as well as providing scrubs that the laundry set a three hour turn around on to ensure supplies would meet demand. Demand that was often put under pressure due to staff taking more than one pair at a time. Yet this remains a target they still hit today, ensuring scrubs are on site for any location that required them.

Mention storage or containers to anyone in Estates and Facilities and they will probably laugh at you. The site became a sea of containers used for storage, fit testing, swabbing and various other uses. Some had water, electricity and phone lines installed locally, some are just storage.



Staff and patient wellbeing

Staff fatigue could and is still being felt across all dimensions of the organisation. It has to be remembered that after the impact of waves 1&2 came the impact of trying to tackle the reset and recovery backlog.

In conjunction to this the Trust still had staff that were shielding and those working from home to facilitate social distancing. It must be recognised that the wellbeing of our staff working from home was as important as those working on site. They could sit for hours in front of a computer moving from one teams call to another and didn't even get the break of stepping into the fresh air and driving to work and home. They generally stepped from their bedroom to their computer desk. For some staff it has been like one marathon after another. In the early stages guidance on shielding nationally was not clear, the boundaries changed and risk assessments needed to be undertaken by already busy managers to support their staff. Then on top of that home working kits needed to be made available and work for staff that did not do a desk job needed to be arranged. Staff from the front line who needed to shield but also wanted to help took on roles they have never done before, learning new skills that will help them with either career progression or changing roles. The trust had over 200 staff shielding at the peak, some of whom are still at home working, fearful they will be stuck there. While long-term others are at home through choice and fear that they are not adequately protected by the vaccine.

Information Technology did an amazing job in supporting all the requests for equipment as fast as they could but they were hindered by deliveries and a national demand.

Staff resignations have hit an all-time high in some areas after the second wave such as theatres where we have seen rates up to 25%. Why we have to ask ourselves and then we have to remember what they were asked to do. Theatre staff stepped up and supported the Intensive Care teams to manage the increase in cases as the numbers requiring ventilation and high flow oxygen increased. Let us not forget that most of our theatre staff while more than clinically capable of doing what was required of them don't deal with death and the dependency of such sick patients day in and day out that they did during their time in ITU. All staff have at some time during this pandemic experienced things they never thought they would in their lifetime in the NHS but for staff that cared for the sickest and the most dependant day on day and dealt with relatives on the end of phones or on an iPad that could not visit that trauma must not be taken lightly.

Trust support for staff came in many ways. From being successful in a bid for a fully staffed Wingman area on both sites that provided staff with a breakout facility to grab a drink, a bite to eat or just a walk away from their place of work, a breath of fresh air and a smiling face. The Wingman project was set up to help NHS staff have a First-Class lounge to unwind, decompress

and de-stress. Their mission statement was "Uniting the aviation community to bring wellbeing to those who need it."

Project Wingman is a charity founded in March 2020 in direct response to the COVID-19 pandemic. Professor Robert Bor, Captain Dave Fielding and Captain Emma Henderson came together to explore how grounded aircrew could support NHS staff during the current health crisis. They put a call out to the airline community with the idea of taking crews into NHS hospitals to look after NHS staff during their breaks in dedicated lounges and thus Project Wingman was born. An incredible 6,500 airline crew answered their call for volunteers, from across every UK airline. They offer their time, knowledge, and skills to serve and support NHS staff, providing vital well-being and mental health support.

As well as the Wingman areas 'Wobble rooms' became accessible across the NHS and MTW. These dedicated areas staffed with Trust employees and volunteers to listen to staff and try to guide them in the right direction if they needed further support were well utilised with further help being directed to Occupational Health and the Trust's well established Employee Assistance Programme (EAP). The EAP is provided by an external organisation offered support to staff and counselling sessions in person or by telephone for work or personal issues a 24/7 service advertised regularly on the intranet and in the monthly newsletter from the EAP service. This was utilised extensively by staff along with wellbeing psychological first aiders (PFAs).

Information Technology did an amazing job in supporting all the requests for equipment as fast as they could, but they were hindered by deliveries and a national demand. The teams worked tirelessly to support the Trust in so many ways to name but a few, they issued:

- 1000 laptops and 200 PCs
- 450 comfort bundles plus over 800 headsets and webcams
- Over 1500 remote working VPN tokens and phone accounts created
- Produced user guides including a YouTube video
- Supported all the office and clinical area reconfigurations and moves
- Provide iPads for patients to communicate with their families
- Created Webex accounts
- Supported Teams roll out
- Worked hundreds of extra hours to support staff on and off site
- 140 iPads for care homes distributed in conjunction with KCC & the ICS

Vaccine Centre - its implementation, its success and learning

In early November 2020, the Trust like many NHSE/I organisations received a letter from NHS England and NHS Improvements outlining the COVID -19 vaccination deployment strategy and operational readiness.

The Trust executive team supported the establishment of a project group made up of all parties required to facilitate the activation and running of the Trust vaccination centre. This included Emergency Planning, Occupational Health, IT, Pharmacy, Communications, Business Informatics and Learning and Development.

We built on an existing Trust plan for mass countermeasures that had been written and tested prior to the Olympics in 2012. Having an existing plan in place that included many of the aspects that were required for the vaccination centre meant we were not starting from scratch and that the timeline for enabling activation of the centre could be met. A critical factor that had to be incorporated was the aspect of PPE, social distancing, inclement weather, and staffing shortages as the mass countermeasures plan had been written without these factors needing consideration. Due to the delivery of the vaccine, we could only take delivery at one of our sites and were not allowed to transport across site so this meant one centre on one site and staff having to manage the logistics of travelling across from TWH to MGH – something staff took in their stride.

We had initially been notified we would be required to go live at the beginning of December 2020 which was then delayed until early January 2021 which we hoped would give some staff time to get a few well earned days off over Christmas but that was not to be. Two weeks later we received notification of go live on the 22nd December 2020. To give a perspective of what the Trust was dealing with while trying to undertake this project we had admitted 34 patients by the 25 April 2020 in the first wave and on the day of activation on 22 December 2020 we had admitted 232 patients in the second wave.

There was unprecedented demand on staff especially clinical staff yet staff from across the organisation pulled together in an effort to provide vaccinators, centre coordinators from many clinical and non-clinical roles, IT specialists, occupation health specialists, pharmacists, housekeeping staff, security staff and supplies some for the centre delivered with the vaccines and some sourced locally.

Creating a collaborative approach that included not only Trust staff but that of partner agencies enabled us to bolster our vaccination teams helping roll the vaccines out across other agencies as well. Collaborative working with East Kent Hospitals University Foundation Trust earlier in the pandemic allowed our staff to access a portal to help manage swabbing requests for patients and staff with the ability to upload results. This was hugely beneficial to us during the vaccination programme allowing us to use the system to build and release clinical slots daily to allow staff to book an appointment convenient for them.

Operational issues that needed to be addressed on a daily basis meant we were constantly reflecting and learning through changes to documentation, patient flow, landscape of the centre and staffing numbers alongside many more. Staff were amazing and approached each day with a clean sheet and took on whatever they were faced with and sometimes this was not easy. We had technical glitches that meant some appointments were cancelled to stop the centre running into the early hours of the morning which meant catch up over the next couple of days. Then came the next blow and NHS organisation were told in late December 2020 and again in early January 2021 to prioritise first doses over second doses which created not only operational challenges but emotional challenges for staff that had booked their second vaccine and were being cancelled in order to achieve more first vaccinations on a tight deadline.

The Trust received recognition for all its hard work in this programme from the Secretary of State for Health and Social Care Matt Hancock in Parliament .



Total number of vaccinations delivered through our centre (includes the vaccines administered by SECAMB and KMPT using our infrastructure, administration and centre etc.)

Month / Year	Number of vaccines administered	Number of vaccines discarded	Reason to discard	Vaccine manufacturer
December 2020	3,029	9	Expired	Pfizer
January 2021	10,472	0	N/A	Pfizer
February 2021	2,336	6	Vial dropped	Pfizer
March 2021	8,586	0	N/A	Pfizer
April 2021	5,941	0	N/A	Pfizer
May 2021	12	0	N/A	Pfizer
June 2021	227	0	N/A	Pfizer
July 2021	74	0	N/A	Pfizer



Percentage of front-line staff who have received their first dose of the COVID vaccine

Front-line staff



Percentage of doctors, nurses and midwives, other front-line staff who have received their first dose of the COVID vaccine

Doctors Nurses and midwives

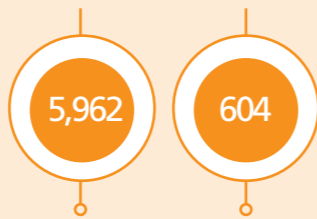


Other front-line staff



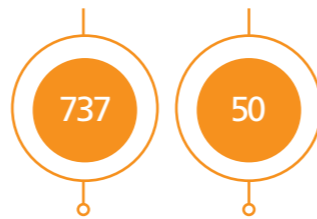
Total numbers of front-line staff who have received their first dose of the COVID vaccine and the total numbers of front-line staff who have not received their first dose of the COVID vaccine

Had first dose of vaccine Not had first dose of vaccine

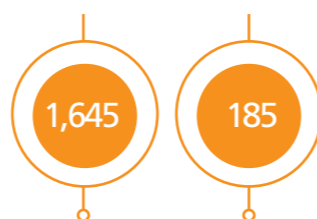


Total numbers of staff who have received the first dose of the vaccine and who have not yet been vaccinated broken down by doctors, nurses and midwives, other front-line staff

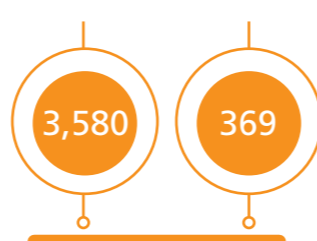
Doctors had first dose of vaccine Doctors not had first dose of vaccine



Nurses and midwives had first dose of vaccine Nurses and midwives not had first dose of vaccine

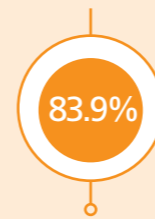


Other front-line staff had first dose of vaccine Other front-line staff not had first dose of vaccine



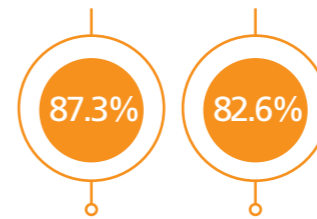
Percentage of front-line staff who have received their second dose of the COVID vaccine

Front-line staff

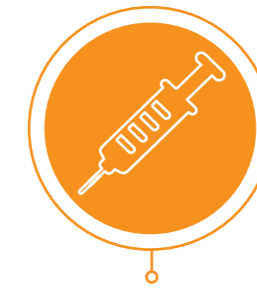


Percentage of doctors, nurses and midwives, other front-line staff who have received their second dose of the COVID vaccine

Doctors Nurses and midwives

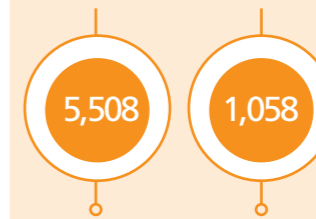


Other front-line staff



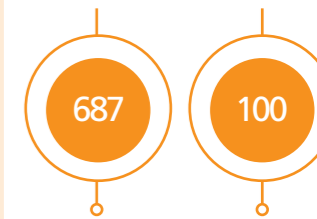
Total numbers of front-line staff who have received their second dose of the COVID vaccine and the total numbers of front-line staff who have not received their second dose of the COVID vaccine

Had second dose of vaccine Not had second dose of vaccine



Total numbers of staff who have received their second dose and not yet received their second dose broken down by doctors nurses and midwives, other front-line staff

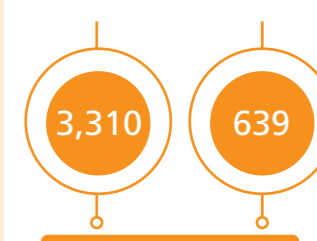
Doctors had second dose of vaccine Doctors not had second dose of vaccine



Nurses and midwives had second dose of vaccine Nurses and midwives not had second dose of vaccine



Other front-line staff had second dose of vaccine Other front-line staff not had second dose of vaccine



From staff to patient and back again

You never think it will happen to you and then it does!

As a clinically registered member of staff who was not on the front line and abided by all IPC rules, I never thought it would happen to me, but it did.

I had been working long hours alongside so many others setting up the Trust Vaccination Centre when overnight on the 23rd December I became very unwell and put it down to exhaustion. I had a Microsoft Teams call with the team whilst working from home on the morning of the 24th December. We chatted through actions and cover for the long Christmas weekend before going about our daily jobs.

The 24th December was my lateral flow testing day which I undertook at 1500 hours that day and was really shocked when it showed a positive result – where would I get a PCR done at that time on Christmas Eve? Of course, no place other than Maidstone Hospital where the guys in the labs were still working hard to keep us all safe. At 2200 that night my Manager and I received email confirmation of my positive result. Not the news I wanted but one that confirmed why I felt so ill and allowed me to ensure my family would be as safe as I could make them, by my isolation.

I spent the next four days locked away in my bedroom hardly able to drink due to the horrific taste in my mouth where my sense of taste had altered dramatically. By day four I had passed out in the bathroom and was feeling very poorly so off to hospital it was.

The staff in ED were told to expect me, as I arrived shaking and wrapped in three jumpers and a blanket the sight of them there dealing with patients who were queuing outside to be triaged in a calm, professional manner made me feel better – I no longer had to try and deal with this alone in my room for fear of my husband becoming unwell. I also felt guilty for being there, having to make them gear up in FFP3 masks, or respirators with filters and all of their PPE – I found it difficult to hear what was being said, probably a combination of how I felt and the masks muffling voices, but they were patient, thorough and very reassuring .

Three nurses and two doctors later, I was cannulated, on oxygen and told I was being admitted to the Respiratory Enhanced Care Unit – this was the unit that I had been part of setting up only a week before! Scared was the thought of the night at that point with a husband who had to say goodbye to me at the front door I was then wheeled to the unit.

Brilliant, caring, helpful, reassuring and kind are the words to describe my colleagues who cared for me in that first 48 hours. I saw and experienced things that I'd only heard about over the next days. When you suffer with claustrophobia, the thought

of a CPAP mask over your face is fear enough and when I expressed that fear the staff calmly said we will do everything to avoid that for you and they did - I cannot explain what that felt like, relief was probably the word of the moment at that time.

Thankfully for me I was then moved to a COVID ward where I spent the rest of my stay in a small side room with a tiny window watching the rain pouring down outside most of the time. I could feel myself starting to become tearful and isolated. The restrictions of movements required to keep staff and patients safe meant there was no access to a shower, no moving outside my room and no visitors - the same experience that so many of our patients had to endure.

This situation did not help staff either, especially at Maidstone where there are very few en-suite side rooms. Even though I knew the rules I still pushed my luck asking some of the staff to allow me to have a shower, and all credit to them even though they knew I was staff they followed the rules and very kindly offered me what alternatives they could.

Feeling both isolated and frightened that I would not see my family, and the occasional night of being scared as my oxygen saturations did not improve has made me appreciate different things in life going forward.

It has taken a long time for me to recover, and I am still not back to where I was. I was discharged on day nine after a long discussion with my consultant as I needed to get home and someone else would unfortunately need my bed.

That was a first, a wheelchair to the front door as I could not have walked if I had wanted to! My home and stairs were the next challenge and thank goodness my stairs are split level as I got a rest halfway. Ten days of no shower, washing by a sink and no hair wash you can imagine what was first on my mind as I got home. A shower don't be silly! I couldn't stand without support, let alone wash my own hair, so to be bathed and have your hair washed by your husband was a first - he tried but he's not used to washing long hair bless him!

The next month was slow as my body was very weak, muscle wasting had taken its toll yet my mind wanted something to do other than think about what my body couldn't do. So with the agreement of Occupational Health and my manager I started working a few hours, as and when at home doing emails and supporting the team - that was a huge positive step for me back to normality.

I am presently working back in the response role that I had been in for the ten months prior to becoming ill, and I am thankful to those that have supported me to get back there and are still supporting me.



If you asked me to sum up my experience, I would say there are not many things we could have done differently as a Trust to help people like myself who have been patients. The little things that I have reflected on that could help patients going forward I have shared with the Nursing Division and Estates and Facilities and some of these changes were made as soon as I raised them.

The staff be they permanent, bank or agency were superstars and even those you could tell who were anxious, double masked and kept more of a distance were caring in their own way.

Being a member of the clinical staff and then a patient admitted with COVID was not only a challenging experience for my family but a physically and emotionally challenging one for myself.

Recovery is ongoing and the support of my team reflects everything I have always felt about Maidstone and Tunbridge Wells NHS Trust. After 36 years at the Trust, it is like being one family, we help each other and we care for each other, and we do not always get it right, but we have ways of raising concerns and resolving situations or finding resolutions that work.

We care about our staff and patients and I'm proud to work here.

Long COVID - a new clinical service

National and local context

NHS England and NHSE/I Improvement launched its five-point plan to support patients suffering the ongoing effects of COVID-19 in October 2020. One of the commitments is to establish post-COVID-19 assessment clinics(PCAS) across England, which give patients access to multi-professional advice, so that they are put onto the right clinical pathway to treat their symptoms.

There are an estimated 60,000 people in the UK, but this is likely to be higher, who currently have ongoing need for post-acute COVID-19 management focusing on recovery and rehabilitation and this is likely to grow as coronavirus infection rates continue to rise.

Prior to the establishment of new clinical services patients were managed on an ad-hoc basis and are dependent on clinicians' knowledge. A recent focus group study indicated that while good care and support was given, many GPs were unsure of how to refer into existing services to provide further support.

The number of patients who need post-COVID syndrome management focusing on recovery and rehabilitation is likely to grow as COVID-19 infection rates continue to rise.

In October 2020 NHS England and NHSE/I Improvement announced a £10 million investment to help local services in every part of the country to bring together the right professionals to provide physical, cognitive and psychological assessments of those experiencing enduring symptoms, so that they can be referred to the right specialist help.

In order to be able to fully support patients (some of which are known to also be staff) through this particularly challenging time MTW were very keen to be involved in the conception of the PCAS service locally. The tendering process began and MTW are now very pleased to be the prime provider of this Kent and Medway wide service delivered in partnership with West Kent Primary Care. The service specification was produced by MTW from national guidance for post-COVID syndrome assessment clinics. The National Institute for Health and Care Excellence (NICE), the Scottish Intercollegiate Guidelines Network (SIGN) and the Royal College of General Practitioners (RCGP) have defined post-COVID syndrome as:

Signs and symptoms that develop during or following an infection consistent with COVID-19 which continue for more than 12 weeks and are not explained by an alternative diagnosis. The condition usually presents with clusters of symptoms, often overlapping, which may change over time and can affect any system within the body. Many people with post-COVID syndrome can also experience generalised pain, fatigue, persisting high temperature and psychiatric problems.

Due to the significant impact this was having both physically and mentally on our patients and staff a Post COVID Assessment Service (PCAS) was required for the Kent & Medway Integrated Care System covering a population of 1.9 million and encompassing the following Integrated Care Partnerships of which MTW was awarded the Prime Provider contract:

- Dartford, Gravesham and Swanley
- Medway and Swale
- East Kent
- West Kent

This meant a co-produced PCAS service led by MTW and delivered through partnership working with West Kent Primary Care has clearly defined outcomes:

Improvements in health outcomes

- Contribute to the reduction in in-hospital and overall mortality from COVID-19
- Improved quality of life for people who have had COVID-19
- A higher proportion of people who have had COVID-19 are able to return to work
- Change in depression, anxiety and/or PTSD when these conditions are present, using IAPT outcome measures

Reduction in inequalities of health care

- All patients have access to post-acute COVID-19 care that meets national best practice standards

Improved sustainability and resilience of post-acute COVID-19 services

- Improved patient flow between different elements of the post-acute COVID-19 pathway so that patients only stay in acute services when needed
- Development and rapid adoption of best practice / evidence based clinical guidelines with consistent implementation across providers, based on the NICE/SIGN guidance once released in December 2020
- Increased innovation and sharing of knowledge across organisations
- More rigorous and consistent monitoring of process and outcome indicators facilitated by improvements in data collection and reporting of data

Ensuring cost effective delivery of post-acute COVID-19 care

- Reduction in overall length of hospital stay
- Patients able to return to work when appropriate
- Resource services sufficiently and recurrently to ensure they become business as usual

Aims and objectives of service

Signs and symptoms that develop during or following an infection consistent with COVID-19 which continue for more than 12 weeks and are not explained by an alternative diagnosis. The condition usually presents with clusters of symptoms, often overlapping, which may change over time and can affect any system within the body. Many people with post-COVID syndrome can also experience generalised pain, fatigue, persisting high temperature and psychiatric problems.

Post-COVID-19 syndrome may be considered before 12 weeks while the possibility of an alternative underlying disease is also being assessed.

This includes patients who:

- Remained at home or in a care setting during their acute COVID-19 illness and who had positive SARS-Cov-2 serology or clinically diagnosed in the absence of a positive test or were not tested at all
- Show likely symptoms of Post COVID and are clinically triaged as such by a Senior Healthcare Professional, despite no COVID-19 diagnosis or antibodies;
- Were hospitalised during their COVID-19 infection and have been discharged

Some patients will require therapeutic input, rehabilitation psychological support, specialist investigation or treatment once they have been assessed at the clinic, and it is the responsibility of the clinic to refer patients on to existing services as needed.

It is anticipated that around 8,000 patients across the Kent & Medway Integrated Care System will experience Long COVID and will be required to be reviewed by the PCAS. Referrals are currently being received in the region of 70 per week. However, demand will be dynamic based on a cohort of patients who are currently waiting to be seen and those affected by future waves of an increase in infections.

The PCAS currently incorporates:

- Triage clinical hub – a clinical MDT who will review referrals on a twice-weekly basis (initially) and sign post patients to the appropriate part of the care pathway or order further diagnostic tests for the patient as required. The MDT consists of a respiratory physiotherapist, GP/physician and psychiatric care professional. Additional clinical staff should be available to join the MDT as required based on the referral requirement.

The hub is supported by a full-time administrator for:

- On-boarding of patients onto an app such as 'Your COVID Recovery' – this will include:
 - Training the patients to use the app
 - Undertaking a baseline assessment of their clinical condition either via the app or through a clinic assessment
- Monitoring of patients virtually through the app dashboards – this will include the review of data entered by the patients and providing advice to the patient or escalation as required on a weekly basis. It is anticipated that patients are managed through the app for a period of up to 12 weeks and then discharged or sign posted to other services as required for longer term management
- Provision of Outpatient appointments – in order to ensure equitable access for all patients, face to face or virtual provision of the MDT must be made available to support patients who are unable to be managed using the app or when a patient is being discharged.

Conclusion

The last 18 months have presented challenges for every member of staff and each department. But in our response to the pandemic colleagues have demonstrated they are a family of exceptional people providing outstanding care.

Everyone working at MTW went above and beyond what was expected of them. Their dedication and adaptability led to the prompt roll out of innovative ideas, new ways of working and a number of significant achievements.

Detailed planning supported the continued delivery of urgent care, the establishment of the ICC and vaccine centre and supplies of PPE – vitally important in protecting our patients and staff.

Departments including Business information, Human resources and Procurement, who have never been required in an incident control centre before, quickly understood the value and clarity provided by a command-and-control discipline.

As we move forwards it is important that we capture all of the lessons learnt and the innovation shown during the pandemic and continue to support our staff with a wide range of health and well-being services.

Recommendations

- Staff wellbeing: BC plans should have identified duties / jobs that can be done remotely.
- Clear processes for allocating home working and catch ups built into BC planning.
- Vaccination plan needs to include the need to make available a period of time for vulnerable staff if appropriate based on nature of outbreak requiring a vaccine.
- All staff working in clinical respiratory areas should be fit tested at local inductions.
- Changes to IT platforms such as Health roster should be maintaining to enable managing staff absence for a variety of reasons and encompassing the use of this data to support staff welfare.
- The trust Pandemic Flu plan will change to an infectious disease outbreak plan.
- Regular exercise test plans both local Business Continuity plans and trust wide plans.

Please find attached two booklets that staff from departments across the trust were able to share their experiences in.



The COVID-19 Pandemic

Our Story...so far



The year 2020 saw the NHS facing one of its biggest challenges - the Covid-19 Pandemic.

As a result we have had to change the way we work and how we care for our patients in a bid to keep not only them but also our staff safe from the virus.

Everyone working at MTW NHS Trust went above and beyond what was expected of them in response to the pandemic, reinforcing the fact that our diverse workforce really is made up of exceptional people who provide our patients with outstanding care.

This booklet has been put together to help highlight how the MTW family pulled together. It contains messages of support and thanks from our Chairman, Chief Executive and Chief Operating Officer, as well images and personal accounts from members of staff working at all levels across the Trust.



A message from our Chairman David Highton

I am proud to write a short note of thanks to all our staff and volunteers at MTW for this booklet which records the extraordinary skills and efforts you have all demonstrated during the COVID-19 pandemic.

For me as Chair of our Board, and for our Non-Executive Directors, the articles in this booklet serve as a permanent testament to the most challenging spring and summer MTW has ever experienced.

At the peak of the pandemic, the Non-Executive Directors and I were briefed daily and held weekly video calls to ensure we were constantly updated on all of your efforts and that we provided support where we could.

We are extremely proud of everything you all did, whether you were wearing full PPE in a red area or working from home. Many of you undertook different roles during the pandemic, using skills from your training or from roles you had not practised for some time. Your commitment, flexibility, skill and resilience were exemplary and you all have the enduring gratitude of the Board for everything you did.

A message from our Chief Executive Miles Scott



I have always been proud to work for MTW but never more so than when the pandemic hit. There was an extraordinary amount of preparation and implementation of work in a short space of time carried out by staff working across all levels of the Trust. The efforts of everyone, including those shielding, working from home or redeployed to a different role, were truly heroic and the sheer scale and pace of transformation in our hospitals has been monumental.

Our fight against the virus isn't over yet and there will be more challenges and hurdles to overcome along the way, but I want to take this opportunity to say thank you to each and every one of you for going above and beyond the call of duty every day.

We couldn't have done it without you and the public will be forever in your debt.

A message from our Chief Operating Officer Sean Briggs



The COVID-19 emergency was a major challenge for the whole of the NHS and our partners too.

It will have had an impact on each of us individually in many ways, from not being able to see loved ones, to changing our working patterns. For many I know it has been a difficult time, but I and the whole Trust board were so impressed and grateful for how everyone rose to that challenge.

At the start of COVID-19 I had been at MTW for just over a year and I already had seen clear examples of the whole organisation rallying to do amazing things for our patients, such as achieving the 95% A&E target, moving from 18 week position upwards by over 10% in a year, our response to

EU Exit and finally moving from being one of the worst performing cancer teams to the best in the country.

COVID-19 was no different with all our teams creating rapid, innovative solutions to the various and complex issues and challenges that arose. From our incredible ITU and medical teams to our amazing portering, estates, procurement and domestic teams, all of our staff played a huge role in making sure we kept our colleagues and patients safe. No Strategic Commander in any organisation could have wished for better support so thank you.

I know everyone worked hard to not only look after our patients but also each other, our volunteers and partner agencies and the response from our local community demonstrated just how well all of you did in managing the pandemic.

I am incredibly proud of all of our staff and you should be proud of the role you played too - whether you were shielding at home, redeployed to a different role or supporting the organisation in some other way.

Thank you for all that you have done for our organisation, staff and patients. I have always felt so lucky to work with just the most fantastic teams and colleagues at MTW and I know the next time we have to rally to meet a new challenge we will all do so just as well again.



Procurement - The Search For PPE

by Bob Murray, Associate Director of Procurement

As a department that generally tries to work quietly in the background, it was quite a change to suddenly find ourselves thrust in to the centre of the Trust's pandemic response, with PPE (Personal Protective Equipment) becoming the NHS acronym of the century.

Due to unprecedented challenges to the supply chain, our traditional supply and logistics partners quickly succumbed to the pressure and fell by the wayside, and we found that we largely had to fend for ourselves in a highly complicated and fast moving market place.

It is huge testament to the skill and dedication of our Commercial Support and Inventory Management System teams that we were quickly able to adjust our strategy. We created international links that allowed us to source stock directly from PPE factories whilst building a relationship with the BSI (British Standards Institution) that ensured we could check the validity of all the products being offered.

Logistically we needed to set up a PPE warehouse operation overnight to manage our stocks and get it into the critical areas when

needed. Our Inventory Management System came into its own here as Omnicell gave us the ability to closely manage our levels, identify trends and react before any PPE lines became critical.

The key moment for me came at a time when the media were screaming about PPE shortages on the frontline and our neighbouring Trusts were reporting significant issues. The Execs were constantly checking on our PPE position and expecting to have to support us in requests for mutual aid, only to find that we had good stocks with no concerns on any lines of PPE.

It was then that there was a gradual dawning of realisation across the Trust that we had got a grip on the situation and so the focus went from challenging our data to collaborating with us on finding further solutions to keep our frontline staff safe.

I cannot fault any member of my team who worked through those first critical months during the fight against COVID-19. A significant number of them took on roles that were alien to them, but no-one thought twice about

pitching in and doing whatever it took to keep the Trust running. Though the supply chain has now managed to catch up, the gradual return to 'business as usual' is presenting its own challenges. From focusing on six key COVID-19 wards and two ITUs, we are now tasked with supporting all clinical and non-clinical areas to keep everyone protected.

This is possibly an even greater challenge than the initial task, and with the potential for a second peak and winter pressures to come, we know we aren't out of the woods yet. But I am confident that with the team behind me we can react and adapt to any situation and, whilst we may not be the first department that people will think of when considering how the Trust fought COVID-19, we will in our own minds be content in the knowledge that 'we did that'.

"No-one thought twice about pitching in and doing whatever it took to keep the Trust running."





Estates And Facilities

by Doug Ward, Director of Estates and Facilities

The reflections from the Estates and Facilities Directorate over the peak of the COVID-19 pandemic are, for all of us, somewhat blurred as the demands which needed to be met across all sectors were substantial.

It was however a period of intense activity and presented an incredible opportunity of working with other members of the Trust that, under normal circumstances, we would never have had the opportunity to do.

Laundry

During the period of April and May 2020, a total of 840,778 pieces of linen were produced. The Trust's normal demand is 400,000 pieces of linen over the same intervening period.

Support was provided to the Trust by the Faversham Linen Service which was grateful for the business as the majority of their clients had closed for the pandemic.

The laundry staff at both locations worked tirelessly to provide a sterling service to the Trust.

Estates

Both the Trust's Estates Department and Interserve constructed and erected at exceptionally short notice, new walls in both acute hospitals to create enlarged ITUs for the treatment of COVID-19 patients.

Single rooms at Maidstone Hospital were converted to negative pressure operation and installed with medical gasses in order to provide single isolation rooms for COVID-19 patients receiving therapy from mechanical ventilators.

The Trust faced an acute projected shortage of medical oxygen supply at Maidstone Hospital. But following an application to NHS Improvement and NHS Estates, MTW was successful in a bid to obtain modifications to the Maidstone Hospital bulk liquid oxygen system. This was achieved by the British Oxygen Company working long hours with the Trust to increase the vaporiser capacity of the liquid oxygen system from 1,400 l/p to 2,800 l/m. Interserve, the hard facilities contractors at Tunbridge Wells Hospital, worked tirelessly

on providing ward construction modifications and providing full assistance with maximising medical oxygen supply.

Facilities

The facilities management domestic services provided an outstanding service by considerably increasing the frequency of cleaning and sanitisation throughout the two acute hospitals. In particular public areas, circulation space and public toilets, including all touch points, were on a continuous 24/7 cleaning cycle.

The catering department provided exceptional service by stepping up to the demand to feed patients and provide free food for the sustenance of exhausted clinic staff. In addition, food packages were prepared and delivered to isolated staff in accommodation.

The Directorate also worked tirelessly with external groups creating offsite testing and pharmaceutical facilities.

The entire experience was both exhausting and highly rewarding for the Estates and Facilities Directorate and the staff within the department who worked extremely hard to support patients and clinical staff.

April - May 2020
840,778 pieces of linen were produced - normal demand is 400,000 pieces.

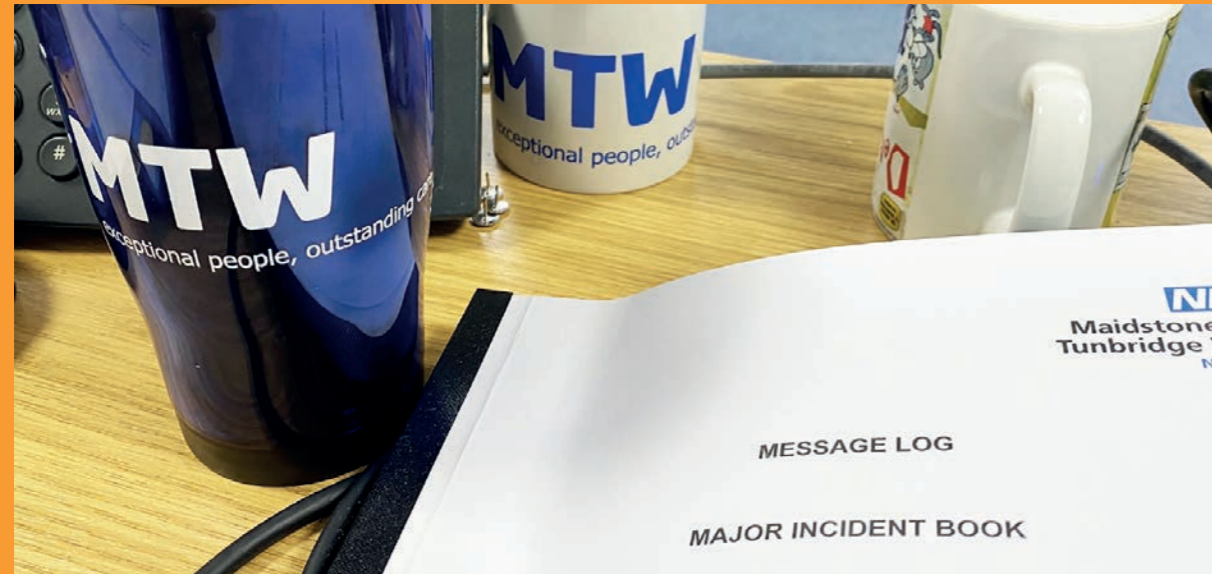


Transformation Team

At the start of the outbreak of COVID-19 the Transformation Team, which consists of Programme Management Office (PMO), Joint Programme Management Office (JPMO), Transformation and Quality Improvement Faculty, extended their working pattern to seven days in order to support the Incident Command Centre (ICC).

With many of the team having previously held clinical or operational roles, a team 'skills check' was done so staff members could be redeployed into key functions, if and when required. In some instances this also meant some members of the Transformation team learning a completely new set of skills so they could support other teams across the Trust such as the Mortuary team. At the start of the outbreak, many of the team were deployed to the COVID Testing Directorate to support FIT Testing, PPE, and swabbing and five members of the team still actively support that directorate.

As Transformation Programme Director, I supported the Strategic Commander and Tactical Commander within the ICC, working alongside clinical and operational colleagues to help deliver 21 projects at pace. Progress updates were provided three times a day to the ICC in order to provide assurances that we continued to have the right things in place at the right time to keep our patients and staff safe.



Command And Control – The Incident Command Centre

by Katie Goodwin, Divisional Director of Operations for Cancer Services, and Charlotte Wadey, Director of Nursing and Quality Cancer Services / Lead Cancer Nurse

How to write about the Incident Command Centre (ICC) in a paragraph?

Not easy, when you consider the sheer number and variety of staff involved (without whom the ICC wouldn't have been nearly as effective as it was), the incline of the learning curve we all climbed during those 10 weeks, and the sheer enormity of the challenge faced.

Charlotte would tell me in her usual frank and practical style – a style, combined with huge amounts of support that I couldn't have appreciated more during our time together in the ICC - to keep it brief!

The story has to start with our Emergency Planning team, without whom we'd definitely still be finding our way around a logbook!

It all started at 7am on Monday 16 March in Costa Coffee with Director of Emergency

Planning and Communications John Weeks (before we had to take the tough decision to remove the seats) attempting to find the part of our brains that recalled our tactical command training. For anybody who knows John, his favourite slightly exasperated look was definitely on show that morning! On the other hand Deputy Head of Emergency Planning and Response Julie Elphick never bothered with the finding the brains bit – instead perfecting the art of telling us what to do whilst making us think we'd thought of it!

And then there was lovely Mel Manktelow who, without any complaints (or any of the abuse), just got stuck into our ever-growing list of problems.

Talking about growing lists, our action log. What a state that was. If I recall correctly, Abi

Hill and Lisa Urquhart looked at it with us at the end of week one and it was well over the 200 mark and not one was ready to be crossed off. And that was all before we had our Monday morning call with our CEO Miles Scott! The Programme Management Office (PMO) team worked their magic to transform our Excel spreadsheet into something that looked like a plan and took on the co-ordination of a growing number of projects.

Now we just had our day-to-day actions (including that list from Miles) and we needed military style co-ordination for that. Who to choose but our board secretary team? Rather than just contending with three emails a week, reminding us to send in our regular cancer report by midday on a Friday, we now had Daryl Judge, Rebecca McQueen and Erica Smith in three huddles a day, glaring at us across the room and whipping us all into shape!

The 10 weeks we spent in the ICC were definitely an education - from Doug Ward, Director of Estates and Facilities, telling me to put on his high vis jacket as we walked out of his office (yes, it was freezing when we started) to dredge up some memories of GCSE physics by a liquid oxygen tank, to Charlotte learning all about blue elbows and her way around a Continuous Positive Airway Pressure (CPAP) machine.

Our brains were definitely left hurting on multiple occasions. As for our poor loggists, they had to write it all down and what a stunning job they did.

Then we come to the nightmare mailbox. We had days where we were receiving 100 emails in an hour. To our rescue came the Patient Safety team and some extremely cheerful trousers, even popping back in when they weren't on shift to make sure we "didn't muck

up the filing system!" From the emails about sitreps to the sitreps themselves! What can only be described as a journey, starting with Charlotte's handwriting all over the walls to the slick operation it is today, with our wonderful Business Intelligence team continuing to crunch the numbers for us on a daily basis even now. We couldn't write a piece on the ICC without mentioning Bob Murray, Sara Mumford, Jack Moss, Gemma Craig and the whole of our procurement and infection control teams. The reason we were able to achieve what we did to keep our patients and staff safe during the peak of the pandemic was absolutely down to them.

We have definitely run out of room to keep writing! There are just too many of you who supported the ICC....Human Resources, our General Managers, our Execs' PAs, our whole Estates and Facilities teams and the Communications team. The list is just endless.

We appreciate we have made light of what has been a really serious situation for everyone both at a personal and a work level, however, it was the jokes, abuse and laughter from all of you in the ICC that allowed us to both keep going over those 10 weeks.

Thank you to everyone for all of your help, support, ingenuity and sheer hard graft – we couldn't have done it without you.





Critical Care

by Lindsey Reynolds, Lead Matron Critical Care Directorate

The Critical Care COVID-19 journey began for most staff with a request to attend a Critical Care Directorate COVID-19 training day, or local training days, which had been organised by the ICU Clinical Educators, and the Simulation team, to help give non-ICU staff an insight into ICU care.

Dr Andy Taylor, with his previous experience of caring for patients with life-threatening infections, led the team through the practical and emotional concerns of caring during a pandemic in order to keep yourself, your family and patients as safe as possible.

Meanwhile, many 'walk rounds' occurred setting out red, green and amber areas as everyone became fluent in the language of donning, doffing, FFP3 and aerosol generating procedures.

Escalation areas were planned for the 400% increase in ICU capacity that we were told to expect. Estates, IT, Procurement, Materials Management, other divisions and directorates all came to our aid to prepare. What previously took weeks to negotiate happened in days or hours - walls were built, equipment found, disposables ordered. It really was NHS teamwork at its best. Rotas were also changed

and all staff working within Critical Care, unless issues were identified, moved to a 24hr internal rotation pattern, including Endoscopy and Theatre staff who don't routinely do nights and weekends. It's fair to say that all of the staff were anxious about the coming tsunami of COVID-19.

COVID-19 in ICU was difficult. Everybody felt stressed, out of their depth or afraid of what the future might hold for themselves or their family at some point. But on reflection what we have learnt is that everyone had something to offer – Operating Department Practitioners (ODPs) had great transferrable skills, whilst Clinical Support Workers (CSWs) watched and reassured patients and reminded staff at the end of their shift to doff safely and not contaminate themselves. The ICU staff also learnt that you can't always be quite as in control as they want to be (which was a very hard lesson for some). We worked together to care for some of our sickest patients, and we are now living with the knowledge that we might have to do this again.

To all of those who helped us, thank you for your hard work and sleepless nights. We will no doubt need your support again in the future and we would welcome you back in an instant.



Anaesthetics and Critical Care

By Dr Kate Stannard, Consultant Anaesthetist

I think all of us in the anaesthetic department remember when we first had to face the prospect of managing the COVID-19 crisis. It was in a consultants' meeting in February, before we had had any admissions but we knew that the major hospitals in London were filling up fast and it was only a matter of time before we did too.

It seemed like an almost impossible task for a relatively small district general hospital to scale up to face such a challenge. A few things were evident though, we did not have enough Intensive Care Beds or enough Intensive Care staff and the anaesthetic department was going to be mainly responsible for managing critically-ill Covid patients - a daunting prospect.

All anaesthetists do intensive care as part of their training but only a subset go on to specialise as a Consultant combining it with a career in anaesthesia. A plan was made for us all to join our ICU colleagues on Intensive Care and in the meantime plans were put in place to increase our ventilated bed capacity from 18 beds across both sites up to a colossal 75.

Our Clinical Director Dr Paul Moran, Anaesthetist Dr Andy Taylor - who has invaluable experience having worked in West Africa during the Ebola crisis, and Lead for ICU Dr Dan Moulton, drew up plans to expand into theatres and theatre recoveries. This was quite an undertaking which involved dividing clinical areas into red and green zones, installing temporary walls, designated intubation rooms, creating red lifts and donning and doffing stations.

Before we knew it we were going live. Our anaesthetic junior doctors were all working as teams with us around the clock and they were superb - they really stepped up beyond any of our expectations and worked tirelessly. We were also so fortunate to have our theatre staff prepared to upskill and look after ICU patients - a real challenge as although experienced in surgery and anaesthesia very few had Intensive care experience. They were amazing and we would never have coped without them.

From a personal perspective, I was so impressed with the way our department ran the show with excellent leadership and organisation. I was also touched by the generosity of our local community with never ending supplies of delicious food delivered day and night which really helped flagging spirits and made us feel like we were never forgotten.

We all learnt a lot from our first exposure to a pandemic that none of us have had to deal with before – from what went well to inevitably what could have gone better. However one thing that can be said with certainty is that all intensive care, anaesthetic and theatre staff did their very best.

Let's Start At The Beginning... by John Weeks, Director of Emergency Planning and Communications

We started 2020 working hard on our EU Exit response, monitoring winter pressures and hoping that snow would stay away. At the same time we also had one eye on the novel Coronavirus (COVID-19) in Wuhan, China. On Friday 24 January the first guidance appeared and in early February we started to ramp up mobile testing plans in conjunction with partners. The swabulance, as it became known, the staff from Kent Community Health NHS Foundation Trust (KCHFT) and MTW did an amazing job to keep the testing going in the early stages long before the response was ramped up. Next came the Coronavirus Assessment Pods which arrived on Friday 7 February. The speed at which we got those up and running was amazing. All the while our teams were getting used to new ways of working but as usual getting to grips with it quickly.

The person on call for Emergency Planning in the early days rarely got an undisturbed night's sleep with endless questions, advice and dynamic changes that had to be set up. We also became best friends with the fab staff in the labs too - often out of hours! Our Incident Command Centre (ICC) which had been set up at the end of February was soon reinforced and we thank the Patient Safety team for moving out to make way for it! Those busy few weeks before we ramped up the Trust's response are a blur now but even then we were privileged to have the help and support of so many MTW staff and volunteers working late into the night and at weekends too. On Monday 2 March the first positive COVID-19 test came back on a person working at an address in Maidstone and then the cases



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started. Two days later the UK had 85 cases. Panic buying soon followed and toilet rolls vanished from the shelves! Almost three weeks later, on Sunday 22 March, Prime Minister Boris Johnson put the UK into lockdown and by then the NHS was in full pandemic response mode. Our Emergency Departments quickly got to grips with triage and streaming those with suspected symptoms and testing those who arrived at the pods. Their ability to deal with the situation at the front door 24/7 and keep flow going was amazing. I also want to pay tribute to our Clinical Site Managers who kept the sites running despite working behind piles of PPE in their office and a dynamic situation changing hour by hour across the sites with good humour and ruthless efficiency. It was amazing to see local business owners and residents supporting the Trust with donations - from flowers on Mother's Day to

thousands of Easter eggs and lots of other gifts such as scrubs, cakes and hand and face creams. On Saturday 28 March we were asked to take the lead in planning for a Nightingale Hospital in our patch – emergency hospitals created from nothing - and so teams from Emergency Planning, Estates, IT, South East Coast Ambulance Service (SECAmb), the Clinical Commissioning Group (CCG) and the Army quickly set to work. Although the plans were not needed we nevertheless proved we could respond quickly and effectively even in the middle of a pandemic. Our staff welfare arrangements were quickly put in place too. Free food and drink were made available as well as staff only break out areas. We were also joined by the Project Wingman teams from the airline industry at the start of May who have been amazing.



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The Hidden Army

by Sharon Melville, Acute Flow Manager

Not everyone was working in our hospitals during COVID-19. Many members of staff were redeployed, worked from home and shielded.

Sharon Melville, Acute Flow Manager, was one of those members of staff. Here's her story....

I have been homeworking since Monday 23 March and my role has evolved into carrying out welfare checks on all of the COVID-19 positive patients who have been discharged from our hospitals. This involves ringing them approximately seven days after discharge and then at approximately six weeks. All of the patients are so grateful to receive the calls. I also enrolled another homeworking Ward Manager for a short time to assist me when I realised that I had at least 300 patients to call, which equated to 600 calls in total!

At the start of the pandemic the first few weeks were a real challenge, not so much because of the homeworking but because I wasn't allowed to leave my house for at least three months as I had to shield.

As time has gone on I have missed the camaraderie of the teams that I work with and see on a daily basis. Not leaving the house, not seeing any family for three months was hard coupled with the fact my partner, who works as a senior sister in the Critical Care Outreach team, and I were almost living separate lives. This was due to the fact that at the height of the pandemic, in order to protect me she moved out of our home and lived in a camper van parked on the drive to ensure I did not come into contact with the virus. Eventually she moved back into our house and slept in the

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living room on a camp bed. I am so grateful to her for protecting me from this potentially deadly virus.

What has gone really well has been the support from IT for the whole homeworking set up. They have given up many hours of their day to help me as there were some challenges with the original set up of the desktop at the start - multiply that by the whole of the homeworking staff who have also contacted them for help and support and I can only say they have done a tremendous job in keeping us all connected.

The loneliness has been tough at times, especially in the early days when my partner was not in the house and working extra shifts to cover the needs of the service. Feeling part of a team was also a challenge. I would love nothing more than to go back to how it was and return to work in the clinical setting, but I know this will not be possible in the short term.

My top 3 tips for homeworking are:

- Keep in touch with the real world on-site.
- Spread your work out to meet your needs - be much more flexible than on-site.
- Only do your hours – it is so easy to work extra and not take proper breaks when at home.

I hope that if homeworking becomes the norm that it is talked about so those in the workplace remember their colleagues who are working from home at all times.

Everyone has faced an unprecedented challenge during the pandemic – and it's not over yet!



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Infection Prevention and Microbiology

by Dr Sara Mumford, Director of Infection Prevention and Control

As a Trust we are used to infection prevention being an important part of everyday life, but we have never experienced anything like COVID-19 before.

Infection Prevention finally became the most important thing in everyone's life as we worked to protect our staff from COVID-19 and keep our patients safe whilst in our care.

From the very start, the Infection Prevention and Control team got involved by helping the wards and the staff prepare for the arrival of the pandemic.

The team were out and about, training ward teams in the wearing of Personal Protective Equipment (PPE), raising awareness of new guidance - especially those issued at 5pm on a Friday ready for implementation on Monday - and all of the many changes that happened as a result of the UK learning how to manage COVID-19 patients over time. We put together guidance documents, posters, checklists, and letters and revised them all several times as the national guidance changed.

We worked closely with the Incident Command Centre (ICC) making many, many decisions about all aspects of infection prevention, including some things that we had never had to think about before. Dressing up in all manner of PPE in the

control room to see if it was suitable to purchase was also a daily occurrence.

We made wonderful new friends and connections throughout, meeting new people and understanding what their roles were and how we could help each other.

Despite there being just five infection prevention nurses, the team worked longer days and provided a 24/7 on call service at the height of the pandemic wave. We welcomed new members to the team with admin support seconded from Health Records and PPE officers seconded from other areas.

The team has done, and continues to do an amazing job during the pandemic and they couldn't have done it without the support of all of the other staff at MTW – what a team!

Meanwhile, in the microbiology laboratory all went quiet as the number of patients admitted suddenly dropped, GP surgeries closed and the number of specimens slowed to a trickle.

Thank goodness we had that time because it was needed to train the biomedical scientists how to use new analysers and new tests for COVID-19. The team had to be trained up rapidly and the new tests validated so that we knew we were providing accurate results.

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The working day was extended to 10.30pm, although on many days the biomedical scientists were still working at midnight ensuring that results were available quickly. This is still the case and the lab team continue to provide rapid results not just to our patients but to our staff, our partner organisations, as well as nursing home patients and staff.

The first positive result was on Saturday 21 March and then the floodgates opened and the lab was soon swamped with swabs. Other lab staff were seconded across from blood science and cellular pathology to support microbiology.

We borrowed equipment and people from the University of Kent, Canterbury Campus and everyone pulled together to make sure that the results were out as soon as possible.

Then there was antibody testing which became a major project with virtually every member of staff in the Trust wanting to be tested. The lab worked closely with the COVID Testing team to devise a plan and it worked! Now it's back to something closer to normal in the main laboratory the team are finding themselves even more stretched with a full microbiology workload as well as the additional COVID testing. A mammoth task!

Surgical Division

by Sarah Davis, Director of Operations for Surgery

The priority for the Surgical Division over the last six months has been to ensure that any patient requiring cancer or urgent and essential care has been able to have surgery when they need it. This proved difficult as our ITU capacity needed to expand to meet the COVID-19 demand. As a result theatres closed and our critical care workforce were utilised to support this. We therefore had to manage our patient flow by instigating the following:

- Patients were transferred to independent sector hospitals across Kent and Consultant Surgeons, Anaesthetic Consultants, some nursing staff and junior doctors were also sent to the hospitals to support our patients.
- All patients on the waiting lists were risk stratified using a national prioritisation framework and then communicated with following that process.
- Clinical administration unit phone lines remained open so anxious patients had a communication line.
- Outpatient appointments were carried out by telephone or video conference calls.
- A COVID communication letter was sent to our longest waiting patients.
- Endoscopy procedures were suspended in line with national guidance.
- Green and red patient pathways were implemented.
- Restart and recovery of the elective pathway for our patients commenced when the ITU provision was able to reduce.

Many staff have gone above and beyond the call of duty in order to keep our patients, wards and departments safe and the divisional management team are immensely proud of the way our teams reacted to the first wave of the pandemic and then to the restart for recovery.



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The IT Departments

The IT Departments

The IT Departments have worked incredibly hard during the pandemic and I am extremely proud of all of them and the work they have accomplished.

The IT family includes IT Services, Health Records, Clinical Systems, IT Programmes and Information Governance. The teams have worked tirelessly to ensure colleagues and patients were supported during the pandemic and did everything they could to bring new ways of working to the Trust. They have been innovative and industrious. They have all supported staff offsite as much as those onsite and I couldn't be more proud of the work that they have undertaken and the support they have given the Trust, and each other. Watching and feeling the camaraderie has been phenomenal. Thank you to each and every one of you!

Health Records Clinical Management Services

The reduction in face-to-face outpatient clinics during the COVID-19 crisis didn't mean rest

and relaxation for our Health Records team – in fact, they were as busy as ever. The reduction in footfall as a result of the crisis allowed the teams to get ahead of the game.

We redeployed three members of staff to help the Infection Prevention and Control team. On a ward, the team opened a pop up office which enabled them to catch up on prepping and scanning eNotes – they also trained over 10 members of staff to help with the process. We have also been able to dedicate time to review the monthly uncashed reports which now means that patients without outcomes recorded on PAS are updated more quickly.

The team have also done a lot of work to validate the list of patients with duplicate alerts and have removed them, as well as merging patients who had one NHS number and two hospital numbers. The Health Records library has never looked so good, it has been fully culled and the remaining records tracked appropriately. Going forwards this makes it so much easier for the team to find health records!



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The Maidstone office is looking good too, having had a spring clean by one of the team, sparking a bit of 'clean envy' from the other offices!

Clinical Systems Management Team

The reduction in footfall of staff didn't mean rest and relaxation for our Clinical Systems Management (CSM) team either; they too were as busy as ever.

Every change to a ward and its configuration meant that the PAS system needed to reflect this, including the creation of our swabbing clinics. New correspondent and appointment letters had to be added to the PAS system as letters were constantly changing as and when new government legislation came in. The wards needed to collect COVID-19 data. The Admit, Discharge and Transfer (ADT) whiteboard module required quick and seamless set up allowing wards to collect vital data so the Incident Command Centre (ICC) could monitor the situation on a continual basis.

The CSM team needed to find new ways to replace face to face training very quickly so they created over 100 videos and user guides and placed them on MTW Learning, thus enabling staff who had being redeployed, recruited, shielding, or working from home to complete system training away from the hospital. COVID-19 also spurred the team on to focus on progressing several work streams to help deliver digital care. This included an upgrade to eNotes.

IT Services and Programmes

During the pandemic our IT teams worked tirelessly to support the Trust in so many different ways. The first was moving the ICC at the start of it all and providing resources for people to work in there.

As the organisation transformed the way it works, with staff working at home or



redeployed to other areas, our teams made a significant contribution to enabling those changes to happen. We issued over 500 computers and laptops for homeworking along with 500 remote access, phone accounts and user guides. This was accomplished in a matter of weeks to enable staff to work from home safely.

The setting up and resourcing of new wards such as the new ICU and office moves were resourced. We have enabled hundreds of Cisco Webex and Microsoft Teams accounts, increased internet bandwidth, provided iPads for staff and also patients so they could keep in touch with their loved ones.

We also deployed WhatsApp and Hospify for many staff, supported the rollout of Video Consultation Appointments, protected the Trust with additional security features, new communications and TV screens and provided the ward areas with additional computers on wheels whilst also dealing with thousands of IT questions!

The team have also supported the delivery of new clinical systems, for example Brainomix to support stroke services, and have continued to work on a large number of projects within the Trust including the Sunrise EPR, the move of radiology onto a new information system and the introduction of the Kent and Medway Care Record.

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Thank you for everything you're doing



The COVID-19 pandemic Our story... chapter two



Joint message from Chief Executive Miles Scott and Chairman David Highton



As we reflect on what has been an unprecedented 18 months, we would like to express our heartfelt thanks and gratitude to our staff who have continued to deliver safe, quality care for our patients during what has been the most difficult time in our NHS history.

As we responded to the pandemic, we've seen an extraordinary amount of work achieved by our staff, in a short period of time, working across all levels of the Trust which has been truly phenomenal.

Demonstrating skills, innovation and dedication, staff have quickly adapted to new ways of working, developed patient pathways and rapidly increased our critical care capacity. Nevermore have the words 'exceptional people providing outstanding care' been clearly shown each day.

Despite these challenges, we have continued to maintain our Emergency Department and cancer services performance, tripled our ITU capacity, and rolled out an incredibly successful vaccination programme, reaching over 6,400 staff in just nine days. We also found ways to support each other even more with the launch of successful schemes such as One Team Runner – a band of non-clinical volunteers who volunteered to work behind the scenes to help our nurses and staff on the wards.

In this booklet, which is the second chapter of 'Our Story', you can read more about these initiatives and personal accounts from some of our exceptional people based on their experiences of working during the COVID-19 pandemic.

Message from Chief People Officer Sue Steen



NHS staff have faced an extraordinary amount of pressure during the COVID-19 pandemic, with so many teams going above and beyond to provide the best care to patients who desperately needed their help. Many staff undertook different roles during the pandemic while trying to maintain their normal workload. Many colleagues also worked alongside different teams and managed to work flexibly and seamlessly to ensure the Trust was able to continue providing lifesaving care.

We are all so proud of our amazing staff who have acted so selflessly during this time, but it is important to remember that your health and wellbeing is also just as important.

It is hard to imagine just what you have all been through during this time, dealing with the stress and exhaustion that you faced while managing to somehow keep going. If you ever feel that you are not okay or you are overwhelmed or struggling, please remember that you can speak up and we will be here for you.

One Team Runner scheme

One Team Runner scheme (OTR) was launched in December 2020 with the simple aim of supporting nurses and staff on the wards who were struggling under the pressure of caring for an overwhelming number of COVID-19 patients.

A band of non-clinical substantive staff volunteered following a Trust-wide plea, to run errands, answer the phone, collect items for patients and generally help behind the scenes.

Their support has been incredibly valuable to the welfare of clinical staff, especially during the height of the second wave of the pandemic.

Growing from an initial response of 14 to 230 people, by January 2021, who stepped forward to help, there has now been an additional layer of new bank staff recruited to support the teams.

The scheme was set up and is run by the Patient Experience Team, Transformation Team and others working as the OTR team alongside their day job. Equipped with appropriate Personal Protection Equipment (PPE) and Hand-Face-Space guidelines, the volunteers can opt-in or out of working in clinical areas. Everyone has different skills to offer such as roster experience, HR skills and stock control.

Kathryn Brown, Transformation Programme Manager and part of the team that initiated the scheme, said: "What makes the OTR scheme unique is the preparation,

on-going training, feedback and growth for all involved. Volunteers are advised about what to expect and what not to do and have a de-brief following their shift. They are allocated a ward or area and stay with them for the duration, allowing knowledge and confidence to build. Information from de-briefs is valuable, not only can it enhance the OTR volunteer experience but it can also provide a fresh perspective, offering helpful ideas for improvement and transformation."

Going forward the OTR team have ambitions to extend the scheme further.

"We are looking at creating OTRs as a permanent fixture, devise a training programme, including patient flow, patient facing activities and offer all staff a 'shop floor' experience once a year," said Kathryn.

If you would like to volunteer or find out more information please contact: mtw-tr.oneteamrunner@nhs.net



Expansion of the Intensive Care Unit

By Lindsey Reynolds, Lead Matron, Critical Care Directorate



The COVID-19 pandemic has placed enormous pressure on Intensive Care Units (ICUs) nationally and the equivalent of 27 more ICUs were opened in the south east in January this year, compared to the same period in 2020.

For MTW this meant planning for a 400% increase in ICU capacity, which thankfully was not reached in the first wave. But with the second wave and the spread of the new Kent variant, the ICUs were again under intense pressure.

Lessons learned from the first wave were implemented with the increased use of non-invasive ventilation and novel therapies such as Dexamethasone and Tocilizumab. But in January we were asked to prepare for super surge capacity, which involved further planning and requests of essential equipment and supplies from the Department of Health and Social Care (DHSC) stores.

The main concern throughout the peak waves was the availability of skilled staff. ICU staff managed patients (sometimes up to four) with the help of other qualified staff, when usually one member of ICU staff would care for one patient on the unit.

From the cardiac monitor and blood results, they made decisions on giving electrolytes (at extraordinary concentrations). They managed medications for all of their patients, and maintained vascular access lines. They also supervised bedside care such as maintaining hygiene, repositioning patients, and aiding their comfort.

Theatres and endoscopy staff were drafted into ICU along with any other staff with critical care skills. The toll on staff was immense, especially for those not used to seeing patients so unwell and the number of patient deaths.

It soon became clear that we needed to expand our ICU to treat the increased number of patients and to separate COVID and non-COVID patients.

At Maidstone Hospital the old Acute Medical Unit was utilised to allow patients to be cared for in bays, spreading our scarce ICU nurse workforce across the area. At Tunbridge Wells Hospital we built a COVID ICU in the area which the Short Stay Surgery Unit (SSSU) used, and during the period between waves one and two this moved to the old Coronary Care Unit.

However, with the second peak and so many patients coming in, the team moved again to SSSU and subsequently back to what is now the High Dependency Unit post the peak of the second wave.

Moving an ICU is no small challenge and would normally take months to plan, but amazingly the teams managed to accomplish these moves in just days.

At Tunbridge Wells Hospital, the previous CCU was also converted into a high dependency unit. Due to the COVID-19 pandemic and demand this area has been used in multiple ways including as a 'red ITU'. The HDU is currently the assigned area for accepting COVID patients as demand requires, and at Maidstone Hospital there has been an increase of 14 extra bed spaces, going from 17 to 31.

The permanent expansion should mitigate the risk of dealing with any further waves and reduce the need to disrupt other services to the levels experienced in the first and second wave.



“Moving an ICU is no small challenge and would normally take months to plan, but amazingly the teams managed to accomplish these moves in just days.”

The health and wellbeing of all staff involved in the ICU expansion remains a priority, and recruitment is underway for additional nursing staff, consultants and the introduction of a new clinical psychologist post. Also, to make sure we are well prepared, additional equipment is being brought in, as well as additional applied health professional support from physiotherapy, dietetics, speech and language, occupational therapy and pharmacy.

The last 12 months has taught us so much, and if there is another outbreak and spike in COVID-19 cases we've got a plan and have procedures in place to deal with it.

The Respiratory Enhanced Care Unit (RECU)



During the pandemic, the Respiratory Enhanced Care Unit (RECU) played a vital role in helping to save the lives of many patients with COVID-19 who required non-invasive ventilation treatment to allow them to breathe.

The unit was created in response to the high number of COVID-19 patients being cared for on Edith Cavell, Pye Oliver and John Day wards who required continuous positive airway pressure (CPAP).

This is a machine which pushes an air-oxygen mix into the mouth and nose at a continuous rate, keeping airways open and increasing the amount of oxygen entering the lungs. It can only be administered by specialist respiratory teams who have undergone training on how to use it.

Due to the number of patients who required constant ventilation support, and the oxygen lines on the wards being heavily used which they weren't designed to deal with, this led to constant alarms warning staff about the pressure.

A solution was quickly found though. Incredibly, in just 24 hours the RECU was moved and set up in the 12-bed unit in the former ITU during mid-December, staffed by highly skilled nurses who had been specially trained to give the specialist care needed to maintain the continuous flow of oxygen to the patients.

Luckily, when the second wave of the virus hit there were enough nurses who had received the specialised training that the hospital was able to cope, with John Day and Pye Oliver wards acting as overflow wards when the numbers in early January were at their highest.

Mansiri Gurung, the matron on the unit, shares her thoughts on what it was like working with the RECU. She said "It was a real struggle at times dealing with so many patients, but it has also been a good teambuilding experience and a great opportunity for staff to show what they were capable of.

"Staff preferred working in the RECU because it was a specialised unit that focused on one specific field, and it has led to some members of staff being interested in further training in enhanced respiratory.

"Staff also felt safer working on the unit as they were no longer split between three different wards. With COVID-19 positive patients being cared for on one ward, this lessened the risk of cross contamination around the hospital."

"Staff preferred working in RECU because it was a specialised unit that focused on one specific field."

Portering through the pandemic – Maidstone Hospital

Throughout the pandemic staff in the Portering Department showed great resilience in adapting to the challenges to maintain their service to the departments, ensure patient safety, while at the same time safeguarding their wellbeing.

One of the major challenges for the department was the movement of severely ill COVID patients from wards to ICU which required detailed forward planning.

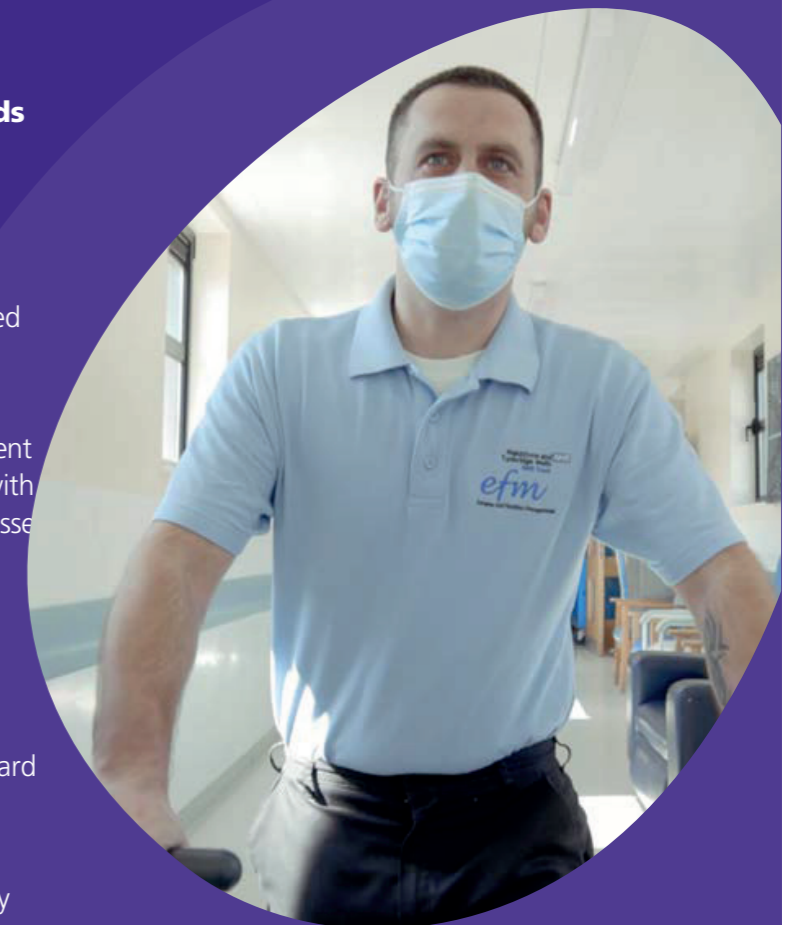
Sarah Gray, Assistant General Manager, Facilities, recalls; "Wards had to be swapped to try to contain the outbreak and this involved the porters having to move all patients and transferring them onto new beds.

"At the height of the pandemic, the requirement to keep the corridors clear was paramount with the constant removal of cleaned beds/ mattresses to the newly erected bed marquee.

"Thankfully a member of the supervisory team kindly volunteered to be trained and take responsibility for all the porters fit testing requirements, which gave the initial testing team more time to concentrate on ward staff.

"By this time, the porters were starting to feel the strain and with many staff affected by COVID-19, this presented us with staff challenges. Thankfully, the pressure eased with the appointment of an additional 13 porters who were ready and eager for action."

In November, the Portering Department introduced a new system to enable departments to allocate tasks to the porters. This took a little while to 'bed in' as staff become familiar with the system through the support and advice of the porters.



Total number of portering jobs completed
Data from 24 November 2020 – 31 January 2021

14,128 Maidstone Hospital

14,570 Tunbridge Wells Hospital



Not just surviving, but thriving – the Endoscopy Team

Across the Trust we have seen some incredible examples of our MTW teams not just surviving, but thriving to overcome the challenges during the COVID-19 pandemic and bring in new ways to provide outstanding care.

A perfect example of this has been our amazing team in the Endoscopy Department across both hospitals.

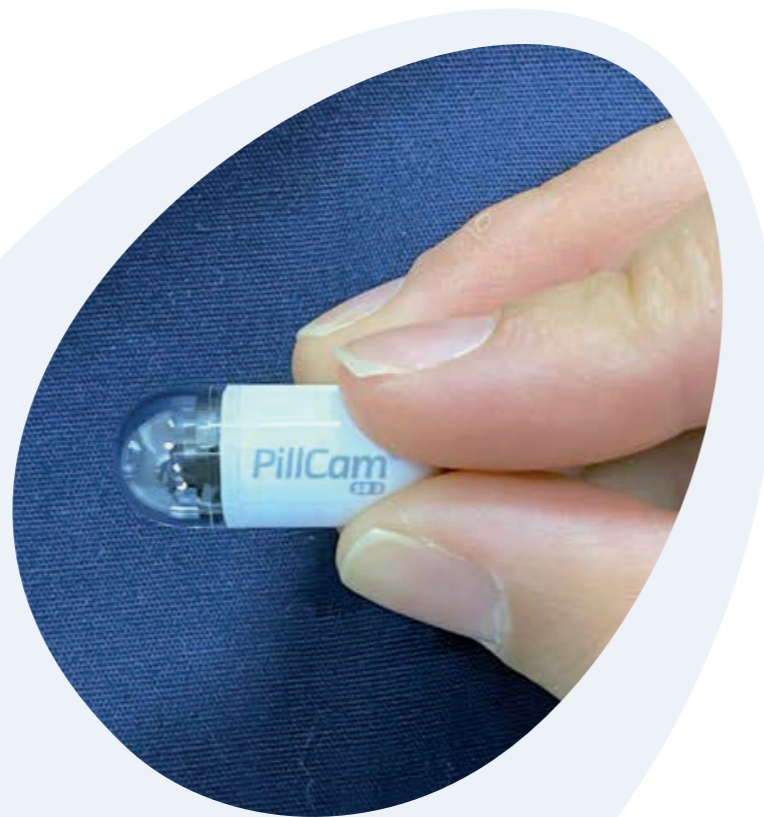
Faced with a 12-week closure of treatment rooms during the first wave of COVID-19, which resulted in a backlog of 2,600 patients, the team embraced new, innovative ways of working to enhance the patient experience at the Trust. Within a matter of weeks, the team had not only tackled the lengthy patient waiting list, but were the first team in the region to roll-out the PillCam capsule endoscopy device.

This scheme involves patients swallowing a tiny camera to check for signs of cancer. The pioneering device provides an alternative to treatments such as colonoscopies, is painless and involves a capsule no bigger than a standard vitamin tablet, which provides a diagnosis within a matter of hours.

The new treatment dramatically reduces the time spent in hospital for the patient and means they can go about their normal day, and in some circumstances continue with work.

The team also took the opportunity to use national funding to replace equipment and increase its workforce while investing in the training of nurse endoscopists and booking resources.

During the pandemic, they worked hard to reassure patients at what can be a nervous time; by developing scripts and guidance for patients about the safety measures in place, the importance of people having their procedure to support early diagnosis and reduce DNAs, and on the day cancellations. This guidance has been adopted and used by other organisations across Kent and Medway.



The Swabbing Team

By **Frances Hope**, Deputy General Manager, COVID Testing and Zara Martin, Head of Performance and Delivery



During the pandemic, the Swabbing Team was vital in helping to maintain the safety of our staff who were at the frontline caring for COVID-19 patients.

At first, the team worked tirelessly to keep a manual log of staff who had been off sick with COVID-19 related symptoms and book them in for a test. Then the Trust adopted a new computer system called PathEKS which made the whole process a lot smoother.

In addition, drive through testing was quickly set up at the Hop Farm with two tents to allow staff to have access to fast testing. This enabled staff with a negative result to go straight back to work. The drive through centre was maintained by staff from both the Head and Neck and Sexual Health teams as both often carried out swabbing in their normal roles.

Volunteers from Kent Community Health NHS Foundation Trust (KCHFT) and Kent and Medway Social Care and Partnership Trust (KMPT) were also on hand to help carry out the large number of tests in such a short period of time for NHS staff, as well as staff from other partner organisations including Kent Police and Kent Fire and Rescue Service (KFRS).

With the national lockdown and increased number of asymptomatic tests being carried out daily last summer, staff were able to return to work and help provide much needed care to patients as the nation tried to return to some kind of normality.

It was in the autumn when children and young people returned to school and the emergence of multiple new variants of the COVID-19 virus,

that we saw a large increase in positive cases in a short period of time which subsequently led to the second wave of the pandemic. At this time, the Trust introduced asymptomatic tests and lateral flow tests (LFT) for staff.

The use of the LFT has been a key tool in keeping the Trust running during the worst of the second wave. It ensured that even if children of staff had to self-isolate due to a COVID-19 outbreak at their school or class, staff could take the LFT to make sure they weren't infected and continue to come into work to provide care for patients.

Due to the number of positive cases in the region, and the fact that the new variants made the virus much more contagious than before, we saw the number of positive PCR tests from both staff and the general public increase dramatically.

Hundreds of PCR tests which were being carried out daily were sent to the Microbiology Department who worked tirelessly to try and get through as many tests as possible on a daily basis – working from 8am to midnight, seven days a week. This enabled staff with negative results to return to work, and those with a positive test result were alerted as quickly as possible to try to contain any further spread of infection to the wider community.



The teams involved in the swabbing process have constantly been learning and adapting during the pandemic, so there is a lot more knowledge of what to do if another spike does occur in 2021.

“The use of the lateral flow tests has been a key tool in keeping the Trust running during the worst of the second wave.”



Health records to infection prevention control

By **Lucy Warren**, Infection Prevention and Control Team Administrator



Lucy Warren started work in the Health Records Team at Paddock Wood on a part-time basis in October 2018, before transferring to a full-time role as part of the Health Records Team at Maidstone Hospital.

As a clinic prep clerk, she was responsible for tracking down healthcare records and ensuring they had the appropriate documentation in them ahead of the patient's outpatient consultation.

That was until 2020 when the COVID-19 pandemic crisis hit and Lucy was approached by her manager to ask whether if she would like to be redeployed into the Infection Prevention and Control (IPC) team.

Lucy explained: "They needed someone to help with the general daily admin tasks and my manager said she thought I would be perfect for the role. I felt really proud to have been asked."

Four weeks later, Lucy was responsible for calling the wards to find out how many COVID-19 swabs they had, inputting results data into Excel and checking them against the Telepath system. Her role also included fielding calls, supporting the team with email queries, helping out where possible from putting results onto the daily side room list to taking minutes for specific meetings.

Lucy said: "I've felt supported from day one, the team is amazing and everyone works so well together. They are incredible and it's really opened my eyes to how much pressure they are under. All the admin staff at MTW do such a fantastic job – we couldn't function as a Trust without everyone pulling together, especially during times like COVID-19. I went home every

night feeling that I'd made a difference and that I'd done my best. I'm proud to work for the NHS."

After doing such a fantastic job throughout the year with the team, Lucy was officially offered a full time role in October 2020. She added: "I'd like to say a special thank you to Dr Sara Mumford, Jacqui Griffin and Jo Green for their continued hard work supporting us as team. Also, a special thanks to the whole Infection Prevention and Control Team for their continued support especially when I first joined full time.

"Most of my family members are part of MTW as well so I would like to say a huge personal thank you to them for all their continued support and hard work during the pandemic."

"I've felt supported from day one, the team is amazing and everyone works so well together. They are incredible people and it's really opened my eyes to how much pressure they are under."

Sally goes back to the frontline



Sally Smith retired from nursing in May 2019 after over 40 years in the NHS. But it wasn't long before she returned to the NHS, this time working in the Complaints Team at Maidstone Hospital, to help fund her son's university fees.

Despite loving her clerical role, in March of 2020, Sally decided to renew her Nursing and Midwifery Council registration for one last time – and thank goodness she did!

With a background in critical care, Sally had worked in intensive care nursing before moving into nurse management in 2000. She then returned to clinical practice as a critical care outreach nurse for six years before moving back into management roles in 2009.

Sally hadn't worked in frontline critical care work for over 10 years, but when the pandemic crisis hit, she decided to offer her support to ITU who were desperate for help.

For someone who spent so much time away from a clinical setting, what was Sally's takeaway from working with staff in the ICU?

"I find it hard to express how incredible the intensive care nurses, doctors and support staff were, working in such challenging conditions," she said.

"They were nursing overflow patients in short stay recovery, in operating theatres and anaesthetic rooms in makeshift intensive care units.

"The PPE, although very welcome and essential, made it very hard to hear what people were saying, to move freely and was incredibly hot and uncomfortable."

Along with Sally, there were also other members of staff, all from different clinical backgrounds, who worked in the ICU but had never worked there before.

"Everyone gave their all. The ICU nurses were so patient, calm and kind, giving clear concise instructions to us as we did our best to be useful. Of particular note were the endoscopy nurses and theatre staff who tirelessly worked long day shifts, way out of their comfort zone, in an unfamiliar clinical area, providing compassionate professional care to the sickest patients in the hospital. They were all amazing!"

During the second wave in the spring, Sally again returned to the frontline, this time to administer vaccinations to staff as part of MTW's highly successful vaccination programme.

"I find it hard to express how incredible the intensive care nurses, doctors and support staff were, working in such challenging conditions."

Being a clinical site manager during a pandemic

By **Gaynor Rickard**, Senior Clinical Site Manager



Overnight when the government announced the first nationwide lockdown, queues for supermarkets grew and the hospital changed.

The hospital corridors, which are normally bustling with staff, patients and visitors on a weekday, were eerily quiet. Big black walls were erected to extend ITU, creating an ominous atmosphere and sense of impending doom.

As clinical site managers during the pandemic, we had to step in to support the staff on the wards and maintain the flow of patients we had in the hospital. This included offering guidance and reassurance to staff and responding to their queries about PPE, what to wear and who was Fit testing. Staff also wanted to know how many patients have been admitted with COVID-19 and whether any staff were sick. Like many, the anxiety of the unknown grew during these unprecedented times.

As more wards were opened to COVID patients, so more training in PPE donning and doffing was needed. Respirators arrived in the site office for us to give out as needed and we did our best to show staff how to use them with little training. We were the first port of call for all enquiries, even during out of hours, and we didn't stop.

When calls started to come through from local shops, restaurants and pubs with donations for the staff, and vans of food, supplies and gifts arrived daily, we greeted the donators outside the hospital, thanked them, and spent hours giving out the donations to all areas, making sure working staff received something each day.

We even delivered flowers to as many of the mums working on Mother's Day, to acknowledge their commitment and sacrifice. This lifted morale and staff began to feel part of a close-knit team again from the clinical staff of all grades to the essential workers.

Then things got worse. Staff were supporting patients, to phone their spouses and children and say goodbye, as they were going to be ventilated and it was unknown if they would survive. We saw many colleagues come out of resus in tears and we were unable to give them a simple hug to comfort them as they tirelessly gave their all to their patients.

When the numbers of deaths increased, we were the ones verifying the patients, talking with the staff and recording that yet another COVID patient had died. After spending 12 hours supporting staff and patients in the hospital both mentally and physically, it was hard to switch off and we would go home hoping we weren't passing on anything to our loved ones.

When staff across the hospital began to get ill, we worked hard to maintain their privacy and dignity.



"We were the first port of call for all enquiries, even during out of hours and we didn't stop"

Our team was affected too and staff had to quarantine, which meant we had shifts with only one site manager on and it was difficult to find time for breaks.

Yet still, we continued to maintain the day to day running of the hospital. We persevered to maintain moving patients through the Emergency Department promptly, not only conscious of the targets (which were maintained) but to ensure the Emergency Department had maximum

capacity at all times. We also supported our colleagues from South East Coast Ambulance Service (SECAMB) and Kent central where we could, checking in on them and making sure they had food and drink.

As a site team, we supported each other and I am so immensely proud of the professionalism, strength and commitment every single one of us gave (as so many did) during this time.

Women and Children's Department

By Dr Sarah Flint, Chief of Service Women, Children's and Sexual Health



When COVID-19 hit the nation all aspects of healthcare were affected, leading to delays and patients being asked to wait until it was safer for them to receive treatment.

But for many of our patients it was crucial we kept our doors open and find ways to adapt our services, so they could continue to receive the best possible care.

Throughout the service there was an immediate review of how we could deliver a safe service with fewer face-to-face contacts. This included moving to telephone consultations for a much wider range of situations and introducing video consultations for more complex consultations.

In sexual health, the team expanded the services available online, introducing a daily telephone triaging service to review urgent referrals allowing many patients to be given advice. Postal services were used for testing rather than patients having to attend in person. This then enabled a smaller number of patients with urgent problems to be seen face-to-face.

To maintain safe social distancing and reduce footfall in the hospital and birth centres, the Maternity Team took the difficult decision to allow only one birthing partner to support their partner, friend or relative through the birth and early postnatal period and this was maintained throughout.

All maternity clinics were able to provide a mix of face-to-face and telephone consultations, but tried to ensure that additional emotional support was given by the community midwives. As we were unable to support partners attending scans we either offered short video clips to be taken at the end of the scan by the patient or provided a free scan photo.

We are extremely proud of the support given to expectant parents from midwives and obstetricians, who have been praised by families for their positive birth experiences.

In paediatrics we agreed to host the Paediatric Emergency Department (ED) services in our paediatric wards to create space in main ED which enabled red and green pathways to be created. The team did a fantastic job to create an ED environment at very short notice, also offering emergency gynaecology clinics three times per week. This has been very successful and over the months we have been able to invest in some building work to improve the safety and experience for families.

The leadership response from the Paediatric Team to meet the challenges of children with mental health, especially eating disorders, was incredible but it was recognised that staff needed extra support, so a new role of paediatric mental health liaison nurse was created and a second support role is currently being recruited.

Supporting community midwives to attend homebirths safely, midwives working long shifts in full PPE on the delivery suite, long waiting lists for gynaecological surgery, and staff shortages were just some of the challenges we faced during the pandemic.

Members of the clinical staff in the Sexual Health Team were also redeployed to help in the vaccination centre when the COVID-19 vaccine was made available.



"Throughout the service there was an immediate review of how we could deliver a safe service with fewer face-to-face contacts."



23,460
referrals

made for women to have scans during their pregnancy between January 2020 – March 2021



167 homebirths
between January 2020 – March 2021



22,000
approximate phone calls to our maternity triage between January 2020 – March 2021

Despite these challenges, each team in the department pulled together and supported each other from the Paediatrics Department supporting the Emergency Department, nursing staff rotating in to the COVID-19 swabbing team to manage children or being redeployed to help with tasks such as making beds, to our staff on our maternity wards offering assistance to the ambulance crew at SECamb who were unable to support our birth centres and homebirths.

Our biggest success was the use of videos to communicate to big teams. This included an explainer video on new pathways on the delivery suite and new routes to access emergency theatres, along with video updates on PPE instructions on the delivery suite.

Throughout the pandemic our staff supported each other, were always flexible with the changes that came their way and responded with positivity. We are so proud of you all.

Radiotherapy Pre-treatment Planning Team

The Radiotherapy Pre-treatment Planning Team at Maidstone Hospital learnt to adjust to a very different way of working over the pandemic.

This team is responsible for scanning cancer patients who require radiotherapy treatment and for creating a specialised plan once the oncologist has demonstrated where they want the radiotherapy dose to be delivered.

They have pulled together to ensure they continue to deliver a remarkably high standard of care for cancer patients. Their workload hasn't reduced in the wake of COVID-19 either and is set to increase as cancer targets need to be sustained.

While many staff have been getting to grips with working from home and very rapidly learning new ways of paperless planning and remote signing of work, the CT team have been getting used to donning PPE for each patient they see. Sarah Clark, the administrator

for the team, has done a brilliant job getting the daily workload prepared and brightens each day with a friendly smile.

Patients have been more anxious than normal and the CT radiographers have spent countless hours offering reassurance to them as they attend the Radiotherapy Department for the first time. Having had telephone consultations with their oncologists to discuss their treatment rather than face-to-face to reduce footfall through the hospital, it's been a worrying time for them.

Despite the new conditions being physically and emotionally challenging, the team have stretched themselves beyond anything they ever thought possible.

"They have pulled together to ensure they continue to deliver a remarkably high standard of care for cancer patients."



Vaccination centre success

By John Weeks, Director of Emergency Planning and Communications

When NHS England and NHS Improvement launched its COVID-19 vaccination deployment strategy and operational readiness in November 2020, MTW was quick to respond by putting in place plans to deliver the mass vaccination programme to its staff.

John Weeks, Director of Emergency Planning and Communications takes up the story.

"It became apparent in the early stages of the pandemic that mass vaccination was key to bringing COVID-19 under control.

A small team of staff from the pharmacy, occupational health, emergency planning and workforce began to meet to look at what additional work would be needed to support a national vaccination programme.

But at the time, there were still many issues to be addressed not least when a vaccine would be approved, how much would the Trust receive and who would be vaccinated.

The Trust were congratulated by the Secretary of State for Health in a speech in the House of Commons for the success of the vaccination centre in response to a question by local MP Tracey Crouch.

Our record number of vaccinations administered in a single day was on 29 December with 1,284 doses.

This equated to approximately one person every 30 seconds for the opening hour!

By day nine, a staggering 6,400 healthcare staff had been vaccinated. The Trust, working with its partner organisations, led all other organisations for the number of vaccinations administered in Kent and Medway. It also supported SECamb in helping to vaccinate its frontline ambulance staff.

We're very proud of our commitment not to waste a single vaccine. The nightly 'count', the development of a waiting list, and the push to get people to the centre at short notice was a particular challenge and a real focus for continuous improvement.

Thanks to the support of our staff from every part of the Trust, our vaccination programme was a huge success."





Maidstone Hospital

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Maidstone
Kent, ME16 9QQ

01622 729000

Tunbridge Wells Hospital

Tonbridge Road
Tunbridge Wells
Kent, TN2 4QJ

01892 823535

Trust Board meeting – October 2021

Quarterly report from the Freedom to Speak Up Guardian	Deputy Freedom to Speak Up Guardian
The latest quarterly report from the Freedom to Speak Up Guardian (FTSUG) is enclosed.	
Which Committees have reviewed the information prior to Board submission? N/A	
Reason for submission to the Board (decision, discussion, information, assurance etc.)¹ Discussion	

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

Board of Directors (Public)

Freedom To Speak Up Guardian Report Q2 (July – September 2021)

Action Requested / Recommendation

The Trust Board is asked to read the report and discuss the content and recommendations.

Summary

This is the 2nd quarter report to the board which identifies trends and issues. It covers progress report from Freedom To Speak Up (FTSU) Guardians, Safe Space Champions and updates on mediation service in the Trust.

Author; Ola Gbadebo-Saba, Deputy Freedom To Speak Up (FTSU) Guardian

Date; October 2021

Freedom To Speak Up Non-Executive Director	Maureen Choong
Freedom To Speak Up Executive Lead	Sue Steen
Freedom To Speak Up Guardian	Christian Lippiatt
Deputy Freedom To Speak Up Guardian	Ola Gbadebo-Saba

The FTSU Agenda is to;

- Protect patient safety and the quality of care
- Improve the experience of workers
- Promote learning and improvement

- Barriers to speaking up are addressed
- Encourage a positive culture of speaking up
- Ensure issues raised are used as opportunities for learning and improvement

By ensuring that;

- Workers are supported in speaking up



FTSU Case Review

The NGO undertook a review of the speaking up culture and arrangements at Blackpool Teaching Hospitals NHS Foundation Trust and the report was released on the 14th of October 2021. The NGO received information indicating that a speaking up case may have not followed best practice. The information also suggested black and minority ethnic workers had potentially worse experiences when speaking up compared to their white colleagues.

Findings from the review which might be used as a benchmark for MTW include;

- Speaking up had not always been responded to in accordance with good practice and some groups of workers faced barriers to speaking up not necessarily experienced by other workers. In MTW, colleagues who raise concerns to us are thanked and we communicate by having regular follow up sessions and sharing updates on the concern raised. In addition to the Deputy FTSU Guardian being BAME, we also have representation of Safe Space Champions in networks across the Trust.
- Leaders, including trust leaders were not always visible and accessible. Employees who worked in satellite sites found this particularly challenging because they felt 'out of sight.' This is an area of improvement at MTW particularly because some staff in Estates and Facilities highlighted during our visits they do not feel appreciated by leaders and feel neglected because they are not based at Maidstone or Tunbridge Wells Hospital sites. These members of staff do not have NHS emails or access to the Trust intranet to view updates from Trust leaders which makes it more challenging.
- The Trust had one Freedom to Speak Guardian which made it particularly difficult to meet the demands of the workforce. There are two FTSU Guardians in MTW (though they equate to 1.0 whole time equivalent) which means workers have options to speak up to either Guardian. The Guardians also have the opportunity to support each other in both the reactive and proactive aspects of the role and share learning. We currently have 27 Safe Space Champions who have received training on FTSU and equity, diversity and inclusion.
- There was misunderstanding among some leaders about the Freedom to Speak Up Guardian role including the preconception that the FTSU Guardian should not proactively encourage workers to speak up and the role of the Guardian in relation to investigations. In line with the proactive role of the Guardian, Guardians work in partnership with others in the organisation to promote the speaking up agenda and tackle barriers to speaking up. In MTW, this includes reaching out to different parts of the organisation, presenting during induction as well as visiting departments.
- Although some cases brought to the Guardian may require investigation, the FTSU Guardian is not responsible for investigating matters brought to them but need to be assured investigations are happening and follow best practice with a fair and transparent outcome.
- The speaking up strategy required updating, including a comprehensive speaking up communications strategy. This is an area where MTW will need to improve because our current communication strategy is not well detailed. The team will be required to develop a robust communication strategy in line with guidelines from NHS England and Improvement.

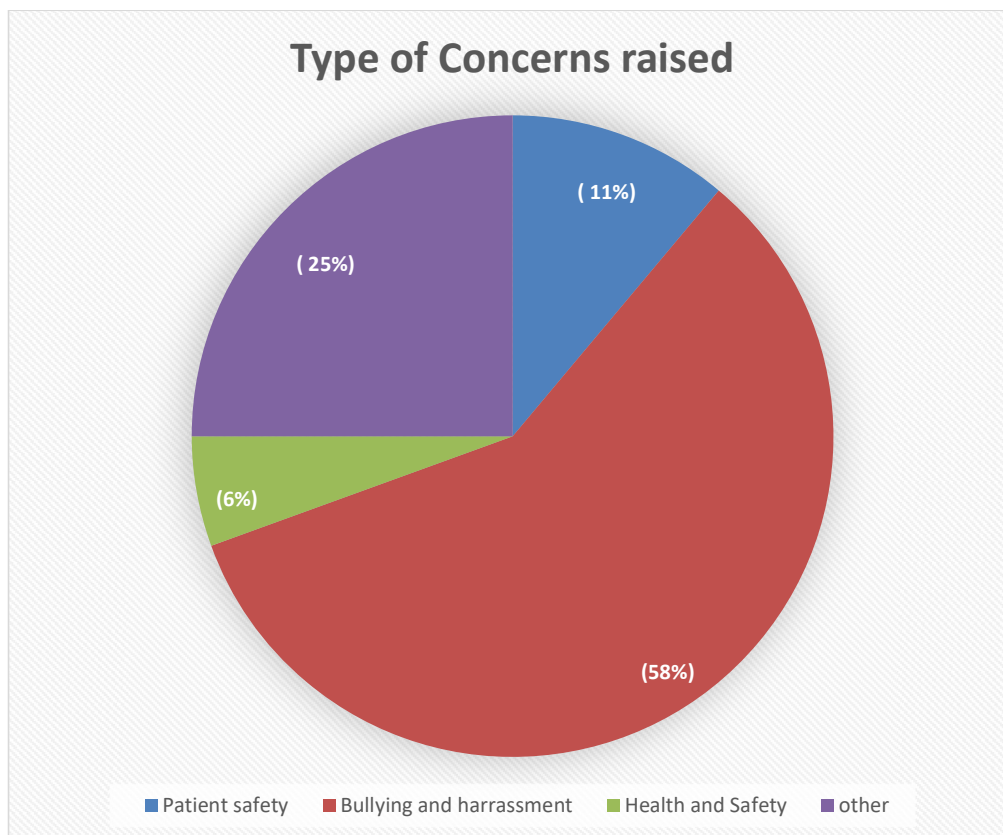
Themes / Issues

A total of **fifty-three (53)** concerns were raised to the Freedom To Speak Up Guardians in the last quarter. **Seventeen (17)** of these concerns were raised on the Anonymous reporting portal on the Trust Intranet and were escalated to the relevant teams based on the level of information received. A number of concerns raised on the portal were in regards to management in Theatres, lack of communication and staffing levels. An initial meeting was set up with the General Manager and Lead Matron of the Directorate to bring the concerns to their attention and discuss possible ways of resolving these concerns.

Out of the **thirty-six (36)** concerns raised directly to the FTSU guardians, **twenty- one (21)** of them were on dignity and respect, **four (4)** were on patient safety, **two (2)** on Health and Safety and **nine (9)** were on other enquiries ranging from questions on where to find the grievance policy in the trust, concerns on poor/lack of communication in teams to concerns on staff shortages. There were reports of increased stress levels in teams due to staff shortages and lack of support from managers.

Staff who raised concerns on Dignity and Respect reported feeling undermined, treated like a child or being shouted at in the presence of colleagues and patients. There were also reports of feeling unvalued and low morale. Some individuals were considering leaving their teams to work in other departments within the Trust while some would prefer to resign from the Trust.

All staff who raised concerns on Dignity & Respect reported they were suffering a heightened level of stress & anxiety. While we adopted the FTSU process to manage the concerns raised, staff members who had not contacted the Psychological Occupational Health team were encouraged to reach out to the team for additional support.



Concern on patient safety were raised by Clinical Support Workers in a Ward at Tunbridge Wells Hospital. There were concerns on staff shortages and high number of falls. This was immediately escalated to the patient safety team to investigate and provide support to the ward. Datix was checked for the ward and there were a number of incidents raised in the ward in June and July which was higher than usual compared to other wards in a month. From a FTSU perspective, a meeting was set up with the Matron and ward manager to inform them of the concerns. Prior to the meeting, the patient safety team had visited the ward and it was mentioned during the meeting the Falls nurse had been contacted and aware of the situation. We were also assured there were plans to recruit new staff to join the team as to resolve issues of staff shortage.

As part of FTSU process, we scheduled a follow up call with the matron and ward manager to receive updates on the concerns and a few actions had been taken. These actions include:

- Recruitment Drive
 - (2) Band 5 nurses
 - (7) Band 5 nurses
 - (2) Clinical Support Workers
- In house training for falls organised by the falls nurse
- Reduction in number of serious incidents recorded in the Ward from compared to previous months which was confirmed by the patient safety team
- A plan to organise regular staff meeting by the new Ward manager as an additional medium to communicate and cascade information down to the team.

One of the concerns raised on dignity and respect at the end of the previous quarter was raised by an Allied Health Professional and during our conversation she highlighted some issues which were affecting the wider team. This quarter, we had some more members of staff from the Team who raised similar concerns on behaviours and the culture of the team. These concerns were escalated to the Deputy Chief People Officer- Organisational Development (Ainne Dolan) and a diagnostic was conducted by one of the organisational development consultants. A report of the diagnostic was shared with the Clinical Director who addressed the team and reassured them they were open to changes and improving the culture and experience of staff. Although one of the members of staff who raised a concern had put in her resignation before the diagnostic commenced, she was pleased it eventually happened during her notice period and she felt she had been listened to and there was going to be positive changes in the team.

As part of our proactive role in promoting FTSU, we visited a team in Estates and Facilities twice in September and used the opportunity to share some promotional materials. During our visit, sixteen (16) members of staff raised concerns around behaviours from managers, contract change and infection control. A member of the team had contacted the infection control team and a visit had been made to the laundry prior to our visit.

A meeting was set up with HR to discuss some concerns raised on behaviours and to receive some more clarity on the contract change. We were informed by the Human Resource Business Partner there was a consultation which staff had been involved with. They had all received a copy of the outcome of the consultation and a letter notifying them of the changes but they were unhappy with the change. The HRBP mentioned there are plans for a review of this but the date is yet to be fixed and communicated.

There is a significant increase in the number of cases being brought to FTSU Guardians and the main theme remains the same around behaviours, relationships / dignity and respect. Concerns have largely been received from Allied Health Professionals (AHPs), Admin/Clerical staff, suggesting there is a level of staff who feel unable to raise their concern through their management route, or have tried but been unable to progress it or feel that their concern has not been listened to and taken seriously.

Although we have had the highest number of recorded concerns this quarter, this can be seen as positive because it highlights to us more staff are aware of the service and accessing some level of support from the team. In addition, some concerns affecting wider teams are being shared in the Organisational Development commissioning meeting by Psychological OH team/ Staff Engagement team or by the Organisational Development team which was raised by some members of staff or managers seeking to support their staff. Some of these concerns are not necessarily raised to the FTSU team prior to the OD commissioning meeting but this suggests that more staff are feeling empowered to speak up, seek support, are assured that someone in the organisation is listening to them and most importantly, some steps are being taken to improve their work experience in the Trust.

FTSU strategy progress report

The FTSU agenda is gaining traction in the Trust and there is an increase in the number of cases being brought to the Guardians. FTSU guardians have also been promoting the agenda through inductions, network meetings, relationship building with various teams and investment in more promotion materials which have been distributed around the Trust.

Safe Space Champions Evaluation

We currently have **twenty-seven (27)** fully trained Safe Space Champions in different roles, departments and networks across the Trust. The role of the Safe Space Champions is to promote the FTSU agenda by listening to concerns, signpost & inform colleagues of support available in the Trust.

The role of the Safe Space Champion is instrumental in supporting staff to resolve their concerns directly and informally. SSC have been promoting their roles within their Directorate/Division and we are currently working on a project with the communications team to release a video promoting the role of safe space champions and the reason some of them signed up for the role. FTSU Guardians and EDI team have a six – eight weeks check in call with the SSC as an opportunity to provide additional support and shared learning.

Growing the Speaking Up Agenda

The National Guardian office in partnership with Health Education England have launched two e-learning packages in regards to speaking up for all workers and line managers which is very useful for promoting the FTSU agenda. The first module – **Speak Up** – is for all workers while the second module, **Listen Up**, for managers and both modules focus on listening and understanding the barriers to speaking up. A final module, **Follow Up**, for senior leaders, will be launched later in the year to support the development of Freedom to Speak Up as part of the strategic vision for organisations and systems.

The first and second module have now been launched on the MTW learning platform and available to all staff. In addition to the other mandatory courses for new starters, Freedom to Speak up training – Speak Up – for all workers is now included in the induction pack.

Data Collection; Concerns Raised

2021/22 details

Quarter	Month/Year	No. of Contacts	Open Cases		Quarter	Month/Year	MGH	TWH	Parkwood	Unknown
Q1	April-June 2021	17	3		Q1	April-June 2021	9	4	0	4
Q2	July - September 2021	53	23		Q2	July - September 2021	11	13	18	11
Total	2021/2022	70	26		Total	2021/2022	20	17	18	15

April -June 2021	
Staff Group	Number
Nursing & midwifery	2
Medical	0
Unknown	4
AHP's	1
Clinical Support	3
A&C	7
Total	17

July – September 2021	
Staff Group	Number
Nursing & midwifery	3
Medical	5
Unknown	9
AHP's	12
Clinical Support	4
A&C	20
Total	53

April – June 2021	
Theme	Number
Patient Safety	0
Bullying/ Harassment	8
Fraud	0
Health & Safety	0
Other	9
Total	17

July – September 2021	
Theme	Number
Patient Safety	4
Bullying/ Harassment	21
Fraud	0
Health & Safety	4
Other	24
Total	53

Summary report from Quality Committee, 13/10/21 Committee Chair (Non-Exec. Director)

The Quality Committee met (virtually, via webconference) on 13th October 2021 (a Quality Committee ‘deep dive’ meeting).

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

- The **progress with previous actions** was reviewed and it was agreed that the Assistant Trust Secretary should liaise with the Director of Estates and Facilities to request that evidence be provided to East Kent Hospitals University NHS Foundation Trust that the Trust had fulfilled the contractual obligations in relation to water quality within the satellite Renal Unit at Maidstone Hospital.
- The Programme Director EPR (Sunrise) and Digital Transformation; the Chief Clinical Information Officer (CCIO); and the Medical Director attended for a **review of the Quality and Clinical Governance issues associated with the implementation of the Electronic Patient Record (EPR)** wherein the Committee acknowledged the operational impacts of the implementation of EPR on staff at the Trust and the importance of ensuring the EPR was tailored to the requirements of specific service areas. It was agreed that the Assistant Trust Secretary should provisionally schedule a “further review of the Quality and Clinical Governance issues associated with the implementation of the Electronic Patient Record” item at the Quality Committee ‘Deep Dive’ meeting in June 2022.
- The Chief Nurse and Assistant Deputy Chief Nurse presented a **review of the Trust’s approach to a Care Quality Commission (CQC) inspection compared to the revised inspection approach which had been adopted by the CQC in 2021**. The presentation gave a comprehensive overview of the Trust’s approach to a CQC inspection and outlined the proposed new methodology which would be utilised. It was agreed that the Chief Nurse should liaise with the Responsible Officer for the “Breakthrough Objective” within the “Patient Access” Exceptional People Outstanding Care Programme strategic theme, to consider the amendment of the “Breakthrough Objective” to include aspirational targets.
- A discussion was held on the **items that should be scheduled for scrutiny at future Quality Committee ‘deep dive’ meetings**, wherein the following agreements were made:
 - That the Chief Nurse and Medical Director should consider, and confirm, to the Trust Secretary’s Office, the scheduling of a “review of impacts of health inequalities and equality of access to services on patient outcomes” item at a future Quality Committee ‘Deep Dive’ meeting
 - That the Assistant Trust Secretary should schedule an “update on the management of Sepsis at the Trust” at the Quality Committee ‘Deep Dive’ meeting in February 2022
 - That the Chief Nurse should liaise with the Divisional Director for Midwifery, Nursing and Quality to ensure that the “further review of maternity services” item at the Quality Committee ‘Deep Dive’ meeting in December 2021 included details of the impact of the temporary closure of the Crowborough Birth Centre (CBC) on both patients and staff, and the plans to safely reinstate services at the CBC

2. In addition to the agreements referred to above, the meeting agreed that: The Assistant Trust Secretary should ensure that the “Review of the decision-making process for ‘clinical design’ within the Trust’s Digital Transformation programme” item was rescheduled from the December 2021 Committee meeting to the February 2022 Committee meeting.

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 People and Organisational Development Committee, 22/10/21
**Committee Chair
(Non-Exec. Director)**

The People and Organisational Development Committee met (virtually, via webconference) on 22nd October 2021 (a 'deep dive' meeting).

The key matters considered at the meeting were as follows:

- The **actions from previous 'deep dive' meetings** were reviewed
- The Committee conducted an in-depth review of the latest **A3 Scorecard and metrics** and the following agreements were made:
 - That the Chief People Officer should liaise with the Deputy Chief Executive / Chief Finance Officer to arrange for further clarification regarding the A3 Strategy Deployment process to be provided at a future "NED Weekly Meeting".
 - That the Chief People Officer should liaise with the Deputy Chief Executive / Chief Finance Officer to ensure the implementation of a robust governance framework in relation to the Strategy Deployment A3 process.
 - That the Chief Nurse and Chief People Officer should ensure that the "Staff and Rostering" section of the "To review the A3 Scorecard and metrics" includes an associated assurance matrix in relation to safe staffing levels at the Trust.
 - That the Deputy Chief People Officer, People and Systems should ensure that future iterations of the "Staff and Rostering" section of the "To review the A3 Scorecard and metrics" report includes details overtime at the Trust.
 - That the Deputy Chief People Officer, People and Systems should ensure that future iterations of the "Staff and Rostering" section of the "To review the A3 Scorecard and metrics" report includes a utilisation target for bank, agency and overtime rates.
 - That the Chief People Officer and Chief Nurse should ensure that further discussions were held with the Chair and Vice Chair of the Committee in relation to the challenges in relation to recruitment and retention at the Trust's and the associated next steps.
 - That the Deputy Chief People Officer, People and Systems should provide Committee members with modelling data on the expected impact of retirement and early retirement on the Trust turnover rate.
- The Chief People Officer provided an update from the **Workforce Supply Taskforce**.
- The Deputy Chief People Officer, People and Systems presented a **review of the key themes and lessons learned from employee relations cases** which highlighted the distribution of cases across the Trust by Division and the proposed next steps, wherein the following agreements were made:
 - That the Deputy Chief People Officer, People and Systems should arrange for additional training to be made available to managers, where required, to ensure that the Trust's managing attendance at work policy and procedure is appropriately enacted.
 - That the Assistant Trust Secretary should schedule an "update on the compliance with the Trust's managing attendance at work policy and procedure" item at the People and Organisational Committee 'Deep Dive' meeting in April 2022.
 - That the Deputy Chief People Officer, People and Systems should check, and confirm to Committee members, the mechanisms by which managers were informed that the Trust's managing attendance at work policy and procedure should be triggered, and the proportion of incidents which were appropriately addressed by managers.
 - That the Deputy Chief People Officer, People and Systems should provide Committee members with trend data for employee relations cases by Equality Diversity and Inclusion characteristics.
 - That the Assistant Trust Secretary should schedule a "Further review of the key themes and lessons learned from employee relations cases" item at the People and Organisational Committee 'Deep Dive' meeting in April 2022.
- The Deputy Chief People Officer, People and Systems presented an informative **review of the Trust's Human Resources Business Partners (HRBPs) operating model** which highlighted

the future investment which was required for the People and Culture function and the wealth of available expertise, external to the NHS, which could be utilised was emphasised. It was agreed that the Deputy Chief People Officer, People and Systems should ensure that '360-degree feedback' on the Trust's Human Resources Business Partners (HRBPs) is implemented in conjunction with the Trust's Clinical and Corporate Divisions prior to the December 2021 People and Organisational Committee 'Deep Dive' meeting. It was also agreed that the Chief People Officer should consider, and confirm to the Assistant Trust Secretary, if, and when, a further "update on the Trust's Human Resources Business Partners (HRBPs) operating model and associated Business Case" should be submitted to the Committee.

- The Committee **confirmed the items to be scheduled for the future 'deep dive' meeting**, in December (i.e. "In-depth review of the relevant aspects of the risk register" and "Review of the Trust's approach to succession planning and talent management").
- The Deputy Chief People Officer, Organisational Development gave an **update on the Gender Pay Gap** wherein the Committee noted the proposed recommendations and it was agreed that the Deputy Chief People Officer, Organisational Development should consider the Equality Diversity and Inclusion support which could be provided in relation to the Trust's Gender Pay Gap.
- The Committee conducted an **evaluation of the meeting** which highlighted the support from Committee members for detailed discussions on key areas of focus.

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

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

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

Information and assurance

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