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

Thu 27 May 2021, 09:45 - 12:15

Virtual Meeting, via webconference

Maidstone and Tunbridge Wells NHS Trust

Agenda

05-1
To receive apologies for absence

David Highton

05-2
To declare interests relevant to agenda items

David Highton

05-3
To approve the minutes of the 'Part 1' Trust Board meeting of 29th April 2021

David Highton

Board minutes, 29.04.21 (Part 1).pdf (9 pages)

05-4
To note progress with previous actions

David Highton

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

05-5
Report from the Chair of the Trust Board

David Highton

Chair's report.pdf (1 pages)

05-6
Report from the Chief Executive

Miles Scott

Chief Executive's report May 2021 FINAL.pdf (2 pages)

Integrated Performance Report

05-7
Integrated Performance Report (IPR) for April 2021

Miles Scott and colleagues

IPR for April 2021 (incl. planned and actual ward staffing).pdf (33 pages)

Planning and strategy

05-8
Update on 2021/22 planning

Amanjit Jhund

Update on 2021-22 planning.pdf (16 pages)

05-9
The ‘go live’ for the Sunrise Electronic Patient Record (EPR)

Peter Maskell

The ‘go live’ for the Sunrise Electronic Patient Record (EPR).pdf (9 pages)

05-10
Strategy Deployment – corporate objectives for 2021/22

Amanjit Jhund

Strategy Deployment – corporate objectives for 2021-22 (May 2021).pdf (12 pages)

05-11
Annual approval of the Trust’s Green Plan

Doug Ward

N.B. This item has been scheduled for 11:20am.

Annual approval of the Trust’s Green Plan.pdf (15 pages)

05-12
To approve the proposal for a Maggie’s Centre to be built at Maidstone Hospital

Katie Goodwin and David Morgan

N.B. This item has been scheduled for 11:30am.

Maggie's Centre proposal.pdf (32 pages)

Quality items

05-13
Quarterly update on progress with the Perinatal Mortality Review Tool (PMRT)

Claire O'Brien

Perinatal Mortality report - May 2021.pdf (6 pages)

Assurance and policy

05-14
Infection prevention and control board assurance framework

Sara Mumford

IPC Board Assurance Framework- May 2021.pdf (44 pages)

05-15
NHS provider licence: Self-certification for 2020/21

Kevin Rowan

Provider Licence self-certification.pdf (13 pages)

Reports from Trust Board sub-committees

05-16
Extraordinary Charitable Funds Committee, 07/05/21

David Morgan

Summary of Extraordinary Charitable Funds Cttee, 07.05.21.pdf (1 pages)

05-17
Quality Committee, 12/05/21 (incl. approval of revised Terms of Reference (annual review))

Maureen Choong

Summary of Quality C'ttee, 12.05.21 (incl. revised ToR).pdf (6 pages)

05-18
Audit and Governance Committee, 13/05/21 (incl. approval of revised Terms of Reference)

David Morgan

Summary of Audit and Governance Committee, 13.05.21 (incl. revised ToR).pdf (8 pages)

05-19
People and Organisational Development Committee, 21/05/21

Richard Finn

Summary of People and Organisational Development Cttee, 21.05.21.pdf (1 pages)

05-20
Finance and Performance Committee, 25/05/21

Neil Griffiths

Summary of Finance and Performance C'ttee 25.05.21.pdf (1 pages)

05-21
To consider any other business

David Highton

05-22
To approve the motion (to enable the Board to convene its ‘Part 2’ meeting) that...

David Highton

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

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 29TH APRIL 2021, 10 A.M, VIA WEBCONFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board	(DH)
	Sean Briggs	Chief Operating Officer	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Neil Griffiths	Non-Executive Director	(NG)
	Peter Maskell	Medical Director	(PM)
	David Morgan	Non-Executive Director	(DM)
	Claire O'Brien	Chief Nurse	(COB)
	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 & Partnerships	(AJ)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Sue Steen	Chief People Officer	(SS)
	Jo Webber	Associate Non-Executive Director	(JW)
	Kevin Rowan	Trust Secretary	(KR)
	Ola Gbadebo-Saba	Deputy Freedom To Speak Up Guardian (for item 04-14)	(OGS)
	Christian Lippiatt	Freedom To Speak Up Guardian (for item 04-14)	(CL)
	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]

04-1 To receive apologies for absence

No apologies were received. DH then welcomed SS to her first Trust Board meeting since joining the Trust.

04-2 To declare interests relevant to agenda items

SDu declared that she was an interim Non-Executive Director at East Kent Hospitals University NHS Foundation Trust.

04-3 To approve the minutes of the 'Part 1' Trust Board meeting of 25th March 2021

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

04-4 To note progress with previous actions

The content of the submitted attachment was noted.

04-5 Report from the Chair of the Trust Board

DH referred to the submitted report and highlighted the key points therein, which included the appointment of two new important consultants, in Diabetes & Endocrinology and Cardiology. DH also congratulated the Vaccination Centre, which had now closed after it had delivered 30,000 vaccinations. DH then noted that the planning process had been delayed by the COVID-19 pandemic, so although the Trust Board would consider the plans for the first six months of the year, the longer-term plan would not be considered until May or June 2021. DH therefore emphasised the continuing uncertainty which needed to be borne in mind when considering other agenda items. The point was acknowledged.

04-6 Report from the Chief Executive

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

- Jo Haworth had been appointed to succeed COB as the Chief Nurse, following COB's retirement, and would start in post at the beginning of August 2021. There would be a proper celebration of COB's time at the Trust in June 2021.
- Sally McKinnon had been appointed to lead the Integrated Care Partnership (ICP) in West Kent
- The Trust's recovery from COVID-19 and next steps was important, and SB would report further details under item 04-7. However, the issues that would not be covered under that item were the re-opening of hospital visiting arrangements, while still ensuring safety in relation to site access; and partners being offered to attend for antenatal appointments.
- There may be a third wave of COVID-19 cases, so the operational teams were preparing for such an eventuality.
- A system-wide approach would be important to the Trust's recovery, particularly for elective activity, and funding, via the Elective Recovery Fund (ERF), would be dependent on meeting a series of activity thresholds. There were also a series of gateways. The system also needed to ensure that inequalities were addressed.
- The Chief of Service, Diagnostics & Clinical Support Services and her team should be congratulated for the successful vaccination campaign, and while over 90% of staff had been vaccinated with at least one dose, the vaccination of the remaining members of staff would continue to be pursued. Vaccines would also be offered to new starters at the Trust.

Integrated Performance Report

04-7 Integrated Performance Report (IPR) for March 2021

MS referred to the submitted report and firstly highlighted that there was an important governance issue to ensure that quality issues were addressed as part of the Trust's recovery. COB then referred to the "Safe" domain and reported the following points:

- The "planned versus actual" / Safe staffing level position had reduced slightly from the previous month. Staff had taken a lot of Annual Leave (A/L) in March, which had been encouraged.
- Falls had reduced slightly in March, but further work was required, and one of the corporate objectives for the year would focus on falls. There had been three Serious Incident (SI)-related falls that month. The falls team had enjoyed the presentation they had given at the recent Quality Committee 'deep dive' meeting.
- The pressure ulcer position had improved slightly, but the position was not as wanted.
- Seven SIs had been reported in the month, which was closer to the expected levels.

SM then referred to the infection control aspects of the "Safe" domain and reported that all healthcare associated infection parameters were at expected levels. SM added that COVID-19 cases had reduced considerably, but the Trust had not quite managed to reach zero cases.

PM then referred to "effective" domain and reported that mortality was at the same level for the previous year, but a 'deep dive' review was underway into COVID-19 deaths, as the Trust had been highlighted as an outlier. Some anomalies had however been identified in the data and Dr Foster had been asked to amend some aspects, as the position did not reflect the positive comparison from the Intensive Care National Audit & Research Centre (ICNARC) data.

DH asked about stroke care. PM confirmed that all four of the Best Practice Tariff parameters had either improved or stayed the same, while the stroke service had been able to operate within the available capacity. PM added that the Trust was however now providing routine thrombectomy referrals into London, which meant that more stroke patients could now be actively treated.

COB then referred to "caring" domain and reported the following points:

- The complaints response performance had been 61% for the month and the target had not been met for 2020/21. Everyone had therefore been asked to refocus to recover the position that had been achieved in recent months.
- There had been some progress with Friends and Family Test (FFT) response rates, in all areas, but continued improvement was required.

MS highlighted that the judgement was that there had been sufficient progress on the quality domains to enable the Trust to proceed 'full steam ahead' with the recovery plans. The point was acknowledged.

SB then referred to "responsive" domain and reported the following points:

- The number of attendances seen had meant the sites had experienced pressure, but staff had responded very well, and the Trust had ended March 2021 as the second or third best performer in the country in relation to Emergency Department (ED) 4-hour waiting time target.
- Same Day Emergency Care (SDEC) had been a major area of focus.
- Elective recovery had progressed well, as SO had provided the funding to enable the Trust to undertake as much activity as possible over the past month. The Deputy Chief Operating Officer and her team had responded to the challenge.
- As of 28/04/21, 514 patients had waited over 52 weeks for treatment, which was almost half the number seen circa four weeks ago.
- The challenge was to be at 70% of pre-COVID-19 activity levels by the end of April 2021 and the data showed that the Trust's activity would be at circa 80%.
- The increased in cancer referrals had meant the Trust had its busiest ever months for cancer referrals, and SB was most concerned with oncology and colorectal. The waiting list backlog had increased slightly, so SB had managed some of the Patient Tracking Lists (PTLs) with the operational teams. The backlog would have an impact on performance in June and July 2021, but if the Trust could achieve the cancer access targets until then, that would be two years of continuous monthly improvement.

SDu asked about the clinical prioritisation of those patients who had waited over 52 weeks, when compared to those who had waited less than 52 weeks. SB stated that all patients were now being categorised into clinical categories P1 to P4 and gave assurance that the most urgent patients i.e. those in categories P1 and P2, had been given priority.

NG noted that outpatients had been an area of consistent challenge, and although progress had been made, asked if the focus would be maintained. SB noted the support and challenge that the Finance and Performance and Quality Committees had given to outpatients, which had been helpful. SB then added that activity was not the main area of challenge, as other performance metrics were important, such as answering telephone calls within one minute. SB continued that there was now a dedicated team, and a Programme Board, in place, while there was monthly reporting to the Executive Team Meeting (ETM). SB noted that he also expected further scrutiny by the Finance and Performance and Quality Committees.

DH noted that the Trust would have circa 120 'Medically Fit For Discharge' patients before the COVID-19 pandemic, and the government had then changed the responsibility for such patients to Local Authorities, via the "discharge to assess" process, which had led to a reduction in such patients. DH continued that the number had now increased, so asked why that was the case. SB explained the reasons for the increase but gave assurance that it was an area of focus, and noted that MS and PM had supported the Trust's efforts, in relation to community pathways.

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

- The end of a very unusual financial year, during which the Trust operated under two different financial regimes, had been reached. The goal for the second half of 2020/21 had forecast a deficit of £5m, which took into account an estimate of A/L accrual, as it had been expected that staff would struggle to take their A/L. However, since that plan had been made, the funding for the A/L had been provided centrally. The plan had therefore been adjusted to a break-even position and the Trust ended the year with a small surplus.
- There was an error in the IPR in the "year to date" column, but the detailed finance report contained the correct data. The IPR would therefore be amended for the formal records.
- There had been a small underspend on the capital programme. The main initiative under the programme was project Ive, which involved replacing all existing PCs and laptops, the network infrastructure, the server infrastructure, improved Wi-Fi at Maidstone Hospital and a complete replacement of the Wi-Fi at Tunbridge Wells Hospital. By the end of the programme, no staff

member would have a device that was older than two years, so staff would no longer be hindered by antiquated IT equipment.

DH congratulated SO and the rest of the Executive Team regarding the capital programme, and noted that the fact that the Trust had received additional capital funding so late in the year reflected the Trust's effective planning, and a strong procurement function, which enabled the funds to be spent swiftly.

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

- There had been some peaks in sickness absence, although the situation had started to improve. It would however continue to be a particular area of focus.
- Agency staff usage and expenditure, for medical and nursing staff, would also be a key area of attention.
- Recruitment had been affected during the latest COVID-19 lockdown but a wide range of methods had been deployed to improve the position.
- Great work had been done on the Divisional action plans arising from the staff surveys, particularly in relation to improving psychological safety.

JW noted that a recent meeting of the COVID-19 Ethics Committee had considered the staff affected by long COVID, so asked what support would be offered. SS acknowledged the point and offered to provide details of the support available to affected staff. JW welcomed the offer.

Action: Provide Trust Board members with details of the support available to staff members affected by long COVID (Chief People Officer, April 2021 onwards)

PM added that the Clinical Commissioning Group (CCG) had been keen to commission an acute provider to provide a long COVID service, but the Trust was keen for its community partners to provide that service, so the Trust was involved in relevant discussions.

RF referred to staff turnover, which was concerning, although it was still subject to common cause variation, and asked for a comment. SS explained the factors that affected the issue but acknowledged the need for some further focused work. SS also noted the new "moving on" survey that had been introduced for staff who had chosen to leave the Trust, to better understand their reasons.

RF also asked whether the Trust had changed the source of its international recruitment, in light of the adverse impact of the COVID-19 pandemic in places like Ghana and India, as it would be inappropriate to draw trained staff away from such countries. SS acknowledged the issues but highlighted that international recruitment was not the only source of recruitment. DM asked how staff turnover in an individual Trust would relate to turnover across the Kent and Medway Integrated Care System (ICS), as turnover it may be high for particular Trusts, but satisfactory for the overall ICS. DM noted that the issue had wider implications for the development of the ICS. The points were acknowledged.

DM then referred to the "Matrix Summary", and asked how the Trust's management used that data to target the areas to escalate. SO replied that the main cell on the matrix was the bottom right corner i.e. those with "Special Cause Concern" and "Fail", and added that the matrix had been initially submitted to the Finance and Performance Committee, as a trial, but had now been included in the Trust Board IPR. SO continued that the information had also been considered at the Divisional Performance Review (DPR) meetings, which had been held on 28/04/21, and all of the indicators in the "Special Cause Concern" and "Fail" had been raised for discussion with the Divisional teams.

DM also asked for further details on the "Elective Spells in London Trusts from West Kent (W)" that had appeared in the matrix for the first time. AJ explained the rationale for the metric, but noted that it was very crude and should not be focused on too much, as it would, in time, be replaced by a more sophisticated metric that would try and monitor the volume of activity being undertaken outside of West Kent that the Trust's clinical strategy stated should be undertaken within West Kent. DM commended the fact that the indicators were being used by management.

COB then referred back to RF's comment regarding overseas recruitment, and the comments he had made at the last meeting of the People and Organisational Development Committee, and confirmed she had contacted the overseas recruitment company the Trust used, to consider how the Trust's future recruitment would be affected.

Planning and strategy

04-8 Operating plans for the first half of 2021/22

AJ referred to the submitted report and highlighted that the first draft of activity templates had been submitted to the ICS on 20/04/21. The ICS would then submit plans to regulators on 06/05/21, with a final submission on 03/06/21. AJ also noted that SDu had asked, at the Finance and Performance Committee meeting on 27/04/21, whether the plans had assumed any changes in demand arising from the post-COVID-19 future and AJ had confirmed that had not been the case, so the plans contained some uncertainty regarding future demand and activity.

JW asked whether the activity plans took account of any likely mutual aid arrangements. AJ confirmed that had not been the case at that stage, as the plans of the Trusts within the ICS all forecast their activity targets to be met, and if fact the plan for Dartford and Gravesham NHS Trust's forecast its activity target to be exceeded. SB added that his Chief Operating Officer counterparts at other local Trusts had agreed to focus on particular areas of challenge, which included ENT and Orthopaedics, and he expected other local Trusts to want to discuss potential mutual aid in the coming weeks. MS stated that it would be helpful to reflect on JW's question during the ICS-related discussion that would take place within the 'Part 2' Trust Board meeting scheduled for later that day. MS however emphasised that the ICS needed to ensure that each Trust was responsible for its own delivery.

SO then referred to the submitted report and highlighted that the finance aspects in the report had changed considerably since the report had been submitted, and discussions were continuing. SO added that the position would however likely be challenging, so some of the issues and risks in the submitted report would still be relevant.

DH asked whether the numbers in the plan would be finalised before the Trust Board meeting in May 2021. SO explained the steps involved in the finalisation process, and added that plans were being developed for the Trust to achieve a break-even position, although the position was not likely to be clear until w/c 03/05/21. MS added that some parameters had been discussed at the Finance and Performance Committee meeting on 27/04/21.

04-9 Strategy Deployment – corporate objectives for 2021/22

DH firstly noted that the Trust had been supported by University Hospitals Sussex NHS Foundation Trust, and therefore some of their nomenclature had been transferred over, although such nomenclature would be changed to reflect the fact that the Trust owned the process. AJ then referred to the submitted report and highlighted the following points:

- Members of the Executive Team had attended a workshop with colleagues from University Hospitals Sussex NHS Foundation Trust, and a "strategic filter" had been applied. The outcome was to define the eight "Mission Critical Trust Corporate Projects", which were "Health and Wellbeing Strategy"; "Outpatient Transformation"; "CQC"; "Sunrise EPR"; "Workforce Supply"; "Staff Rostering"; "KMMS"; and "Acute and urgent care".
- Further work would now take place to develop the objectives.
- The Trust Board was asked to consider whether the "Mission Critical Trust Corporate Projects" were the right priority areas.

EPM referred to the "Strategic Project Filter" and asked whether anything had been placed in "Deselect" or a "Holding" list. AJ referred to page 7 of 17 and stated that there were three issues within the "Deselect" category i.e. "Paperlight", "Staff and patient Safety" and "Kent and Medway Care Record".

EPM also asked how the Members of the Executive Team felt about the process and the priorities. MS stated that he had found the process beneficial, but it was important to ensure there was a clear responsibility.

MC noted that "Staff and patient Safety" had been included in the "Deselect" category and asked for an explanation. SM noted that she had been the Senior Responsible Officer (SRO) for that workstream and confirmed that all of the work had now become 'business as usual'.

RF commended the work, but asked about the relationship between "Mission Critical Trust Corporate Project" and "Strategic Initiatives", as he did not believe it would be appropriate to take two to three years to focus on the "Culture and Leadership Programme". AJ confirmed that the categories under "Strategic Initiatives", which included the "ICP", would need to be progressed over the next 12 to 18 months. RF stated that there were therefore 14 main priorities, not just eight. The point was acknowledged.

RF asked where environmental impact featured in the work. AJ replied that this would be covered by the "Facilities and Estates" category under "Strategic Initiatives", although some of SO's work would also be pertinent. SO acknowledged that some of the work on infrastructure would be relevant but confirmed that the label referred to by RF did not feature literally, so that could be reflected in the further work referred to by AJ. DH noted that it was not uncommon to have cross-cutting themes, so asked that RF's point be considered in that context. MS stated that he would prefer to have a more considered response before making any commitments. DH confirmed he was content for a more considered response to be issued. This was agreed.

Action: Arrange for the Trust Board to receive a considered response to the challenge posed at the Trust Board meeting on 29/04/21 as to where environmental impact should feature within the Trust's future objectives (Chief Executive, April 2021 onwards)

DM then emphasised the need for caution before setting targets. As there was a risk of having intended consequences. The point was acknowledged.

04-10 <u>Review of nurse staffing for ward and non-ward areas (major review)</u>

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

- The methodology involved meeting with a wide range of staff, to collaboratively review the staffing numbers and related Key Performance Indicators (KPIs), as well the environmental challenges, patient acuity, dependency and risks. The challenges in involving such staff in the discussions were considerable, given the COVID-19 situation.
- The process also involved ongoing discussions with Matrons.
- The Lord Carter Model Hospital metrics data showed that the Trust was comparatively low for Care Hours Per Patient Day (CHPPD).

COB then elaborated in detail on the content of the "Key findings of the review" and "Trust Recommendations" sections, the latter of which included a further Trust wide review of planned staffing levels, to consider an uplift of the Nursing and Midwifery establishments in some key areas. COB then confirmed she would discuss the recommendations with the incoming Chief Nurse.

DH commended the quality of the work, but noted that many of the recommendations required further consideration by the members of the Executive Team, to evaluate the financial impacts, but proposed that the Trust Board recommended the recommendations to the Executive Team. This was agreed. DH therefore confirmed that the recommendations should be considered by the Executive Team and the Trust Board should be notified of the response/outcome.

Action: Arrange for the recommendations in the "Nursing & Midwifery staffing review" that was discussed at the Trust Board meeting on 29/04/21 to be considered by the Executive Team, and notify the Trust Board of the response/outcome (Chief Nurse, April 2021 onwards)

Assurance and policy

04-11 Year-end review of the Board Assurance Framework, 2020/21

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

- The report concluded the Board Assurance Framework (BAF) process for 2020/21, following the numerous in-year reports that had been submitted to the Trust Board, and its sub-committees throughout the year.
- The report included year-end ratings for each of the nine objectives, which were selected by the lead member of the Executive Team for each objective. The options were "Fully achieved", "Partially achieved" or "Not achieved". Five objectives had been rated as "Fully achieved, four had been rated as "Partially achieved" and none had been rated as "Not achieved".
- The Trust Board was asked to consider whether the proposed year-end ratings matched the position understood from the in-year BAF reports, and the wide range of other information submitted to the Trust Board and its sub-committees, and were therefore valid.
- The confirmed ratings would feature in the Trust's Annual Report for 2020/21.
- The report was also the last BAF report that would be submitted to the Trust Board, following the Trust Board's confirmation at its last meeting that the "Strategy Deployment" process, and the monitoring and reporting of the objectives therein, would replace the Trust's BAF from 2021/22.

DH noted that the COVID-19 pandemic had affected many of the objectives listed as "Partially achieved", and that adverse impact should be recorded. KR agreed.

The year-end ratings for each objective were then confirmed valid as submitted.

04-12 Infection prevention and control board assurance framework

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

- Just before Christmas, the Trust had exceeded the national guidance, and allowed staff who were providing direct care to suspected or confirmed COVID-19 patients to wear FFP3 masks, but as the risk has now decreased considerably, staff would now revert to using fluid-resistant surgical masks for non-aerosol generating procedure (AGP) care.
- Visitors had been readmitted to the Trust, on alternate days, but ensuring that patients had access to contacting their family and friends on the days that visiting was not allowed.
- Visiting had now been reopened in the mortuaries, to enable loved ones to view the deceased on an appointment-only basis.

04-13 Six-monthly update on Estates and Facilities

MS referred to the submitted report and highlighted that the report followed-on from the external review of Estates and Facilities that had been undertaken and which had been incorporated into a single transformational programme. Questions were invited. None were received.

04-14 Quarterly report from the Freedom to Speak Up Guardian

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

- A report on the survey of Freedom to Speak Up (FTSU) Guardians conducted in 2020 had been released by the National Guardian's Office, and the key findings included that Black and Asian Minority Ethnic (BAME) groups were under-represented, with 90% of respondents from NHS Trusts being identified as white. The Trust was one of the few NHS Trust that has a BAME FTSU Guardian.
- 16 concerns had been raised in the last quarter. Six were via the anonymous reporting tool and 10 were raised directly to the FTSU Guardians. One of the anonymous concerns related to patient safety and OGS explained the action that had been taken in response.
- In comparison to 2019/2020, the highest number of concerns raised were concerns around bullying/harassment and health and safety. Patient safety concerns had declined during 2020/21, when compared to 2019/20.

- Work was taking placed with the Learning and Development team to include the "Speak Up", "Listen Up" and "Follow Up" training modules, and these were recommended to be mandatory for all Trust staff.
- "Safe Space Champions" were being recruited.

EPM noted the decline in reporting concerns during the COVID-19 pandemic and asked whether the reasons were known, such as whether the online portal for reporting for was sufficiently well known. OGS acknowledged that further work was required to promote the awareness of the service, but CL highlighted the likely importance of the many staff that were absent due to sickness, as well as the limited time available for other staff to raise concerns, particularly those who had been deployed to other clinical areas.

EPM also noted the link between the findings from the FTSU survey and the "moving on" survey so asked SS whether that would be considered. SS confirmed the triangulation of the data was being undertaken, and she had already discussed that issue with CL.

DM highlighted the 'curve' in concerns that should be expected when improvements occur to FTSU arrangements i.e. people may not raise concerns because they did not have confidence that changes would be made, then when they became confident, concerns would increase, and these would then reduce as the concerns were addressed. DM therefore asked where the Trust was in that journey. OGS gave her observations and CL acknowledged that an increase in concerns was part of the Trust's journey to excellence.

RF asked what "resolution" of a bullying and harassment issue looked like. CL explained that resolution related to accessing the various specialist services within the People function i.e. learning and development, Organisational Development etc., and responding to learning or development needs.

RF also asked what action would be taken after someone had attended the short courses, and the evidence showed that such courses did not change behaviour. CL clarified that the courses were more about raising awareness, and ensuring participants understood the routes to speak up.

Reports from Trust Board sub-committees

04-15 Charitable Funds Committee, 23/03/21

DM referred to the submitted report and highlighted the key points therein, which included that the departure of the Trust's Fundraising Manager would provide the opportunity to review the current arrangements; and progress had been made in relation to the proposed partnership with Maggie's Centres, so there should be some positive developments to report in the near future.

04-16 Quality Committee, 14/04/21

SDu referred to the submitted report and highlighted that the meeting had a presentation from the falls and tissue viability teams which showed that the Trust had had no grade three or four pressure ulcers for the last year, for the first time since 2015, which was a very good outcome.

SDu then reported that the Committee had undertaken a 'deep dive' into a misplaced nasogastric tube incident, and the issues reflected the issues identified from a similar incident circa two years ago. SDu therefore noted that although assurances were believed to have been provided, the issue would be considered again in June 2021.

04-17 People and Organisational Development Committee, 23/04/21 (incl. quarterly report from the Guardian of Safe Working Hours; and approval of revised Terms of Reference)

DH referred to the submitted report and highlighted that the revised Terms of Reference had been submitted for approval; the Guardian of Safe Working Hours was included in the report. EPM added that some findings from "moving on" surveys had been considered.

The revised Terms of Reference were approved as submitted.

04-18 Finance and Performance Committee, 27/04/21

NG referred to the submitted report and highlighted that the meeting had involved a passionate conversation about the future of the laundry service, as frustration had been expressed that no ICS-wide progress had been able to be made, so it was agreed that further efforts would be made to make progress.

04-19 To consider any other business

There was no other business.

04-20 To approve the motion (to enable the Board to convene its 'Part 2' meeting) that in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest

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

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

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress[1]
04-7	Provide Trust Board members with details of the support available to staff members affected by long COVID.	Chief People Officer	April 2021 onwards	A verbal update will be given at the meeting.
04-9	Arrange for the Trust Board to receive a considered response to the challenge posed at the Trust Board meeting on 29/04/21 as to where environmental impact should feature within the Trust's future objectives.	Chief Executive	April 2021 onwards	A verbal update will be given at the meeting.
04-10	Arrange for the recommendations in the "Nursing & Midwifery staffing review" that was discussed at the Trust Board meeting on 29/04/21 to be considered by the Executive Team, and notify the Trust Board of the response/outcome.	Chief Nurse	April 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'
N/A	N/A	N/A	N/A	N/A

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
09-12	Arrange for the Responsible Officer's Annual Report for 2020/21 to include details of the key messages arising from medical staff appraisals (rather than just the statistics associated with such appraisals).	Medical Director	September 2021	The report is not scheduled to be considered at the Trust Board until September 2021
09-13	Ensure that the Health & Safety Annual Report for 2020/21 included content on water-related safety issues.	Chief Operating Officer (via the Risk and Compliance Manager)	September 2021	The report is not scheduled to be onsidered at the Trust Board until September 2021

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

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

Consultant appointments

I and my Non-Executive colleagues are responsible for chairing Advisory Appointment Committees (AACs) for the appointment of new substantive Consultants, 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	Surname	Department	Potential / Actual Start date
12/05/21	Consultant Obstetrics & Gynaecologist – Lead for Postnatal Service	Elena	Chmilevskaya	Obstetrics & Gynaecology	TBC
17/05/21	Consultant Clinical Oncologist	Gemma Kathryn	McCormick	Oncology	TBC
19/05/21	Consultant Obstetrics and Gynaecologist - Medical Education	Sadia	Muhammad	Obstetrics & Gynaecology	TBC

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

NHS Maidstone and Tunbridge Wells NHS Trust

Report from the Chief Executive **Chief Executive**

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

1. As of Monday 17 May, we updated our visiting guidance to support more visiting across our sites. This update means we're supporting visiting seven days a week and outside of visiting hours, our staff are also doing all they can to support contact with friends and family via the iPads we have on the wards. Despite the relaxation in lockdown rules within the community, to ensure the ongoing safety of our patients, staff and visitors we continue with our social distancing measures, wearing of masks and continue to promote the importance of hand hygiene. All colleagues continue to undertake twice weekly lateral flow tests (LFT) at home even after receiving their second dose of the vaccine.

2. Our recovery programme continues apace and elective activity is now almost at pre-pandemic levels, with good progress being made on patients who have waited a long time for treatment. We have recently opened the Tree Tops unit for paediatric elective surgery at Tunbridge Wells Hospital, enhancing the surgical pathway for our children. Over the last month we have seen emergency activity recover to pre-Covid numbers, experiencing our busiest day ever in our Emergency Departments on Monday 10 May. We have continued to meet our two week wait cancer target for the last 20 months, a fantastic achievement by all involved. We have recently seen a significant increase in the number of maternity bookings at the Trust and our staff are working hard to ensure all patients receive the best possible care. We have once again been able to increase our radiology scanning capacity through the utilisation of mobile scanners provided by NHS England – our teams have been commended for their efficient use of the scanners achieving the best utilisation of the Reset and Recovery Mobile Scanners in the country.

3. After extensive planning, preparation and testing our new Electronic Patient Record system will launch on 16 June across our clinical areas. This will bring change to the way we work across the whole Trust and key benefits will include saving time and improving the uniformity of notes.

4. The Trust has invested in new technology to help make our website more accessible for users with a disability. The Recite Me accessibility assistive toolbar solution is now live on the Trust website and allows website visitors to customise the site in a way that works for them. At a touch of a button, the Recite Me toolbar can be launched providing text to speech functionality, fully customisable styling features, reading support aids and a translation tool with over 100 languages, including 35 text to speech voices and many other features.

5. The Trust submitted a planning application in March to Tunbridge Wells Borough Council to build new medical student accommodation and an academic teaching building at Tunbridge Wells Hospital. The development will house Kent and Medway Medical School (KMMS) students and provide them with learning facilities while they are on their clinical placement with the Trust in years three, four and five of their studies. Once fully established, a total of 144 students would be housed in the new purpose-built student accommodation. Tunbridge Wells Borough Council is expected to make a decision on the application in June. If this planning permission is granted, work is expected to start in July and completed by March 2022 ready to welcome the first intake of KMMS students in September 2022.

6. The work of the West Kent Integrated Care Partnership (WKICP), of which the Trust is a partner, has been recognised not once, but four times in the HSJ Value Awards 2021. Working collaboratively with the other health and social care organisations that form the WKICP, which is supported by the Joint Programme Office (JPMO) team, the WKICP has been shortlisted as finalists in the following four categories: Diabetes Care Initiative of the Year; System or Commissioner Led Service Redesign Initiative; Acute Service Redesign Initiative and Urgent Emergency Care Initiative of the Year.

7. On Monday 10 May we launched our MTW story which set out the key organisational priorities for the next 12 months and beyond. Our story supports our objectives and priorities as we come out of Covid and focus on what we need to achieve and deliver to take MTW to outstanding. This month we also rolled out our Exceptional Leaders programme - our Senior Leadership Development Programme - which is a crucial foundation to delivering our vision of Exceptional People, Outstanding Care. Following the launch this month the programme will run to July 2022, involving not only the Executive Team, but also 330 Senior Leaders within the Trust.

8. Following feedback from our latest staff survey we want to further encourage a culture of civility, dignity and respect for all at the Trust, where staff feel confident to speak out on issues concerning themselves and patients. In order to develop this approach, we have recruited a team of Safe Space Champions who will take on this additional role. The role involves providing a listening ear, encouraging staff to discuss worries and concerns with their manager and signposting to support services where necessary.

9. The crisis India is currently facing has been felt on a very personal level by colleagues at the Trust as we have many staff who are from India, or they have family and friends who live there. The Trust has ensured that support is in place for those colleagues who have been impacted and provided access to resources and tools to support their wellbeing and welfare. Staff from our chronic pain unit also undertook a sponsored 24 hour pedalathon in aid of the Christian Mission Hospital in Vellore, India and have to date raised over £16,500 – a fantastic achievement.

10. Congratulations to the winner of the Trust's Employee of the Month scheme for April – Jackie Farr from Clinical Coding. On behalf of the Trust Board I would like to say thank you to Jackie for her fantastic work to help support our colleagues and patients.

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

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

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

NHS Maidstone and Tunbridge Wells NHS Trust

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

The IPR for month 1, 2020/21, is enclosed, along with the monthly finance report and the latest 'planned vs actual' nurse staffing data.

Which Committees have reviewed the information prior to Board submission?

- Finance and Performance Committee, 25/05/21 (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

NHS
Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report

April 2021

MTW
exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells NHS Trust

Contents

Appendices (Page 24 onwards)

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

MTW
exceptional people, outstanding care

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

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.

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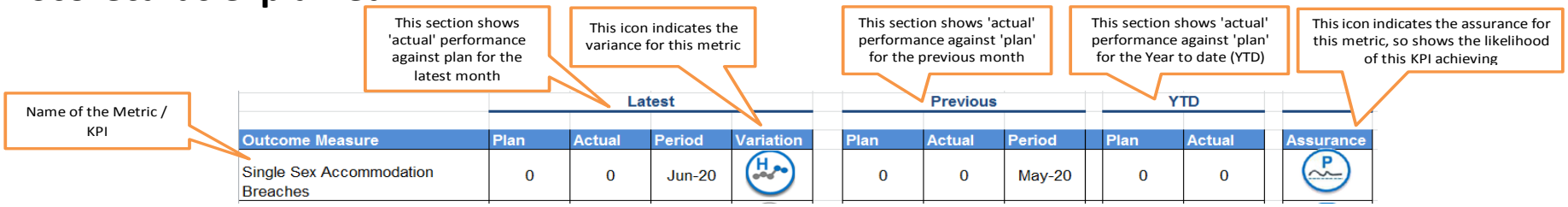
Maidstone and Tunbridge Wells NHS Trust

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)

Scorecards explained



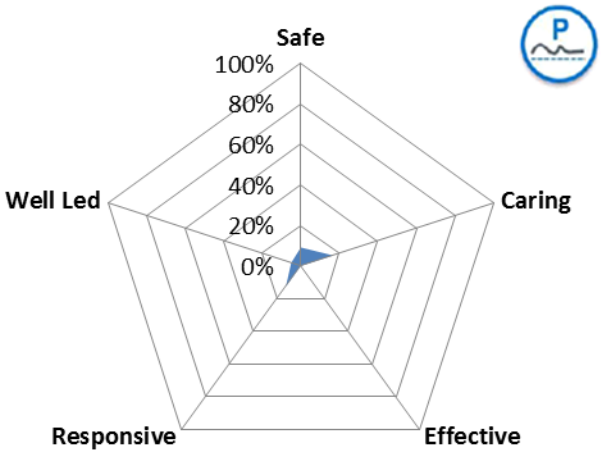
Further Reading / other resources

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

MTW exceptional people, outstanding care

Executive Summary

Consistently Passing



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

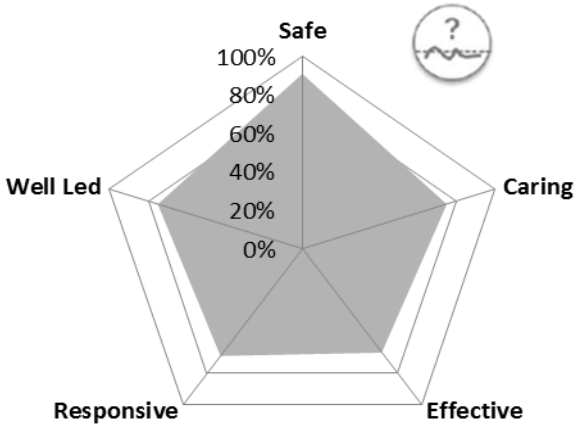
Safe:
- Trust Mortality (HMSR)

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

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

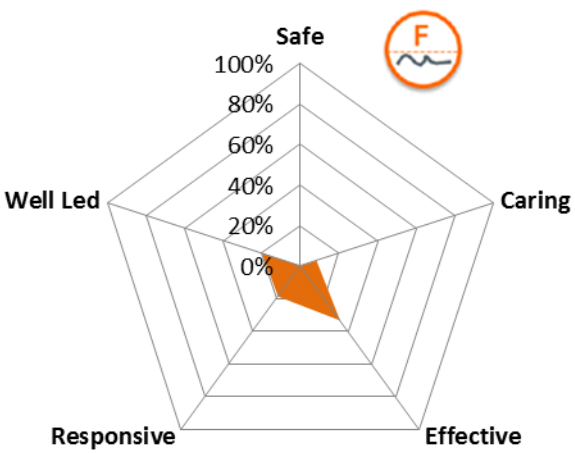
Effective:
- Outpatients DNA Rates and Hospital Cancellations, Readmissions & Stroke Indicators

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

Responsive:
- Diagnostics Waiting Times, 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, Sickness Rates, Vacancy Rates, Appraisals, Staff FFT Recommended to work, Staff FFT Recommended Care, Health and Well-Being and Clinical Strategy Indicators

Consistently Failing



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

Caring:
- OP Friends & Family Response Rate

Effective:
- Percentage of Virtual OP Appointments
- Outpatient Utilisation
- Outpatient –Calls answered within 1 min
- Outpatient – Calls Abandoned

Responsive:
- RTT performance
- RTT Number of >40 week Waiters
- RTT Number of >52 week Waiters
- Theatre Utilisation

Well-Led:
- Agency Staff used
- Agency Spend
- Turnover Rate
- Percentage of Trust policies within review date

Matrix Summary

April 2021

Variance	Assurance: Pass	Assurance: Hit and Miss	Assurance: Fail
Special Cause - Improvement	Stat and Mandatory Training (W)	Infection Control - Number of Hospital acquired MRSA (S), Stroke Best Practice Tariff (E), IP Friends & Family (FFT) % Positive (C), A&E Friends & Family (FFT) % Positive (C), Number of specialist services (W), Elective Spells in London Trusts from West Kent (W), Number of advanced practitioners (W), Staff Friends and Family % recommended work (W), Staff Friends and Family % recommended care (W), Appraisal Completeness (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),	**See box (right)**	Calls Answereed in under 1 min (E), Theatre Utilisation (R), Agency Spend (W), Turnover (W)
Special Cause - Concern	% VTE Risk Assessment (C)	Nursing vacancies (W), Vacancy Rates (W)	Percentage of Virtual OP Appointments (E), Percentage OP Clinics Utilised (slots) (E), RTT (Incomplete) performance against trajectory (R), Number of patients waiting over 40 weeks (R), 52 week breaches (including those reported last month) (R), Use of Agency (W)

Hit & Miss /

Safe Staffing Levels (S), Sickness Rate - Covid (S) Infection Control - Hospital Acquired 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), Never Events (S), OP New DNAs (E) OP Follow Up DNAs (E) Outpatient Hospital Cancellation (E), Outpatient Cancellations < 6 weeks (E), Total Readmissions <30 days (E), Non-Elective Readmissions <30 days (E), Elective Readmissions < 30 Days (E), Rate of New Complaints (C), % complaints responded to within target (C), IP Resp Rate Recmd to Friends & Family (C),	A&E Resp Rate Recmd to Friends & Family (C), Mat Resp Rate Recmd to Friends & Family (C), Maternity Combined FFT % Positive (C), OP Friends & Family (FFT) % Positive (C), Access to Diagnostics (<6w eeks standard) (R), Average for new appointment (R), A&E 4 hr Performance (R), Super Stranded Patients (R), Ambulance Handover Delays Rate > 30mins (R), Bed Occupancy (R), NE LOS (R), Cancer - 31 Day (R), Size of backlog (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), Research grants (£) (W) Sickness (W)

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: None

Caring: None

Effective: % of Virtual OP Appointments, OP Utilisation, Outpatient DNA Rate

Responsive: RTT performance, RTT > 40 weeks

Well-Led: Use of Agency, Nursing Vacancies, Vacancy Rates

Executive Summary Scorecard

Current Month Overview of KPI Variation and Assurance Icons

Trust Domains	Variation					Assurance				Total
									No SPC	
CQC Domain Safe										
Infection Control	3			1				4		4
Harm Free Care	2							2		2
Incident Reporting	2							2		2
Safe Staffing	2							2		2
Mortality	1					1				1
Safe Total	***10***	***0***	***0***	***1***	***0***	***1***	***0***	***10***	***0***	***11***
CQC Domain Effective										
Outpatients	6	2					4	4		8
Quality & CQC	3				1			4		4
Strategy - Estates									5	5
Effective Total	***9***	***2***	***0***	***0***	***1***	***0***	***4***	***8***	***5***	***17***
CQC Domain Caring										
Complaints	2							2		2
Admitted Care	3	1				2		2		4
ED Care	1				1			2		2
Maternity Care	2							2		2
Outpatient Care	1	1					1	1		2
Caring Total	***9***	***2***	***0***	***0***	***1***	***2***	***1***	***9***	***0***	***12***
CQC Domain Responsive										
Elective Access	2	1	2				4	1		5
Acute and Urgent Access	4							4	1	5
Cancer Access	5					2		3		5
Diagnostics Access	1							1		1
Bed Management	1							1		1
Responsive Total	***13***	***1***	***2***	***0***	***0***	***2***	***4***	***10***	***1***	***17***
CQC Domain Well-Led										
Staff Welfare	2							2	4	6
Finance and Contracts	2						1	1	4	6
Leadership					2			2	1	3
Strategy - Clinical and ICC	2		1	2	2		1	6	1	8
Workforce	2		2		2	1	2	3		6
Well-Led Total	***8***	***0***	***3***	***2***	***6***	***1***	***4***	***14***	***10***	***29***
Trust Total	***49***	***5***	***5***	***3***	***8***	***6***	***13***	***51***	***16***	***86***

Corporate Scorecard by CQC Domain

Safe

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
S2	Number of cases C.Difficile (Hospital)	4	3		
S6	Rate of Total Patient Falls	5.80	7.00		
S7	Number of Never Events	0	0		
S8	Number of New SIs in month	11	6		
S10	Overall Safe staffing fill rate	93.5%	89.8%		

Responsive

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
R1	Emergency A&E 4hr Wait	95.0%	94.5%		
R4	RTT Incomplete Pathway	86.7%	63.4%	L	F
R6	% Diagnostics Tests WTimes <6wks	99.0%	88.0%		
R7	Cancer two week wait	93.0%	95.8%		P
R10	Cancer 62 day wait - First Definitive	85.0%	85.4%		P

Effective

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
E2	Standardised Mortality HSMR	Lower conf <100	94.2		P
E3	% Total Readmissions	14.6%	16.0%		
E6	Stroke: Best Practice (BPT) Overall %	50.0%	59.1%	H	
R11	Average LOS Non-Elective	6.50	6.26		
R12	Theatre Utilisation	90.0%	84.6%		F

Well-Led

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
W1	Surplus (Deficit) against B/E Duty	0	0	No SPC	No SPC
W2	CIP Savings (£k)	434	85	No SPC	No SPC
W7	Vacancy Rate (%)	9.0%	13.9%	H	
W8	Total Agency Spend	12	1,574		F
W10	Sickness Absence	3.3%	3.2%		

Caring

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
C1	Single Sex Accommodation Breaches	0	0		P
C3	% complaints responded to within target	75.0%	73.3%		
C5	IP Friends & Family (FFT) % Positive	95.0%	98.5%		
C7	A&E Friends & Family (FFT) % Positive	87.0%	96.0%	H	
C10	OP Friends & Family (FFT) % Positive	84.0%	83.5%		

Variation			Assurance			
H / L	H / L		P	?	F	No SPC
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

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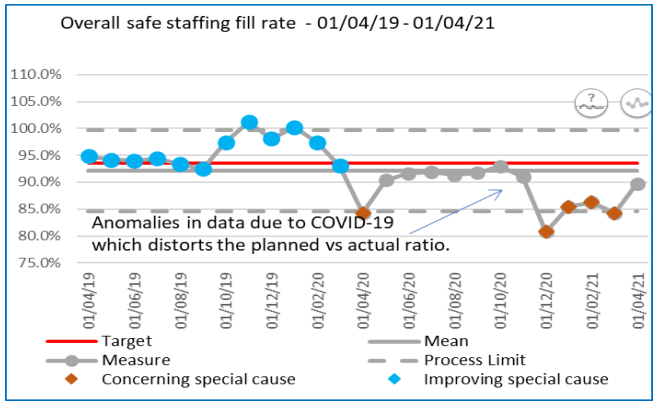
Safe - CQC Domain Scorecard

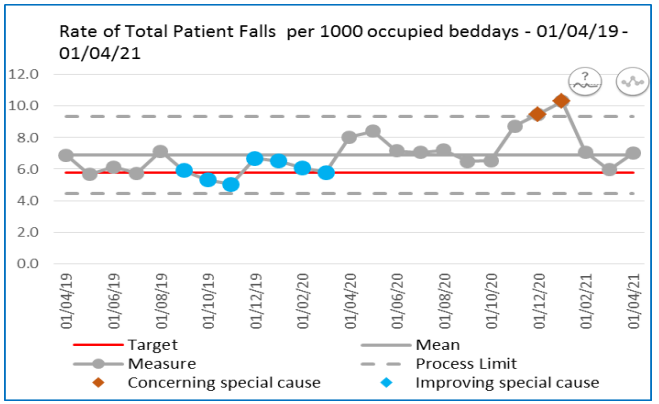
Reset and Recovery Programme: Patient and Staff Safety

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Safe Staffing Levels	93.5%	89.8%	Apr-21		93.5%	84.2%	Mar-21	93.5%	0.0%	
Sickness Rate - Covid	0.0%	0.3%	Mar-21		0.0%	2.9%	Feb-21	0.0%	1.2%	
Infection Control - Hospital Acquired Covid	0	0	Apr-21		0	1	Mar-21	0	0	
Infection Control - Rate of Hospital C.Difficile per 100,000 occupied beddays	23.2	18.0	Apr-21		23.2	37.6	Mar-21	22.6	18.0	
Infection Control - Number of Hospital acquired MRSA	0	0	Apr-21		0	0	Mar-21	0	0	
Infection Control - Rate of Hospital E. Coli Bacteraemia	19.0	12.0	Apr-21		19.0	25.1	Mar-21	30.8	12.0	
Number of New SIs in month	11.0	6	Apr-21		11	7	Mar-21	132	6	
Rate of Total Patient Falls per 1,000 occupied beddays	5.8	7.0	Apr-21		5.8	7.2	Mar-21	5.8	7.0	
Rate of Hospital Acquired Pressure Ulcers per 1,000 admissions	2.3	1.9	Apr-21		2.3	2.6	Mar-21	2.3	1.9	
Standardised Mortality HSMR	100.0	94.2	Jan-21		100.0	89.6	Dec-20	100.0	94.2	
Never Events	0	0	Apr-21		0	0	Mar-21	0	0	

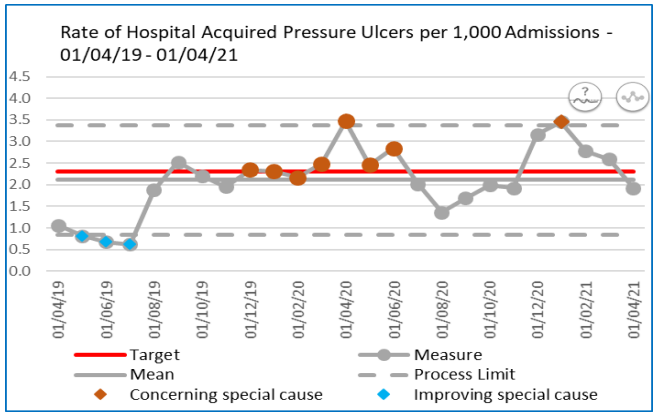
Safe - Reset and Recovery Programme: Patient and Staff Safety



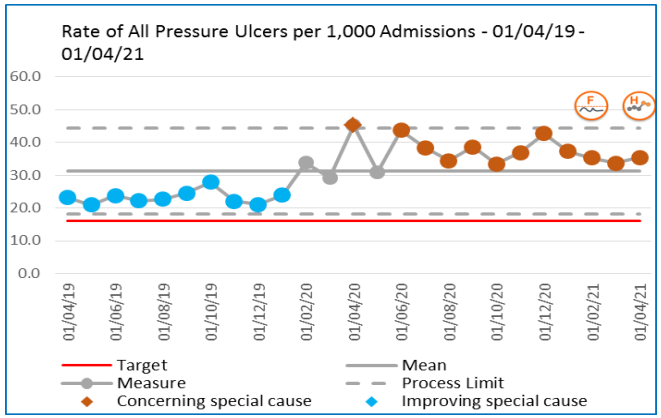
April-21
89.8%
Variance Type
Metric is currently experiencing common cause Variation
Target (Internal)
93.5%
Target Achievement
Metric is experiencing variable achievement



April-21
7.0
Variance Type
Metric is currently experiencing common cause Variation
Max Target
5.8
Target Achievement
Metric is experiencing variable achievement



April-21
1.9
Variance Type
Metric is currently experiencing common cause Variation
Max Target
2.3
Target Achievement
Metric is experiencing variable achievement



April-21
35.4
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Max Target (Internal)
16.0
Target Achievement
Metric is currently not achieving the target

Summary:

Safe Staffing Fill Rate: The level reported is returning to usual levels and has returned to common cause variation and experiencing variable achievement of the standard.

Falls: The number of Falls has returned to mean levels across both sites and the overall rate for the Trust is now within common cause variation.

Pressure Ulcers: The rate of all pressure ulcers is experiencing special cause variation of a concerning nature and is not achieving the target. Hospital Acquired Pressure Ulcers continues to be within common cause variation.

Actions:

The Trust admitted 9 patients with Covid-19 infection during April, with no cases of probable or definite hospital acquired infection. There were no outbreaks of Covid-19. Key messages on the importance of PPE, social distancing and hand hygiene continue to be raised with staff. Visiting arrangements to be reviewed for the next stage of lifting of restrictions by 17 May.

Regular staffing huddles continue which prospectively review the nursing staff rosters to enable planning and action to ensure staffing is as safe as possible across the whole Trust; and to ensure joint working between the nursing teams and the Bank office. Bank team members continue to engage with Matrons at the daily afternoon huddle to update on fil rate, key areas to focus on and deployment of staffing from the established Rapid response unit and targeted lines of work for areas with a lower fill rate.

We continue to monitor falls rate monthly across the Trust and on individual wards. Risk assessment on the increased falls rate was completed and has been added to risk register with further reviews of actions planned.

Assurance:

Patients and visitors wear masks and are encouraged to undertake hand hygiene regularly. Outbreak control measures implemented on affected wards and areas including contact tracing and quarantine of patient contacts. Lateral flow testing available for all staff. Rapid testing available in ED on both sites.

Regular staffing huddles with divisional leads and staff bank are ongoing to review substantive and temporary staffing requirements across all areas. The Trust launch of "Safe Care" to enhance the monitoring and oversight of patients acuity more effectively and support decisions around staffing requirements continues. Training with NHSI / E arranged for June available to DDNQs, Matrons and Ward Managers with representation across all clinical areas. . All staffing levels are reviewed for every shift, every with oversight monitored by the Senior Leadership Team and appropriate redeployment to support staffing levels across the trust.

Continuing to monitor falls across all areas. Themes and trends for falls identified and shared at Fall Group meeting. To raise awareness of falls being everyone's business and as staffing improves, some of the challenges in implementing preventative measures should ease.

Effective - CQC Domain Scorecard

Reset and Recovery Programme: Outpatients

	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Percentage of Virtual OP Appointments	60.0%	34.7%	Apr-21	L	60.0%	39.2%	Mar-21	60.0%	34.8%	F
Percentage OP Clinics Utilised (slots)	85.0%	52.6%	Apr-21	L	85.0%	50.4%	Mar-21	85.0%	53.2%	F
OP New DNAs	5.0%	6.8%	Apr-21		5.0%	6.3%	Mar-21	5.0%	6.8%	?
OP Follow UP DNAs	5.0%	7.1%	Apr-21		5.0%	7.0%	Mar-21	5.0%	7.1%	?
Outpatient Hospital Cancellation	20.0%	18.2%	Apr-21		20.0%	20.3%	Mar-21	20.0%	18.2%	?
Outpatient Cancellations < 6 weeks	10.0%	13.4%	Apr-21		10.0%	16.0%	Apr-21	10.0%	13.4%	?
Calls Answereed in under 1 min	95.0%	44.2%	Apr-21		95.0%	50.1%	Apr-21	95.0%	44.2%	F
Percentage of Calls abandoned	0.0%	10.0%	Apr-21		0.0%	9.3%	Apr-21	0.0%	10.0%	F

Organisational Objectives: Quality and CQC

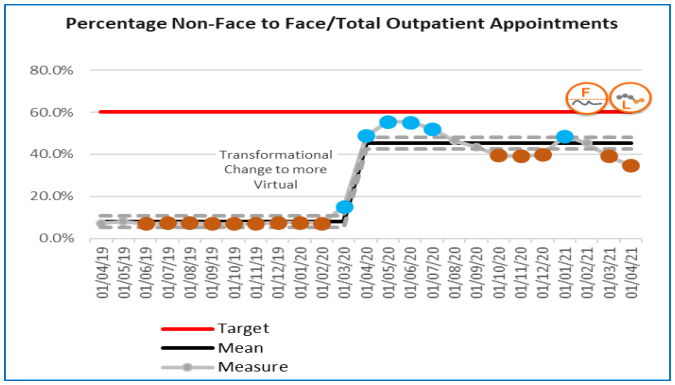
	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Total Readmissions <30 days	14.6%	16.0%	Mar-21		14.6%	16.7%	Feb-21	14.6%	15.1%	?
Non-Elective Readmissions <30 days	15.2%	16.3%	Mar-21		15.2%	16.8%	Feb-21	15.2%	15.3%	?
Elective Readmissions < 30 Days	7.8%	9.6%	Mar-21		7.8%	14.7%	Feb-21	7.8%	9.8%	?
Stroke Best Practice Tariff	50.0%	59.1%	Apr-21	H	50.0%	68.3%	Mar-21	50.0%	59.1%	?

Effective - CQC Domain Scorecard

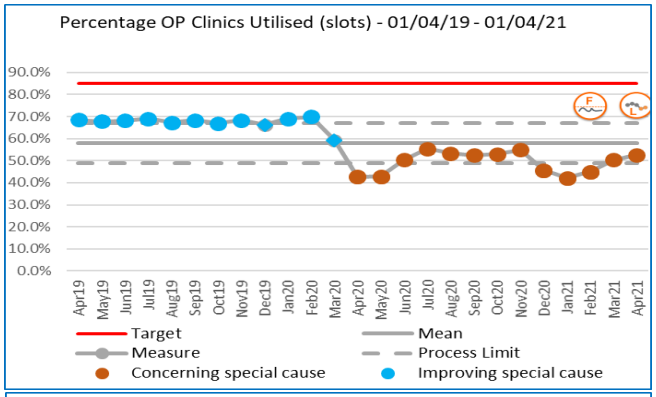
Organisational Objectives: Strategy - Estates

	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Utilised and unutilised space ratio	Under review	100:0	Apr-21	No SPC	Under review	100:0	Mar-21	Under review	100:0	No SPC
Footprint devoted to clinical care vs non clinical care ratio	Under review	4.4:1	Apr-21	No SPC	Under review	4.4:1	Mar-21	Under review	4.4:1	No SPC
Admin and clerical office space in (sqm)	Under review	5808	Apr-21	No SPC	Under review	0	Mar-21	Under review	5808	No SPC
Staff occupancy per m2	Under review	22.6	Apr-21	No SPC	Under review	0.0	Mar-21	Under review	22.6	No SPC
Energy cost per staff	Under review	£ 979.43	Apr-21	No SPC	Under review	£ 979.80	Mar-21	Under review	£ 979.4	No SPC

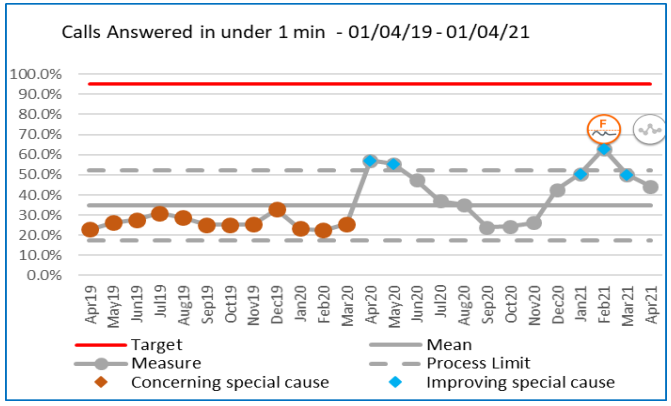
EFFECTIVE- Reset and Recovery Programme: Outpatients



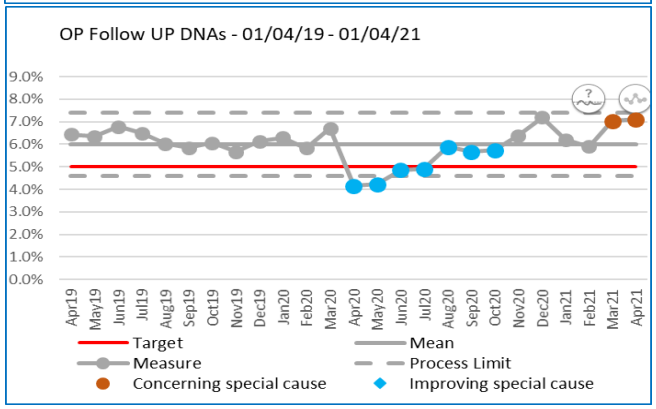
Apr-21
34.7%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
60%
Target Achievement
Metric is consistently failing the target



Apr-21
52.6%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
85%
Target Achievement
Metric is consistently failing the target



Apr-21
44.2%
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
95%
Target Achievement
Metric is consistently failing the target



Apr-21
7.1%
Variance Type
Metric is currently experiencing common cause variation
Max Target (Internal)
5%
Target Achievement
Metric is experiencing variable achievement

Summary:

Using the reset target, the percentage of Non-Face to Face OP Appointments is experiencing special cause variation of a concerning nature and is consistently failing the target

All non urgent outpatient appointments have been cancelled or converted to virtual. This has led to a fall in the volume of consultations and an increase in the number of hospital cancellations.

The number of calls answered in less than 3 minutes and less than 1 minute are both experiencing common cause variation but are consistently failing the 100% target.

As expected due to the COVID-19 pandemic outpatient utilisation levels have decreased and remain lower than usual levels – continuing out of wave 2

DNA rates for both New and Follow up are now experiencing common cause variation and variable achievement of the target.

Actions:

Outpatient attendances have been impacted by COVID-19 but where clinically appropriate appointments have been moved to either a telephone or virtual appointment to avoid cancellations & DNAs.

The Trust is reviewing the demand and capacity as part of the Reset and Recovery Programme for Outpatients. This includes viewing the clinic templates to ensure that utilisation is a true reflection.

Appointments are being reassessed as to what can be converted and cancelled due to the second wave. Activity is currently being assessed now we are in Opel 3 to see what clinics can start up again. Activity is beginning to restart so should see an increase in volume of activity and reduction in cancellations.

Assurance:

Outpatient restart and recovery plan is being considered with the different speciality teams and will be implemented with support from PMO.

The demand and capacity remodelling has been completed and shared with the divisions. This is being reviewed to ensure we are aiming to achieve reset and recovery targets and that activity where clinically appropriate remains virtual.

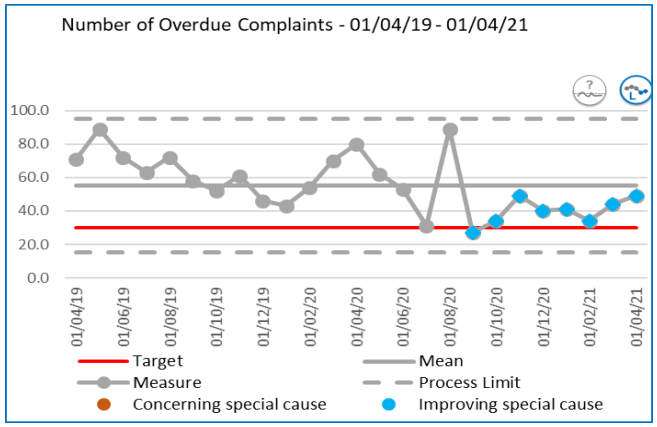
Weekly meeting with specialties regarding clinics restarting is being undertaken to ensure we operate safety and the most efficient possible.

Caring - CQC Domain Scorecard

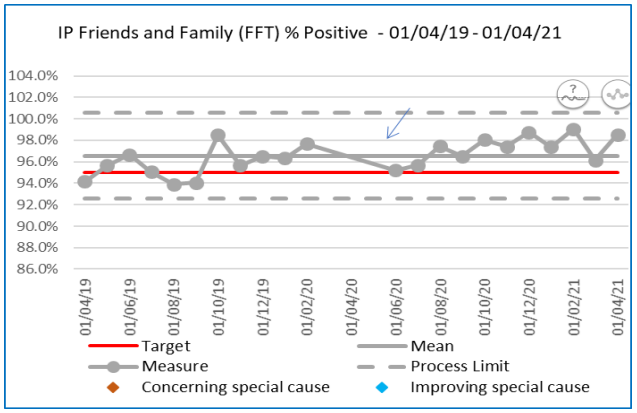
Organisational Objectives – Quality & CQC

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Single Sex Accommodation Breaches	0	0	Apr-21		0	0	Mar-21	0	0	P
Rate of New Complaints	3.9	2.7	Apr-21		3.9	2.6	Mar-21	3.0	2.7	?
% complaints responded to within target	75.0%	73.3%	Apr-21		75.0%	61.1%	Mar-21	75.0%	73.3%	?
IP Resp Rate Recmd to Friends & Family	25.0%	9.2%	Apr-21		25.0%	14.0%	Mar-21	25.0%	9.2%	?
IP Friends & Family (FFT) % Positive	95.0%	98.5%	Apr-21		95.0%	96.1%	Mar-21	95.0%	98.5%	?
A&E Resp Rate Recmd to Friends & Family	15.0%	2.4%	Apr-21		15.0%	1.9%	Mar-21	15.0%	2.4%	?
A&E Friends & Family (FFT) % Positive	87.0%	96.0%	Apr-21	H	87.0%	97.7%	Mar-21	87.0%	96.0%	?
Mat Resp Rate Recmd to Friends & Family	25.0%	15.3%	Apr-21		25.0%	5.2%	Mar-21	25.0%	15.3%	?
Maternity Combined FFT % Positive	95.0%	100.0%	Apr-21		95.0%	96.2%	Mar-21	95.0%	100.0%	?
OP Friends & Family (FFT) % Positive	84.0%	83.5%	Apr-21		84.0%	84.1%	Mar-21	84.0%	83.5%	?
OP Resp Rate Recmd to Friends & Family	68.0%	17.3%	Apr-21	L	68.0%	17.1%	Mar-21	68.0%	17.3%	F
% VTE Risk Assessment	95.0%	95.4%	Apr-21	L	95.0%	96.6%	Mar-21	95.0%	95.4%	P

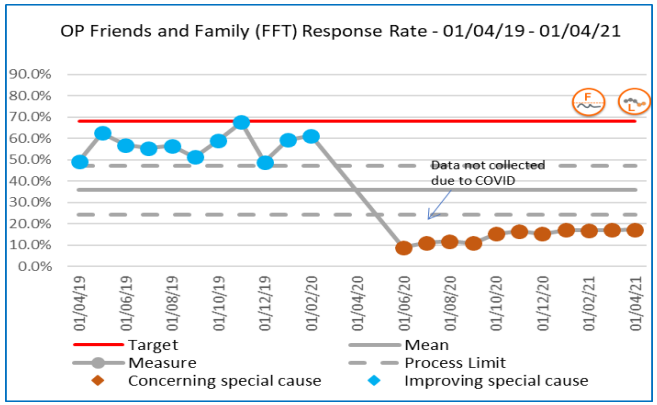
CARING- Organisational Objective: Quality and CQC



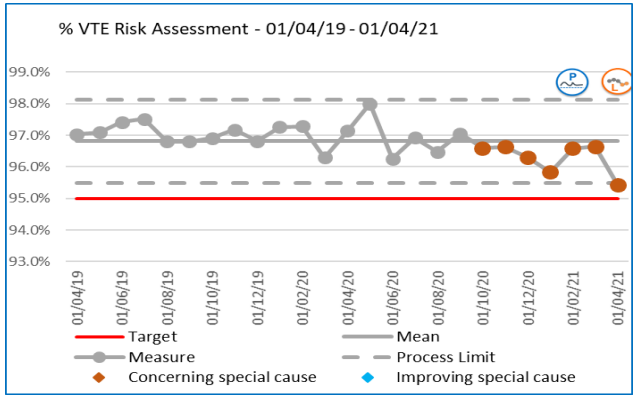
Apr-21
49
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Max Target (Internal)
60
Target Achievement
Metric is experiencing variable achievement



Apr-21
98.5%
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Target (Internal)
95%
Target Achievement
Metric is experiencing variable achievement



Apr-21
17.3%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target
68%
Target Achievement
Metric is consistently failing the target



Apr-21
95.4%
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:

Complaints: The number and rate of new complaints received continues to remain consistent experiencing common cause variation. However performance for the number of overdue complaints continue experiencing special cause variation of an improving nature

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

Inpatient Friends and Family % Positive Rate is now experiencing special cause variation of an improving nature

VTE Risk Assessment has returned to experiencing special cause variation of a concerning nature and consistently achieving the target (this could be attributed with delays in data entry).

Actions:

Complaints: Regular meetings with key divisional staff reinstated to monitor progress on open complaints. New format weekly reports issued with particular emphasis on overdue cases.
Realignment of complaints leads' portfolios to address fluctuations in activity between divisions. – under ongoing review.

OP FFT: OP Matron working with OPT & PE team to increase use of surveys / responses. IPADS purchased and VCA survey to be reconfigured with service leads post pandemic
FFT: IQVIA commissioned new provider of paper surveys; this caused a reduction in submissions in the last month. Issues now identified and expect an improving picture despite the transition.
VTE: Delays in data input due to the wards been under considerable pressure through December and January had impacted the performance reported, however these issues have now been resolved and performance is back to consistently achieving the target.

Assurance:

Complaints: Continued regular monitoring of all open complaints with reports to CN. Learning and key messages published in the Governance Gazette.
Continued compliance despite operational challenges and no significant reductions in complaint activity.

OP FFT: Monthly monitoring of submissions; working with AGM/GM and Matron's to further engage staff in the process. Large number of surveys submitted via VCA

FFT: Risk of paper cards submission delays are reducing as online submissions increase. FFT meeting engagement has increased, new service lines added to ensure submission from newly established areas. Reporting feedback from each departments continues via FFT group. FFT group to consider an FFT 'Perfect Week' to demonstrate best practice with FFT submission and utilisation of feedback.

Responsive- CQC Domain Scorecard

Reset and Recovery Programme - Elective Care

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
RTT (Incomplete) performance against trajectory	86.7%	63.4%	Apr-21	L	86.7%	61.7%	Mar-21	86.7%	63.4%	F
Number of patients waiting over 40 weeks	222	893	Apr-21	H	222	1204	Mar-21	222	893	F
52 week breaches (including those reported last month)	0	423	Apr-21	H	0	822	Mar-21	0	423	F
Access to Diagnostics (<6weeks standard)	99.0%	88.0%	Apr-21		99.0%	89.0%	Mar-21	99.0%	88.0%	?
Average for new appointment	10.0	10.1	Apr-21		10.0	9.0	Mar-21	10.0	10.1	?
Theatre Utilisation	90.0%	84.6%	Apr-21		90.0%	85.5%	Mar-21	90.0%	84.6%	F

Reset and Recovery Programme – Acute & Urgent Care

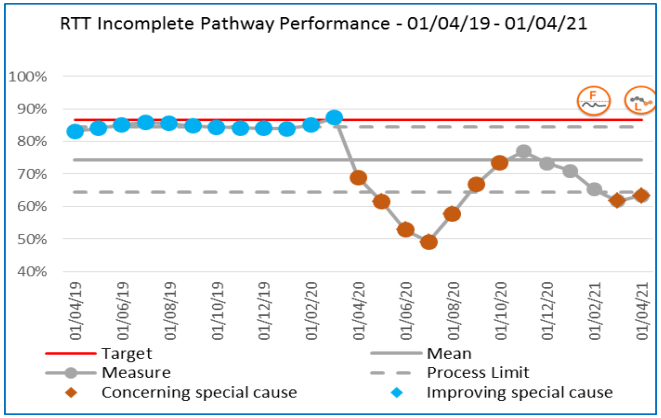
	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Referrals to ED from NHS 111	Coming May 21		Apr-21	No SPC	Coming May 21		Mar-21	Coming May 21		No SPC
A&E 4 hr Performance	95.0%	94.5%	Apr-21		95.0%	96.6%	Mar-21	95.0%	94.5%	?
Super Stranded Patients	80	72	Apr-21		80	61	Mar-21	80	72	?
Ambulance Handover Delays Rate > 30mins	7.0%	4.2%	Apr-21		7.0%	4.6%	Mar-21	7.0%	4.2%	?
Bed Occupancy	90.0%	85.4%	Apr-21		90.0%	82.6%	Mar-21	90.0%	85.4%	?
NE LOS	6.5	6.3	Apr-21		6.5	6.5	Mar-21	6.5	6.2	?

Responsive - CQC Domain Scorecard

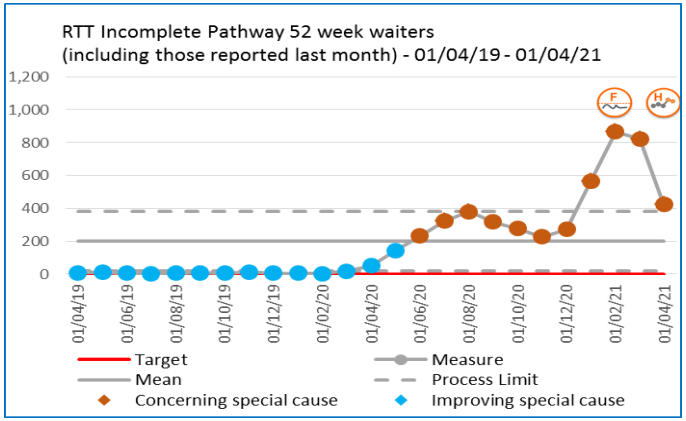
Reset and Recovery Programme – Cancer Services

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Cancer - 2 Week Wait	93.0%	95.8%	Mar-21		93.0%	97.4%	Feb-21	93.0%	95.8%	
Cancer - 31 Day	96.0%	95.0%	Mar-21		96.0%	94.9%	Feb-21	96.0%	95.0%	
Cancer - 62 Day	85.0%	85.4%	Mar-21		85.0%	86.8%	Feb-21	85.0%	85.4%	
Size of backlog	30	83	Apr-21		30	66	Mar-21	30	83	
28 day Target	75.0%	81.9%	Mar-21		75.0%	79.6%	Feb-21	75.0%		

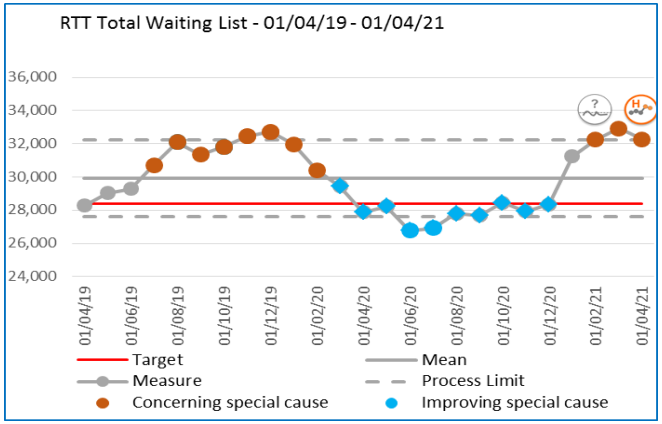
RESPONSIVE- Reset and Recovery Programme: Elective



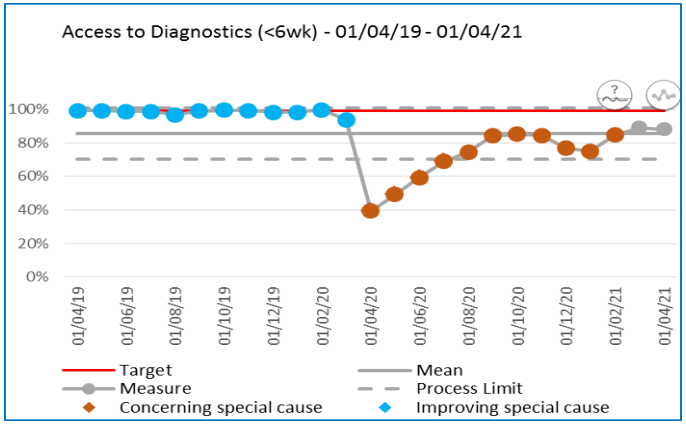
Apr-21
63.4%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
86.3%
Target Achievement
Metric consistently failing the target



Apr-21
423
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Max Target (Internal)
8
Target Achievement
Metric consistently failing the target



Apr-21
32,274
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
28,412
Target Achievement
Metric is experiencing variable achievement



Apr-21
88%
Variance Type
Metric is currently experiencing common cause variation
Target
99%
Target Achievement
Metric is experiencing variable achievement

Summary:

Performance has started to improve with May's performance sitting at 62.8% The April performance of 62.6% was a 1% improvement on March 21.

There has been huge efforts made to reduce the number of 52 week waiters with a current position of 423. The number of 52 week waiters new in month was 46 which is now once again experiencing common cause variation.

With the reopening of theatres, nearly 90% of 2019/20 elective activity levels were achieved and the Trust is on track to achieve the desired levels in May. Outpatients also achieved 95% of 2019/20 activity levels.

CT Scans in April were at 120% of 2019/20 Activity levels, MRI has a reduced performance of 90% of 2019/20 Activity levels and NOUS is running below plan at 86%.

Actions:

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

Robust monitoring of patients in order to maximise clinic & theatre time & increase productivity.

To increase capacity & improve the waiting times for MRI and NOUS

Assurance:

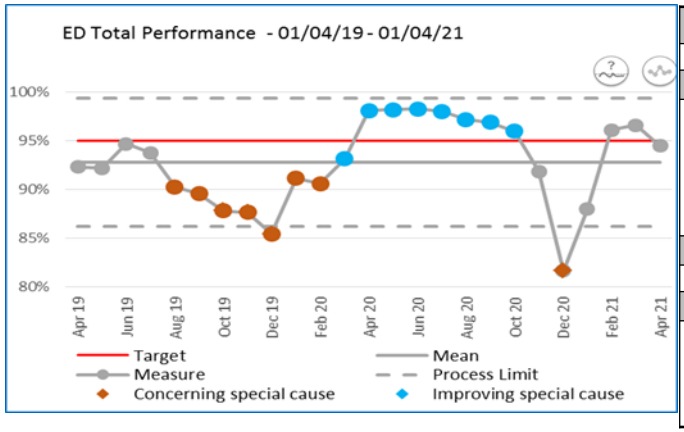
Weekly performance meeting in progress, 6-4-2 and scheduling meetings, cancellations RCA's completed to identify trends. TUB re-instated on the 17th May.

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.

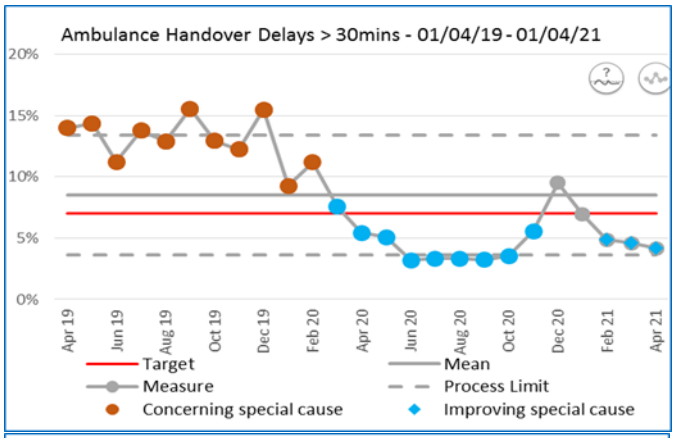
Work is ongoing on the managed MRI project and is on track to deliver. We continue to work closely with ISP partners.

Work continues to streamline process and link with ISP where appropriate

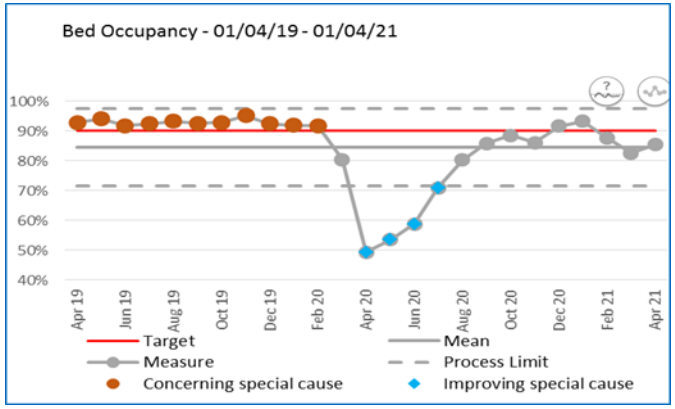
Responsive - Reset and Recovery Programme: Emergency Care



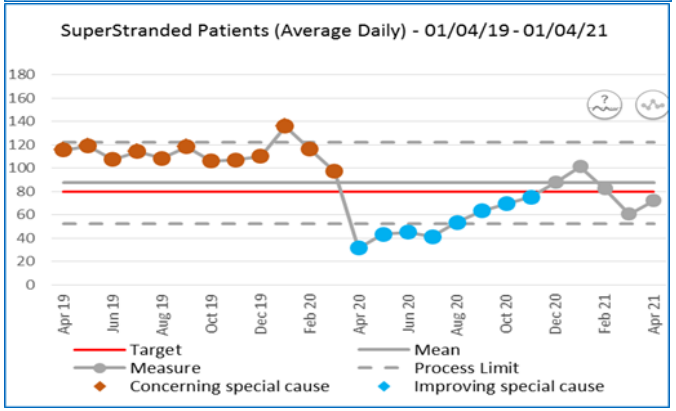
Apr-21
94.5%
Variance Type
Metric is currently experiencing common Cause Variation
Target
95%
Target Achievement
Metric is experiencing variable achievement



Mar-21
4.2%
Variance Type
Metric is currently experiencing Common Cause Variation
Max Limit (Internal)
7.0%
Target Achievement
Metric is experiencing variable achievement



Mar-21
85.4%
Variance Type
Metric is currently experiencing Common Cause Variation
Max Limit (Internal)
90%
Target Achievement
Metric is experiencing variable achievement



Mar-21
72.2
Variance Type
Metric is currently experiencing Special Cause Variation
Max Limit (Internal)
80
Target Achievement
Metric is experiencing variable achievement

Summary:

ED 4hr performance (inc MIU): Following the downward trend seen during the height of the second wave performance has stabilised and is still experiencing common cause variation (94.5% in March). Arrivals (Type 1) were only 1.8% below model in April, seeing attendance levels returning to normal, early indicators suggest an increase above this.

Ambulance delays had settled into 3.0-3.5%, but increased during the height of the second wave due to diverts for mutual aid and Covid. This is now starting to recover and is back to experiencing common cause variation (4.2% in April).

Total bed occupancy continues to recover and is now experiencing common cause variation.

Superstranded patients had been showing a steady increase but is experiencing common cause variation, with an increase last month after the reductions over the previous 2 months.

Actions:

Flow Coordinators appointed across both sites. Developing cross-site rota plus appropriate competencies.

Development of 11/UTC in progress to extend service. Discussion with IC24 to increase referrals from ED to IC24 from April 21. IC24 contract extended by 1 year by CCG

Power BI report in development with four main KPIs to give daily info on key KPI's. Shadowing of new ED clinical standards from April 21 although no targets currently set.

4 WTE ED Consultant posts with interview date in March to support RAP

Development of improved handover times to reduce number of over 30 mins handovers in preparation for targets/winter.

Assurance:

Directorate/ Divisional meetings to review figures, with appropriate escalation.

CQC Focus Group Re-instated with Clinical Leads

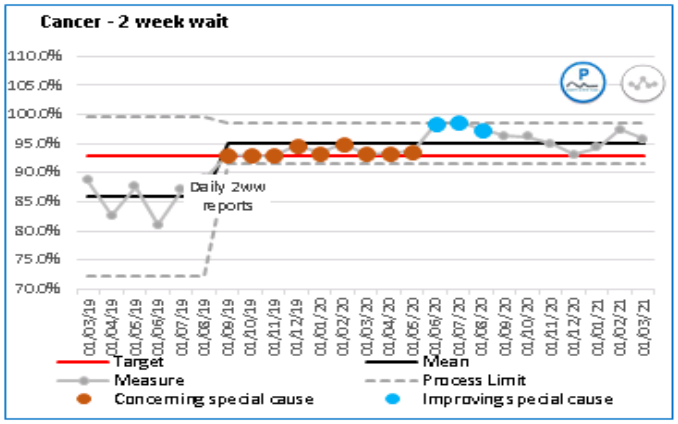
What's App groups in place to promote improved communications with larger team, giving daily performance updates.

Twice weekly meetings with Site Clinical Leads to ensure adequate junior ward/ on call cover for Medicine with Rota Team.

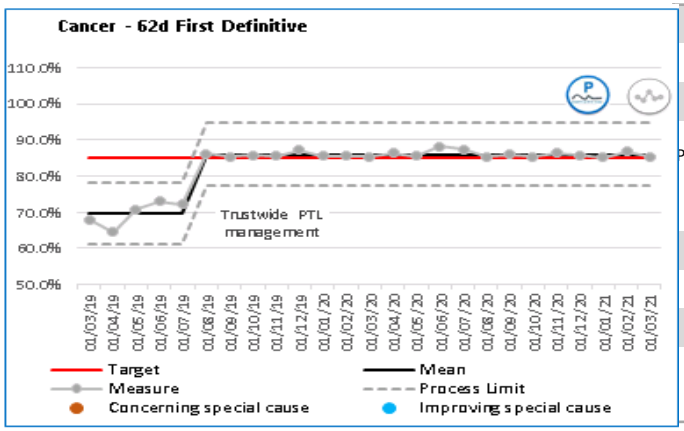
Good working relationship with SECAmb.

Visit from Director of OPs East Kent week commencing 15th March to share processes.

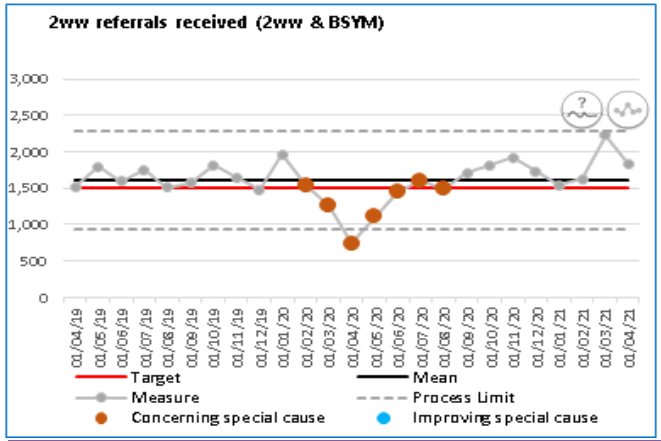
RESPONSIVE- Reset and Recovery Programme: Cancer



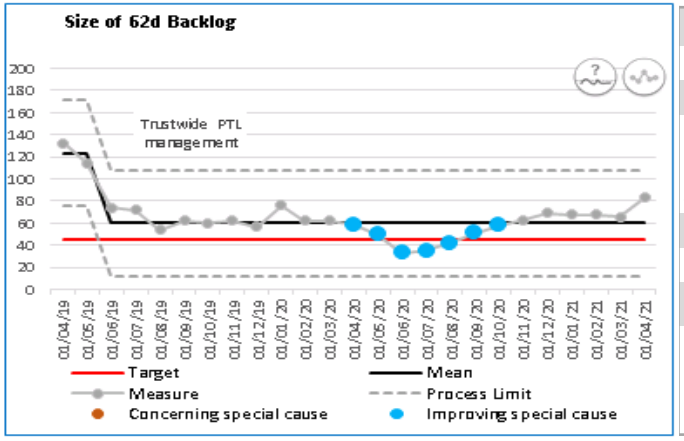
Mar-21
95.8%
Variance Type
Process change Sept 2019 now showing common cause variation
Max Target (Internal)
93%
Target Achievement
Metric is currently achieving the target



Mar-21
85.4%
Variance Type
Process change Aug 2019 now showing common cause variation
Max Target (Internal)
85%
Target Achievement
Metric is currently achieving the target



Apr-21
1833
Variance Type
Metric is currently experiencing Common Cause Variation
Max Target
1500
Target Achievement
Metric is experiencing variable achievement of locally set target



Apr-21
83
Variance Type
After improvement in process from June 2019 – metric is experiencing common cause variation
Max Target (Internal)
45
Target Achievement
Metric is experiencing variable achievement of locally set target

Summary:

The 2ww standard continues to achieve the 93% target, and the process remains within expected levels of variation. The Trust has continued achievement of the 62 day standard and is reporting 85.4% for March 2021. The 2ww referral numbers have seen a significant increase, with 2227 referrals received in March 2021 and 1833 in April 2021 – this remains within expected variation at this time. There will likely be pressure on the 2ww target as these referrals are appointed through April and May. The backlog on the 62d PTL is being consistently managed within expected variation limits

Actions:

Ongoing work is needed to engage all services further and to ensure that both the 28 day FDS and the 62 day performance targets can be met.

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.

Additional resource has helped to support pathway implementation e.g. STT nurses and pathway navigators.

Assurance:

The ongoing daily huddles with each tumour site team are in place and monitoring the growth in the PTL as referral numbers fluctuate. 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 meetings have been implemented to manage data completeness and ensure we are submitted a representative view of our performance.

Weekly triumphvariate meetings help to support key areas of concern and give clinical guidance across services.

Well Led - CQC Domain Scorecard

Reset and Recovery Programme: Staff Welfare

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Climate Survey - Engagement: Number of people completing the Climate survey	Improving Quarterly	909	Jan-21	No SPC	Improving Quarterly	688	Sep-20	Improving Quarterly	688	No SPC
Climate Survey - Percentage of staff who feel fully supported in their role		69.0%	Jan-21	No SPC		67.0%	Sep-20		67.0%	No SPC
Climate Survey - Percentage of staff who feel the Trust has a genuine concern for their safety		71.0%	Jan-21	No SPC		68.0%	Sep-20		68.0%	No SPC
Climate Survey - Percentage of staff who feel able to cope with the demands that are being		69.0%	Jan-21	No SPC		69.0%	Sep-20		69.0%	No SPC
Health and Wellbeing: How many calls received	40	38	Apr-21		40	41	Mar-21	480	385	?
Health and Wellbeing: What percentage of Calls related to Mental Health Issues	44%	45%	Apr-21		44%	36%	Mar-21	44%	51%	?

Organisational Objectives: Workforce

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Sickness	3.3%	3.2%	Mar-21		3.3%	3.7%	Feb-21	3.3%	4.6%	?
Turnover	10.0%	11.4%	Apr-21		10.0%	11.4%	Mar-21	10.0%	11.4%	F
Vacancy Rates	9.0%	13.9%	Apr-21	H	9.0%	14.8%	Mar-21	9.0%	13.9%	?
Use of Agency	81	234	Apr-21	H	81	314	Mar-21	81	234	F
Appraisal Completeness	95.0%	91.0%	Apr-21	H	95.0%	91.0%	Mar-21	95.0%	91.0%	?
Stat and Mandatory Training	85.0%	90.1%	Apr-21	H	85.0%	89.9%	Mar-21	85.0%	90.1%	P

Well Led - CQC Domain Scorecard

Reset and Recovery Programme: Finance & Contracts

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Surplus (Deficit) against B/E Duty (£k)	0	0	Apr-21	No SPC	- 5,896	- 566	Mar-21	0	0	No SPC
CIP Savings (£k)	434	85	Apr-21	No SPC	No data		Mar-21	434	85	No SPC
Cash Balance (£k)	40,828	40,828	Apr-21	No SPC	1,000	26,221	Mar-21	40,828	40,828	No SPC
Capital Expenditure (£k)	161	119	Apr-21		1,329	18,922	Mar-21	161	119	?
Agency Spend (£k)	12	1,574	Apr-21		1,668	1,903	Mar-21	12	1,574	F
Use of Financial Resources	No data		Apr-21	No SPC	No data		Mar-21	No data		No SPC

Reset and Recovery Programme: ICC

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Nursing vacancies	13.5%	20.1%	Apr-21	H	13.5%	20.3%	Mar-21	13.5%	20.1%	?
Covid Positive - number of patients	0	9	Apr-21		0	11	Mar-21	0	9	?

Well Led - CQC Domain Scorecard

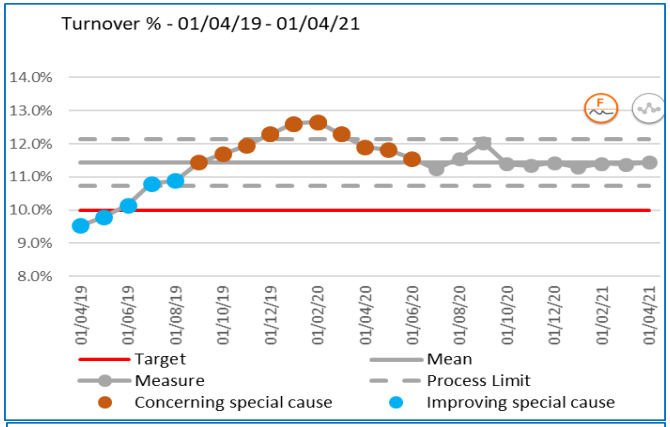
Organisational Objectives - Strategy – Clinical

	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Number of specialist services	35	30	Apr-21	L	35	30	Mar-21	35	360	?
Elective Spells in London Trusts from West Kent	329	200	Apr-21	L	329	300	Mar-21	329	3,532	?
Service contribution by division	Coming May 21		Apr-21	No SPC	Coming May 21		Mar-21	Coming May 21		No SPC
Research grants (£)	126	149	Apr-21		126	76	Mar-21	126	1,262	?
Number of advanced practitioners	25	31	Apr-21	H	25	31	Mar-21	25	31	?
Percentage of Trust policies within review date	90.0%	76.2%	Apr-21	H	90.0%	77.3%	Mar-21	90.0%	76.2%	F

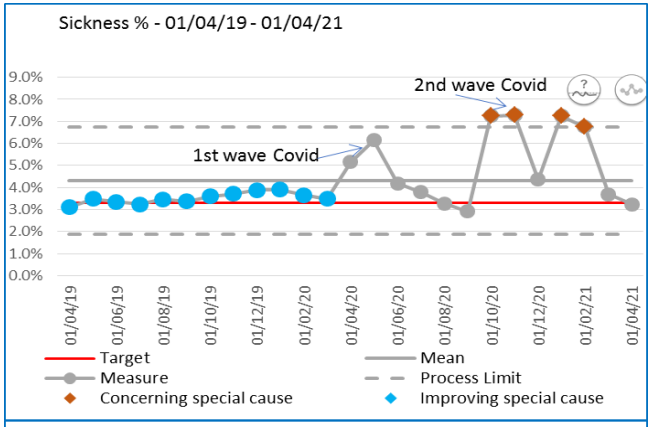
Organisational Objectives – Exceptional People

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Staff Friends and Family % recommended work	70.0%	71.3%	Apr-21	H	70.0%	71.3%	Mar-21	70.0%	71.3%	?
Staff Friends and Family % recommended care	80.0%	81.4%	Apr-21	H	80.0%	81.4%	Mar-21	80.0%	80.0%	?
Equality, Diversity and Inclusion reducing inequalities metrics / dashboard	Coming May 21		Apr-21	No SPC	Coming May 21		Mar-21	Coming May 21		No SPC

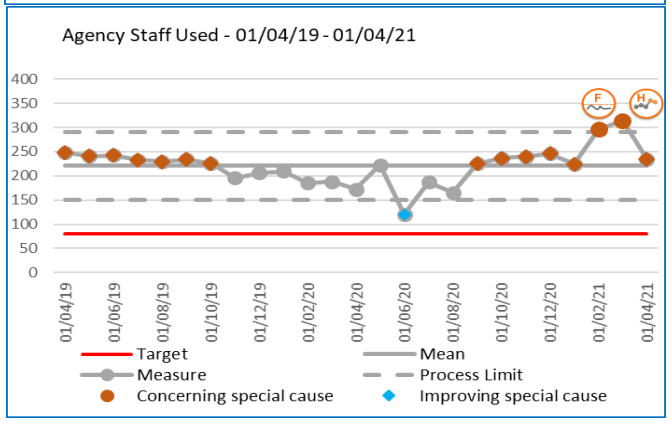
WELL LED- Operational Objective: Workforce



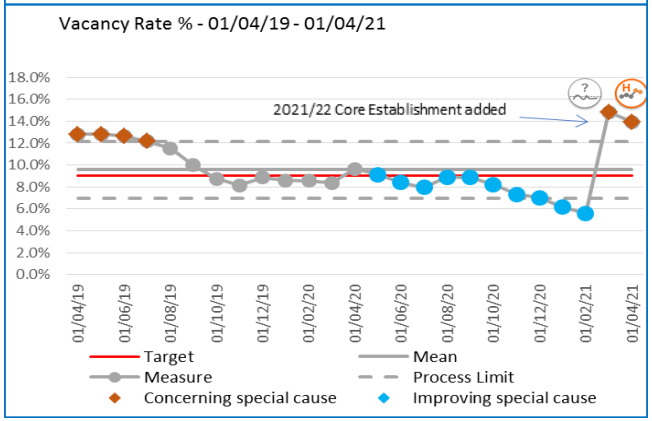
April-21
11.4%
Variance Type
Metric is currently experiencing Common Cause Variation
Max Target (Internal)
10%
Target Achievement
Metric is consistently failing the target



Mar-21
3.2% (One Month Behind)
Variance Type
Metric is currently experiencing Common Cause Variation
Max Target (Internal)
3.3%
Target Achievement
Metric is experiencing variable achievement



April-21
234
Variance Type
Metric is currently experiencing Special Cause Variation of a concerning nature
Target (Internal)
81
Target Achievement
Metric is consistently failing the target



March-21
13.9%
Variance Type
Metric is currently experiencing Special Cause Variation of an concerning nature
Max Limit (Internal)
9.0%
Target Achievement
Metric is experiencing variable achievement

Summary:

The Turnover rate is once more within common cause variation but continues to consistently fail the target.

The level of Sickness continues staying at post wave 2 levels in March (data reported one month behind) to 3.2% (of which 0.3% was COVID related sickness) . This is a drop on the previous month and is now within common cause variation as well as meeting the 3.3% standard for the first time since September 2020.

The level of Agency staff used has decreased in April but continues to experience special cause variation of a concerning nature.

Vacancy rate continues to experience special cause variation of a concerning nature. The increase seen last month is as a reflection of using the 2021/22 core establishment figures which account for agreed investment across the Trust moving forward.

Actions:

Turnover: A deep dive into turnover is taking place to identify hotspots and a "Moving On" Survey has been implemented in recent months. The Trust is working to improve the Appraisal Process and is implementing an Exceptional Leaders Programme.

Sickness: We continue to actively monitor and model any impact on safe staffing.

The Workforce (People) Function has 4 areas of focus: Temporary Staffing (Staff Hub) Recruitment, Vaccinations and Staff Welfare. We have completed the last Climate survey in February and preparing action plans to act on the results to drive local interventions to aid retention and implementation plans.
In April we saw a decrease in demand of c.18% for Temporary Staffing. Nursing saw a decrease of almost 20% compared to the previous month but still sees levels considerably higher than the same period last year (similarly the same for CSW's). Medical demand decreased by c.5% compared to the previous month and c.10% compared to the same period last year. Agency usage, although higher than plan has continued to reduce year on year with ongoing plans to migrate agency staff. The Covid-19 second wave impacted significantly on staffing, with additional increases in demand due to the end of the annual leave year.

Assurance:

Nursing and CSW workforce plans have been agreed between the clinical leads and Recruitment team which shows a current need of 332.35WTE across bandings between 2-8. The Recruitment team are now working alongside the divisions to create a plan to achieve this target by the end of the financial year.

From April 2021 to present we have recruited 48 international nurses (32 OSCE Ready and 16 Non OSCE). We have a further 83 international nurses in the pipeline. 12 of the nurses in the pipeline are from India which has a current pause on nurses coming to the UK meaning their start dates will be delayed.

The recruitment team are currently running a pilot with the Women's services directorate for EDI champions. This is running from May- July and will involve EDI champions being involved with the recruitment process of shortlisting and interviewing. All EDI champions have been trained by an external provider to help them recognise bias, both conscious and unconscious, in themselves and others and to help them provide support to recruiting panels

The Trust is reviewing options with could include 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.

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 85.4% and 95.8% respectively. A&E 4hr performance has stabilised after the reduction during wave 2 of Covid and continues to experience common cause variation at 94.5% in April. RTT performance increased in April as elective activity is recovers following the re-opening of Theatres. The national target for April to get back to 70% of 2019/20 elective activity levels were exceeded for inpatients at 89% and total outpatients are now back to 2019/20 levels (95% for First Appointments). The Trust is on track to achieve the desired levels in May. Demand and capacity analysis has been undertaken for all specialities in order to reset the recovery plan for elective care. Patient safety and quality indicators continue showing signs of improvement as bed occupancy and staffing issues start to reduce.

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. The Trust admitted 9 patients with Covid-19 infection during April, however there were no cases of probable or definite hospital acquired infection. Assurance of compliance continues through the IPC BAF. Focus on reminding staff to continue with lateral flow testing and appropriate registering of results .

- **Falls:** The overall rate of falls continues to experience common cause variation and variable achievement of the target. Two SIs relating to Falls was reported. Falls rate continue to be monitored monthly across the trust and on individual wards. Risk assessment on the increased falls rate was completed and added to risk register with further reviews of actions planned.

- **Pressure Ulcers:** The rate of hospital acquired pressure ulcers continues to decrease and remains in common cause variation. The higher level of Deep Tissue Injuries (DTIs), particularly in the Medical and Care of the Elderly specialties has returned to previous levels. Total pressure ulcers (including inherited) continues to experience special cause variation of a concerning nature. The Pressure Ulcer group have discussed learnings from recent incidents to ensure that they are shared across Directorates. Pressure Ulcer information has been provided to the Governance gazette for the next newsletter, to enable learnings to be shared with all Professional groups.

- **Incidents and SIs:** The level of SIs reported decreased to 6. Of these, 2 relate to Falls, 1 related to treatment delay, 1 related to quality of care, 1 related to VTE, and 1 related to an obstetric incident. The level of incidents reported and the rate of incidents that are severely harmful remains below the maximum limit of 1.23.

- **Stroke:** Three of the four Stroke Indicators, including the overall Best Practice Indicator, are now experiencing special cause variation of an improving nature and variable achievement of the target. All four indicators have achieved the internal targets for four consecutive months.

- **A&E 4 hour Standard and Flow:** Following the downward trend seen during the height of the second wave performance has stabilised and is back to experiencing common cause variation (94.5% in April). The Trust continues to implement the ED improvement action plan to support flow throughout the Trust with Flow Coordinators appointed across both sites. Development of 111/Urgent Treatment Centre (UTC) is in progress to extend the service. A&E Attendances are returning to normal levels (1.8% below model). Early indication in May show attendances increasing further as Covid restrictions relax. Emergency admissions have reduced slightly in April, increased in the last 2 months driven by SDEC attenders. Total Bed Occupancy had been steadily increasing from pandemic levels to a high in January but continues to recover and is now experiencing common cause variation. Both Medical Outliers and Super-Stranded Patients are also starting to recover. The A&E Conversion rate is showing an increasing trend due to the decrease in minor injury attendances.

- **Ambulance Handover Delays**: Ambulance delays had settled into 3.0-3.5%, but increased during the height of the second wave due to diverts for mutual aid and Covid. This continues to recover and is back to experiencing common cause variation (4.2% in April).

Supporting Narrative Continued

- **Referral to Treatment (RTT) Incomplete Pathway:** RTT performance increased to 63.4% as elective activity has started to recover. With the reopening of theatres, nearly 90% of 2019/20 elective activity levels were achieved in April 21 and the Trust is on track to achieve the desired levels in May. First Outpatient Appointments achieved 95% of 2019/20 activity levels in April. A further recovery plan is being devised which includes increased use of the Independent Sector. There has been huge efforts made to reduce the number of 52 week waiters. Diagnostics waiting <6 weeks is starting to recover and is back to common cause variation (88% for April).

- **Cancer 62 Day:** From August 2019, when the Trust implemented robust PTL management with service managers across the Trust, the 62 day standard has shown an improved performance and has consistently achieved the 85% standard (reporting 85.4% for March 2021). A process step change has been applied to reflect this and this shows a significant improvement, where the calculated mean up to August 2019 was 66.7% and is now 86.1%, consistently above the target of 85%. The updated chart now reports common cause variation as confirmation of a currently stable process. The 62d Backlog remains at 5% of the total PTL.

- **Cancer 2weeks (2ww):** From September 2019, there has been a continued improvement in the achievement of the 2ww first seen standard, with a consistent achievement of the target (reporting 95.8% for March 2021). The recent 6 months of improved performance is likely due to the lower than expected number of 2ww referrals and the Trust continuing to appoint suspected cancer patients as a priority – utilizing the virtual clinics where possible. A process step change has been applied to this metric, which shows the improved performance increasing from a calculated mean of 86.7% up to September 2019 to 95.0% currently, consistently above the target of 93%.

- **Cancer 2weeks (2ww) Referrals:** After the drop in referral numbers at the beginning of April due to COVID-19, incoming referral numbers have increased through the remainder of 2020, with some months reporting in excess of 114% over the same period in 2019. Overall the numbers of referrals being processed through the 2ww office has returned to expected numbers and is reporting common cause variation.

- **Finance:** The Trust delivered the plan in the month which was to deliver a breakeven position. Income underperformed by £0.6m in April, the Trust is still finalising the performance associated with the Elective Recovery Fund (ERF) and therefore no income was included in the April positon which resulted in a £0.4m adverse variance to plan. If the Trust succeeded in over performing against this target (70% of April 2019) this will be reflected in the May financial position. The remaining underperformance (£0.2m) within income was due to low private patient and RTA activity (£0.1m) and £0.1m bowel scope income underperformance (service has ceased). Discussions are on going relating to the impact of reducing the bowel screening age criteria, it is hoped this will offset in part this income loss. Expenditure budgets underspent by £0.6m. Underspends within pay budgets (£0.8m) and non-pay (£0.3m) were partly offset by unidentified CIP slippage £0.4m and increase in reserves (£0.1m). In line with NHSE/I guidance additional income (£0.6m) has been included in the month 1 position to offset additional costs for PCR swabbing, Rapid testing and vaccination centre.

- **Workforce**: The Safe Staffing Nursing Fill Rate reported is returning to usual levels and has returned to common cause variation, which has impacted on the overall fill rate. Regular staffing huddles with divisional leads and staff bank continue to review prospectively the nursing staff rosters to enable planning and action to ensure staffing is as safe as possible across the whole Trust. Increased multi professions representation are on the wards to help support the nursing staff. The level of Agency staff used had shown a considerable increase but is now starting to reduce. It continues to experience special cause variation of a concerning nature. The bank team continue to work closely with the site team and matrons on finding solutions to reduce agency spend. The Turnover rate remains similar and is consistently failing the target. The Trust is working to improve the Appraisal Process and is implementing an Exceptional Leaders Programme. Climate survey and the "Moving On" survey data is being used to drive local interventions to aid retention. Following the high sickness levels reported in January as expected this has started to reduce with March at 3.2%, achieving the Trust target and experiencing common cause variation. Of the 3.2% reported 0.3% was COVID related sickness. The non-Covid related sickness remains at expected levels for this time of year. The level of Stress/Anxiety and Depression related sickness saw an increasing trend at the height of the Covid Waves but has now reduced. The Trust Daily Staff Hub / Cell continue to review and respond to any Covid pressures but this is now easing as the number of Covid patients within the Trust remains low.

Additional Metrics – in development

Metric	Domain	Corp. Ob / R&R Prg.
Reduction in number of paper blood and X-ray requests received within MTW	Effective	EPR
Reduction in number of requests for paper records from health records	Effective	EPR
Reduction in print costs for pre- printed paperwork	Effective	EPR
Reduction in missing records reported as incidents	Effective	EPR
Reduction in duplicate tests being ordered	Effective	EPR
Dementia rate	Effective	ICP / External
Mental health – Children – Hospital admissions as a result of self harm (age 1(	Effective	ICP / External
Frailty – Admissions due to falls	Effective	ICP / External
System financial performance (£)	Effective	ICP / External
West Kent estates footprint (sqm)	Effective	ICP / External
Number of staff home working against plan	Well Led	Social Distancing / Home
Staff swabbing compliance against guidelines	Well Led	Social Distancing / Home
Compliance with risk assessments e.g. BAME / at-risk staff / VDU	Well Led	Social Distancing / Home
Use of associated technology e.g. MS Teams	Well Led	Social Distancing / Home
Staff reporting having the equipment they need to comply with rules	Well Led	Social Distancing / Home
Implementation of Teletracking	Well Led	ICC
PPE availability	Well Led	ICC
Number of medical students at Trust	Well Led	Education / KMMS
Number of clinical academic posts	Well Led	Education / KMMS
Number of non-medical educators	Well Led	Education / KMMS
% of students reporting a good or better educational experience	Well Led	Education / KMMS
% of medical students retained as FY1s	Well Led	Education / KMMS

The metrics listed above have been removed from the main report whilst the Business Intelligence Team work with Corporate Objective and Programme Leads to source the required to report against these, then they will be reintroduced to the report.

Please note that some metrics relate to programmes that are not live at this point e.g. Tele-tracking and Sunrise, so these will be included at the appropriate time.

REVIEW OF LATEST FINANCIAL PERFORMANCE

Plan Update

- The Trust submitted a financial plan on the 6th May, this was a 6 month plan for the period April to September 21 referred to as H1 (half 1).
- The plan is a breakeven position but includes £7.2m of medium and high risk items. The plan includes a CIP requirement of £2.6m and contingency of £2.5m.

- The Trust's capital plan agreed with the ICS/STP for 2021/22 is **£10.57m** comprising:
- **Net Internal funding (£8.9m):**
  - £15.9m depreciation
  - £0.7m in-year cash surplus
  - £0.28m System Emergency PDC for HASU
  - £0.08m Salix Loan (second year)
  - less £8m of PFI finance and capital investment loan repayment
- **PFI lifecycle** per Project model of **£1.2m** - actual spend will be notified periodically by the Project Company.
- **Donated Assets** of **£0.4m** relating to forecast donations in year

- The Plan figure of £10.57m 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 ICC modular build and KMMS enabling work.
- **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. Trust wide equipment will be prioritised.

April Financial Position

- The Trust delivered the plan in the month which was to deliver a breakeven position.
- In line with NHSE/I guidance additional income (£0.6m) has been included in the month 1 position to offset additional costs for PCR swabbing, Rapid testing and vaccination centre.
- The Trusts key variances to the plan are:
  - Income underperformed by £0.6m in April, the Trust is still finalising the performance associated with the Elective Recovery Fund (ERF) and therefore no income was included in the April position which resulted in a £0.4m adverse variance to plan. If the Trust succeeded in over performing against this target (70% of April 2019) this will be reflected in the May financial position. The remaining underperformance (£0.2m) within income was due to low private patient and RTA activity (£0.1m) and £0.1m bowel scope income underperformance (service has ceased). Discussions are on-going relating to the impact of reducing the bowel screening age criteria, it is hoped this will offset in part this income loss.
  - Expenditure budgets underspent by £0.6m. Underspends within pay budgets (£0.8m) and nonpay (£0.3m) were partly offset by unidentified CIP slippage £0.4m and increase in reserves (£0.1m).
- Capital spend in month 1 was £119k against the Plan of £161k. The majority of this relates to the EPR project but there were also elements of carry forward spend from projects commenced in 2020/21.

Cash Update

- The Trust carried forward a balance of £26.2m from 2020/21 and was able to pay some significant statutory and contractual creditors in March for payments that would otherwise have awaited April cash funding. This has led to a higher closing cash balance at the end of April of £40.8m.

- 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 continuing to finalise the various adjustments based on this assessment and to incorporate any new items for 2021/22 H1 as well as the repayment of the £8.6m 2020/21 adjustment included within the carried forward cash balance of £26.2m. The cashflow is currently forecasting this repayment in March 2022. The remaining 6 months of the cashflow is based on similar values to the first 6 months with some minor adjustments. This will need to be updated alongside H2 Income & Expenditure planning. At present the closing cash balance is assumed at a level of £5m but this will need to be updated to reflect H2 assumptions.
- Part of the carried forward balance of £26.2m also relates to c£6m capital creditors where invoices were not received in March. These are expected to be paid within the first quarter of 2021/22. The capital programme for the year is £10.6m which the cashflow has currently phased monthly in accordance with the submitted capital plan. The phasing of the capital spend is back ended but will be revised when projects are confirmed and approved. The balance sheet is assuming a reduction in capital creditors carried forward from c£6m to closing creditors of £2m within the cash flow - therefore the capital cash spend overall in the cash flow is c£14.6m.
- Monthly business rates and NHS Resolution (clinical negligence) payments are paid over 10 months which are phased within the cash flow compared to the I&E which phases these over 12 months.
- The Trust has reduced to having two capital investment loans which along with interest are repaid in September and March, the Salix loans are capital repayment only, interest free and are paid in April and October. The Trust also has PDC repayments totalling £2.8m repaid in September and March.

Maidstone and Tunbridge Wells NHS
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1. Dashboard

April 2021/22

	Current Month				Year to Date				Annual Forecast / Plan (Month 1-6)			
	Actual £m	*Plan* £m	*Variance* £m	*RAG*	*Actual* £m	*Plan* £m	*Variance* £m	*RAG*	*Actual* £m	*Plan* £m	*Variance* £m	*RAG*
Income	47.9	48.5	(0.6)		47.9	48.5	(0.6)		291.0	291.0	0.0	
Expenditure	(45.2)	(45.9)	0.6		(45.2)	(45.9)	0.6		(274.8)	(274.8)	0.0	
EBITDA (Income less Expenditure)	2.6	2.6	0.0		2.6	2.6	0.0		16.1	16.1	0.0	
Financing Costs	(2.7)	(2.7)	(0.0)		(2.7)	(2.7)	(0.0)		(16.4)	(16.4)	0.0	
Technical Adjustments	0.1	0.0	0.0		0.1	0.0	0.0		0.3	0.3	0.0	
Net Surplus / Deficit (Incl Top Up funding s	**0.0**	**0.0**	**0.0**		**0.0**	**0.0**	**0.0**		**0.0**	**0.0**	**0.0**	
Cash Balance	40.8	40.8	0.0		40.8	40.8	0.0		36.4	36.4	0.0	
Capital Expenditure (Incl Donated Assets)	0.1	0.2	0.0		0.1	0.2	0.0		1.7	1.7	0.0	

Summary Current Month:

- The Trust delivered the plan in the month which was to deliver a breakeven position.
- Income underperformed by £0.6m in April, the Trust is still finalising the performance associated with the Elective Recovery Fund (ERF) and therefore no income was included in the April positon which resulted in a £0.4m adverse variance to plan. If the Trust succeeded in overperforming against this target (70% of April 2019) this will be reflected in the May financial position. The remaining underperformance (£0.2m) within income was due to low private patient and RTA activity (£0.1m) and £0.1m bowel scope income underperforamance (service has ceased). Discussions are on going relating to the impact of reducing the bowel screening age criteria, it is hoped this will offset in part this income loss.
- Expenditure budgets underspent by £0.6m. Underspends within pay budgets (£0.8m) and nonpay (£0.3m) were partly offset by unidentified CIP slippage £0.4m
and increase in reserves (£0.1m).
- In line with NHSE/I guidance additional income (£0.6m) has been included in the month 1 position to offset additional costs for PCR swabbing, Rapid testing and vaccination centre.

Risks within reported finanical 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 £0.9m has been incorpated to offset the costs reported in the month.
    - Stroke development (£0.2m)

2. COVID 19 Expenditure and Income Impact

2020/21 Summary of Cost Reimbursement

Expedniture

Breakdown by Allowable Cost Type	£000s
Expanding medical / nursing / other workforce	0
Sick pay at full pay (all staff types)	15
COVID-19 virus testing (NHS laboratories)	0
Remote management of patients	0
Support for stay at home models	14
Direct Provision of Isolation Pod	0
Plans to release bed capacity	0
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	0
Segregation of patient pathways	619
Enhanced PTS	0
Business Case (SDF) - Ageing Well - Urgent Response Accelerator	0
Existing workforce additional shifts	82
Decontamination	0
Backfill for higher sickness absence	1
NHS 111 additional capacity	0
Remote working for non patient activites	0
National procurement areas	4
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	55
PPE - locally procured	0
Other	150
COVID-19 virus testing- rt-PCR virus testing	603
COVID-19 - Vaccination Programme - Provider/ Hospital hubs	3
COVID-19 virus testing - Rapid / point of care testing	30
Total Expenditure (£000s):	**1,576**

Income

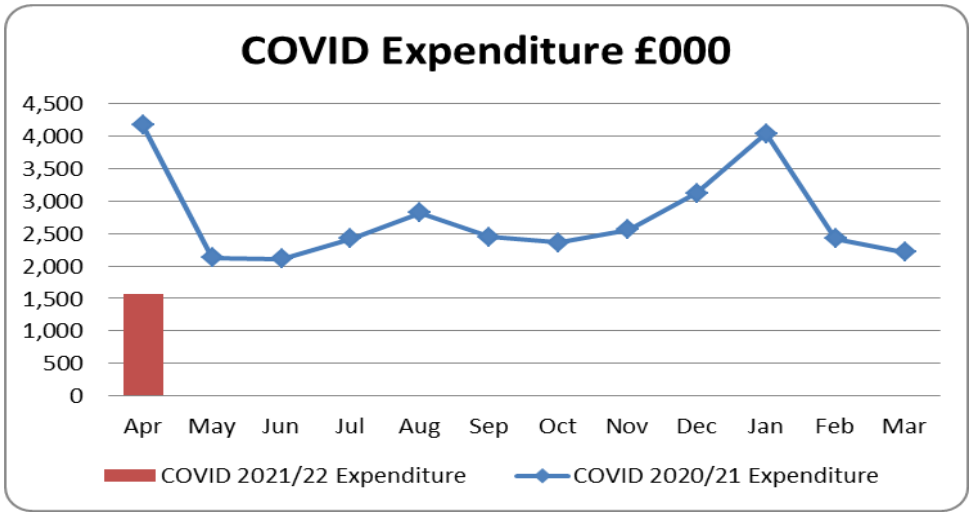
Breakdown by income type	£000s
Free staff car parking	47
Catering - Income loss	13
Total Income (£000s):	**60**

Grand Total (£000s):	**1,636**

Commentary:
The Trust has identified the financial impact relating to COVID to be £1.6m.

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.

The Trust has included £0.6m income in the position to offset the costs of COVID swabbing , rapid testing and vaccination programme. This will be validated by NHSE/I over the next few months before funding is confirmed.



Apr-21		DAY				NIGHT				TEMPORARY STAFFING						Nurse Sensitive Indicators				Financial review		
Hospital Site name	Health Roster Name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Bank/Agency Usage	Agency as a % of Temporary Staffing	Bank / Agency Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand Unfilled -RM/N (number of shifts)	Overall Care Hours per pt day	FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Stroke Unit (M) - NK551	67.0%	105.6%	-	100.0%	87.4%	102.4%	-	-	30.6%	29.8%	328	20.80	94	9.4	0.0%	0.0%	12	0	271,510	236,038	35,472
MAIDSTONE	Culpepper Ward (M) - NS551	101.9%	89.1%	-	-	96.7%	103.2%	-	-	27.5%	29.2%	43	2.94	3	5.2	0.0%	0.0%	2	0	108,091	107,548	543
MAIDSTONE	John Day Respiratory Ward (M) - NT151	98.5%	94.2%	-	-	101.4%	102.6%	-	-	34.2%	26.7%	100	6.90	6	6.3	0.0%	0.0%	6	1	141,330	156,523	(15,193)
MAIDSTONE	Intensive Care (M) - NA251	87.9%	124.2%	-	-	72.6%	96.3%	-	-	8.1%	0.0%	96	5.53	39	44.0	200.0%	100.0%	0	0	245,486	202,430	43,056
MAIDSTONE	Pye Oliver (Medical) - NK259	84.1%	87.3%	-	-	110.0%	103.2%	-	-	34.6%	46.7%	142	8.58	41	6.7	8.5%	100.0%	6	1	119,709	136,090	(16,381)
MAIDSTONE	Whatman Ward - NK959	79.7%	85.6%	-	100.0%	104.5%	153.8%	-	-	38.7%	21.0%	124	8.35	19	8.3	0.0%	0.0%	0	0	89,023	114,463	(25,440)
MAIDSTONE	Lord North Ward (M) - NF651	85.9%	83.2%	-	100.0%	98.8%	83.7%	-	-	19.1%	8.2%	58	3.90	17	7.8	0.0%	0.0%	1	1	106,494	107,543	(1,049)
MAIDSTONE	Mercer Ward (M) - NJ251	96.3%	82.2%	-	-	104.3%	98.5%	-	-	22.1%	25.0%	83	5.47	16	5.8	0.0%	0.0%	0	0	106,617	111,571	(4,954)
MAIDSTONE	Edith Cavell - NS459	75.1%	126.8%	-	100.0%	88.4%	254.8%	-	-	59.4%	41.5%	194	13.46	45	6.8	0.0%	0.0%	8	0	114,962	100,792	14,170
MAIDSTONE	Acute Medical Unit (M) - NG551	84.1%	87.5%	-	-	136.6%	187.9%	-	-	36.6%	18.4%	136	9.19	43	15.0	0.0%	0.0%	3	0	136,864	140,058	(3,194)
TWH	Ward 22 (TW) - NG332	81.7%	103.3%	-	100.0%	96.8%	126.3%	-	-	41.9%	31.4%	150	10.51	40	8.2	7.1%	100.0%	15	2	126,783	148,457	(21,674)
TWH	Coronary Care Unit (TW) - NP301	73.7%	87.1%	-	-	84.9%	-	-	-	33.1%	39.3%	116	6.92	46	12.6	0.0%	0.0%	0	1	67,534	64,034	3,500
TWH	Ward 33 (Gynae) (TW) - ND302	96.9%	93.6%	-	-	98.4%	100.0%	-	-	39.6%	3.0%	63	3.92	6	8.0	38.6%	100.0%	0	0	111,429	107,401	4,028
TWH	Intensive Care (TW) - NA201	143.3%	102.0%	-	-	130.1%	69.4%	-	-	22.6%	0.0%	158	10.13	10	44.4	0.0%	0.0%	0	0	376,174	269,647	106,527
TWH	Acute Medical Unit (TW) - NA901	79.1%	95.8%	-	100.0%	101.9%	101.1%	-	-	24.1%	17.2%	196	13.70	78	11.7	0.0%	0.0%	9	0	206,716	196,592	10,124
TWH	Surgical Assessment Unit (TW) - NE701	100.4%	99.5%	-	-	51.3%	59.7%	-	-	13.2%	0.0%	16	1.07	0	-	0.0%	0.0%	0	0	69,264	53,743	15,521
TWH	Ward 32 (TW) - NG130	78.8%	72.5%	-	100.0%	72.6%	63.0%	-	100.0%	14.8%	8.2%	74	4.76	13	8.7	0.0%	0.0%	1	0	139,999	103,058	36,941
TWH	Ward 10 (TW) - NG131	107.5%	96.7%	-	100.0%	96.0%	110.2%	-	-	37.0%	14.8%	134	8.42	22	7.0	0.0%	0.0%	2	0	130,327	147,809	(17,482)
TWH	Ward 11 (TW) Winter Escalation 2019 - NG144	0.6%	1.6%	-	-	0.0%	0.0%	-	-	0.0%	No hours	No Demand	No Demand	No Demand	-	0.0%	0.0%	-	0	0	-298	298
TWH	Ward 12 (TW) - NG132	89.2%	101.7%	-	100.0%	98.9%	99.9%	-	-	29.7%	11.0%	109	6.34	39	6.3	0.0%	0.0%	8	0	135,385	142,808	(7,423)
TWH	Ward 20 (TW) - NG230	98.3%	110.6%	-	-	132.1%	112.1%	-	-	52.1%	37.3%	202	13.93	51	6.1	0.0%	0.0%	5	2	158,596	143,486	15,110
TWH	Ward 21 (TW) - NG231	89.6%	94.9%	-	100.0%	92.6%	122.6%	-	-	29.3%	29.1%	150	9.44	49	7.1	0.0%	0.0%	6	1	142,779	156,535	(13,756)
TWH	Ward 2 (TW) - NG442	86.8%	97.9%	-	100.0%	119.2%	134.8%	-	100.0%	28.1%	18.6%	122	7.62	52	9.6	0.0%	0.0%	13	1	136,753	152,220	(15,467)
TWH	Ward 30 (TW) - NG330	97.7%	99.3%	-	100.0%	101.1%	133.3%	-	-	33.2%	4.6%	94	5.46	27	8.2	13.3%	87.5%	3	0	125,658	140,063	(14,405)
TWH	Ward 31 (TW) - NG331	87.1%	100.4%	-	100.0%	96.8%	133.3%	-	-	48.3%	16.4%	181	11.02	56	7.1	31.7%	84.4%	9	1	134,914	143,561	(8,647)
Crowborough	Crowborough Birth Centre (CBC) - NP775	39.1%	89.3%	-	-	36.5%	44.4%	-	-	3.6%	0.0%	16	0.87	0		0.0%	0.0%		0	69,201	65,323	3,878
TWH	Midwifery (multiple rosters)	81.0%	54.4%	-	-	92.1%	90.4%	-	-	16.3%	1.0%	780	43.98	123	12.3	53.4%	98.5%	1	0	683,537	706,686	(23,149)
TWH	Hedgehog Ward (TW) - ND702	109.6%	99.9%	-	-	105.0%	-	-	-	30.9%	53.7%	169	11.49	32	14.2	0.8%	100.0%	1	0	135,425	178,679	(43,254)
MAIDSTONE	Maidstone Birth Centre - NP751	110.6%	90.0%	-	-	98.2%	100.0%	-	-	17.0%	0.0%	23	1.44	0		0.0%	0.0%	0	0	70,015	77,233	(7,218)
TWH	SCBU (TW) - NA102	82.2%	922.7%	-	100.0%	92.1%	-	-	-	21.0%	0.0%	143	7.73	2	17.3	0.0%	0.0%		0	172,746	182,995	(10,249)
TWH	Short Stay Surgical Unit (TW) - NE901	49.6%	91.5%	-	-	48.2%	75.0%	-	-	21.0%	7.1%	40	2.57	6	12.3	0.0%	0.0%	0	0	73,587	56,035	17,552
MAIDSTONE	Accident & Emergency (M) - NA351	97.9%	67.7%	-	-	116.3%	115.1%	-	-	47.5%	27.2%	518	35.16	155		0.0%	0.0%	0	0	274,825	324,765	(49,940)
TWH	Accident & Emergency (TW) - NA301	73.7%	64.4%	-	100.0%	87.9%	80.2%	-	-	40.4%	44.5%	606	42.16	171		4.7%	96.0%	3	0	377,965	387,182	(9,217)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	78.1%	37.8%	-	-	65.6%	-	-	-	12.6%	7.5%	13	0.80	1	12.2	0.0%	0.0%	0	0	65,523	44,804	20,719
MAIDSTONE	Peale Ward COVID - ND451	76.8%	79.2%	-	100.0%	124.7%	50.3%	-	-	23.7%	48.5%	101	6.89	30	18.8	41.2%	92.9%	0	0	107,230	94,873	12,357
MAIDSTONE	Foster Clark - NS251	92.2%	83.9%	-	100.0%	108.9%	84.9%	-	-	18.9%	0.0%	19	0.89	0	9.2	0%	0%	3	0	115,187	146,747	(31,560)
MAIDSTONE	Short Stay Surgical Unit (M) - NE751	62.8%	34.4%	-	-	25.7%	0.0%	-	-	1.5%	45.5%	41	3.10	36	18.1	0%	0%	0	0	50,173	42,795	0
																				5,697,811	**5,690,286**	**7,525**
																				Total Established Wards		
																				Additional Capacity beds	Cath Labs	54,431	41,813	12,618
																					Whatman	0	0	0
																					Ward 32 (Wells Suite) (TW) - PP01	0	0	0
																					Chaucer	0	744	(744)
																					RECU - NS459	0	0	0
																					Foster Clarke Winter Escalation 2(	0	4,548	(4,548)
																				Other associated nursing costs		4,568,125	3,909,718	658,407
																						10,320,367	**9,647,109**	**673,258**

RAG Key

Under fill / Overfill

Green: Greater than 90% but less than 110%
Amber Less than 90% OR greater than 110%
Red Less than 80% OR greater than 130%

NHS Maidstone and Tunbridge Wells NHS Trust

Update on 2021/22 planning **Director of Strategy, Planning and Partnerships**

Please find enclosed an update on 2021/22 planning.

Which Committees have reviewed the information prior to Board submission?
- Finance and Performance Committee – 25/05/21

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

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

Planning Update

Activity and Financial Plan

MTW

NHS
Maidstone and
Tunbridge Wells
NHS Trust

This document reflects the latest planning position covering Q1 and Q2 of 21/22, which will feed into the K&M ICS submission

- This document reflects the trust position on 20th May 2021
- Provider trajectories are due for submission to the ICS on 26th May
- There are no provider meetings with ICS colleagues proposed on operational planning in advance of the final K&M submission on 3rd June

Validation of Aprils' actual activity vs. our internal model provides confidence to improve our activity plan submission significantly beyond phase 4 target levels. The improvement in April vs. model is driven by completion of cashing up clinics and better recognition of independent sector activity.

First OP Total	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Phase 4 Target	70%	75%	80%	85%	85%	85%
Actual 21/22 as % of 1920	95%	35%	0%	0%	0%	0%
21/22 Plan as % of 19/20	95%	105%	106%	104%	114%	101%
FUP OP Total	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**
Phase 4 Target	70%	75%	80%	85%	85%	85%
Actual 21/22 as % of 1920	106%	34%	0%	0%	0%	0%
21/22 Plan as % of 19/20	100%	102%	98%	104%	105%	100%
All OP Total	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**
Phase 4 Target	70%	75%	80%	85%	85%	85%
Actual 21/22 as % of 1920	102%	35%	0%	0%	0%	0%
21/22 Plan as % of 19/20	99%	103%	100%	104%	108%	101%

Elective IP	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Phase 4 Target	70%	75%	80%	85%	85%	85%
Actual 21/22 as % of 1920	99%	23%	0%	0%	0%	0%
21/22 Plan as % of 1920	95%	89%	94%	97%	94%	90%
Elective DC	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**
Phase 4 Target	70%	75%	80%	85%	85%	85%
Actual 21/22 as % of 1920	88%	17%	0%	0%	0%	0%
21/22 Plan as % of 1920	87%	82%	88%	93%	92%	84%
Total Elective	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**
Phase 4 Target	70%	75%	80%	85%	85%	85%
Actual 21/22 as % of 1920	89%	17%	0%	0%	0%	0%
21/22 Plan as % of 1920	88%	83%	89%	94%	92%	85%

The effect of EPR deployment has been modelled through e.g. for Gastroenterology and Neurology – OP capacity has been reduced by 30% week one, 15% week two (given these specialities are piloting the whole pathway change), order comms specialities will lose 1 hour of OP activity per day for 1st week e.t.c. In total these changes only cause a -0.88% variance to total activity in June.

The 52 week wait position will improve significantly through June 2021. There is a negative effect of patients currently waiting in the over 18 and26 week categories tipping over to become 52 week breaches which we will have recovered by the end of the financial year.

		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
RTT	52 wk waiters	435	179	140	220	333	469	440	400	380	280	210	160

Core diagnostic modalities remain broadly compliant following validation of Aprils activity. NOUS capacity has improved from first submission.

MRI	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Phase 4 Target	100%	100%	100%	100%	100%	100%
21/22 Plan as % of 1920	90%	95%	101%	92%	91%	98%

CT	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Phase 4 Target	100%	100%	100%	100%	100%	100%
21/22 Plan as % of 1920	104%	97%	102%	99%	99%	100%

NOUS	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Phase 4 Target	100%	100%	100%	100%	100%	100%
21/22 Plan as % of 1920	81%	77%	85%	85%	88%	87%

Colonoscopy	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Phase 4 Target	100%	100%	100%	100%	100%	100%
21/22 Plan as % of 1920	70%	70%	70%	70%	70%	70%

Flexi Sigmoidoscopy	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Phase 4 Target	100%	100%	100%	100%	100%	100%
21/22 Plan as % of 1920	100%	100%	100%	100%	100%	100%

Gastroscopy	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Phase 4 Target	100%	100%	100%	100%	100%	100%
21/22 Plan as % of 1920	100%	100%	100%	100%	100%	100%

- The colonoscopy plan has deteriorated as we are not providing a bowel scope service which was active in 19/20. We have requested the activity is removed from our baseline.
- It was assumed that extension of the age range to a bowel screening service would replace this activity, however this is not starting until October 21.
- We are working with the service to improve the position in advance of the final return
- We are liaising with the ICS and NHSI/E to determine if the baseline position can be adjusted to take account of this

Cancer trajectories are compliant with all standards.

		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Q1	Q2
Cancer 2WW (93%)	Peformance %	93.1%	93.0%	93.0%	93.0%	93.0%	93.0%	93.01%	93.00%
		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Q1	Q2
Cancer 2WW Breast (93%)	Peformance %	93.33%	93.10%	93.24%	93.26%	93.55%	93.33%	93.23%	93.38%
		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Q1	Q2
Cancer 31 Day First (96%)	Peformance %	96.25%	96.23%	96.18%	96.14%	96.06%	96.20%	96.22%	96.13%
		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Q1	Q2
Cancer 31 Day Surgery (94%)	Peformance %	94.12%	96.67%	96.97%	96.88%	96.88%	96.15%	95.88%	96.67%
		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Q1	Q2
Cancer 31 Day Drugs (98%)	Peformance %	98.25%	98.25%	98.18%	98.97%	98.78%	98.13%	98.22%	98.60%
		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Q1	Q2
Cancer 31 Day Radio (94%)	Peformance %	94.05%	94.07%	94.12%	94.03%	94.31%	94.16%	94.08%	94.16%
		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Q1	Q2
Cancer 62 days (85%)	Peformance %	85.03%	85.12%	85.17%	85.05%	85.25%	85.10%	85.11%	85.14%
		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Q1	Q2
Cancer 62 day Screening (90%)	Peformance %	92.86%	90.00%	90.00%	90.00%	90.00%	90.00%	91.23%	90.38%
		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Q1	Q2
Cancer 62 day Upgrade (85%)	Peformance %	85.71%	88.46%	88.24%	87.50%	88.24%	86.67%	87.84%	87.34%
		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Q1	Q2
Cancer Faster Diagnosis 28 Days	Peformance %	75.01%	75.04%	75.04%	75.04%	75.01%	75.00%	75.03%	75.02%

A&E trajectory is challenged in July and August 2021. The West Kent ICP development board is discussing the current levels of demand across the partners, which may support delivery.

		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Q1	Q2
A&E Type 1, Type 3 (inc Crowb)	Peformance %	94.63%	97.14%	95.00%	91.15%	90.07%	96.85%	95.62%	92.68%
	Number of arrivals	3,716	3,780	3,843	3,930	3,962	3,994	11,340	11,887
	Delays 15-30mins	1,561	1,588	1,422	1,258	1,070	879	4,570	3,206
	Delays 30-60 mins	111	113	115	118	119	120	340	357
Ambulance Handover delays	Delays >60mins	-	-	-	-	-	-	-	-

Financial Plan submitted 6 May 2021

Statement of comprehensive income	20 April Execs 2021/22 Plan H1 £'000	6 May Submission 2021/22 Plan H1 £'000
Operating income from patient care activities	270,702	272,261
Other operating income	20,146	20,146
Employee expenses	(177,381)	(174,163)
Operating expenses excluding employee expenses	(105,491)	(102,039)
OPERATING SURPLUS / (DEFICIT)	7,976	16,205
FINANCE COSTS	(16,512)	(16,512)
NET FINANCE COSTS	(8,536)	(307)
Technical Adjustments	307	307
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(8,229)**	**0**
Central Assumption Surplus	5,112	0
Gap from central assumption	**(13,341)**	**0**

- A Financial Plan has been developed to in line with the planning guidance for H1 2021/22.
- The plan is a breakeven position but includes £7.2m of medium and high risk items. The plan includes a CIP requirement of £2.6m and contingency of £2.5m.
- The system has removed the requirement for the Trust to have a surplus of £5.1m.
- Kent and Medway CCG has confirmed funding to MTW which was £6.1m lower than previously expected. The plan assumes additional income from K&M CCG of £6.7m which has not yet been confirmed and income from the Elective Recovery Fund of £2.2m.

Movements from 20 April to 6 May and Risks

Movements from 20 April to 6 May		
Gap at 20 April	(13,341)	
Surplus requirement removed	5,112	
Change in CCG income assumptions	(6,126)	
Internal adjustments	(1,751)	
Sub total	(16,106)	
Improvements to plan		Risk
Stroke Funded	1,372	Low
Income for prime provider	5,400	High
ERF	2,200	Low
Reduce Covid Spend	2,000	Low
CCG Income Support	3,300	Low
CIP stretch and cost reductions / slippage in recruitment	1,834	Medium
Revised Plan	(0)	
Other mitigations		
Contingency	2500	
CCG commitment to support ERF if not achieved as a system	2200	

Movements

- The change in CCG income assumptions and surplus requirement in addition to smaller internal changes gives a £16.1m deficit. The Trust has identified improvements to reduce this gap to a breakeven position but this includes £5.4m high level and £1.8m medium level risks. It does retain a contingency of £2.5m.

Risks

- The plan assumes additional income from Kent and Medway CCG for Stroke (£1.4m) and Prime Provider (£5.4m) which has not yet been confirmed.

- The plan assumes income from the Elective Recovery Fund of £2.2m. This is dependent on system performance as well as Trust performance. The value could be increased if the internal activity plan is fully delivered. The CCG have committed to cover the ERF assumption if funding isn't received nationally therefore this reduces the risk to low.

- The plan assumes a reduction in Covid spend of £2m, this will be possible if segregation of pathways and social distancing measures can be reduced.

- The plan assumes a further CIP target or cost reduction of £1.8m. Further work is needed to confirm this value.

Assumptions:

Assumptions

- Non Pay is based on 19/20 activity levels plus inflation uplift
- Pay is based on the agreed establishments, with an adjustment at Divisional level for vacancies and temporary staff premiums.
- Income is based on the envelope agreements from the CCG for H1.
- We expect to meet the threshold targets for the ERF, we hope to be able to access the ERF to support additional waiting lists and outsourcing but this is dependent on overall system performance. There is an assumption of additional income of £2.2m from the ERF but no additional expenditure above the established capacity.

Assumptions

- The following items are expected to be funded outside of the K&M system envelope;
  - Ockenden – A bid has been submitted for £1.1m support to midwifery and Obstetrician investment required to support the actions from the Ockenden report.
  - Med Tech – we are reviewing if we can implement the four recommendations
  - COVID out of envelope including swabbing and vaccination centres
- AFC Pay Award funding will be allocated following pay review settlement.

CIP:

Target H1 £2.6m

- The total CIP requirement for a breakeven position is £2.6m. This consists of the national efficiency requirement CIP of 0.28% for H1 (£0.8m) , in addition the Trust needs to deliver a further CIP of £1.8m to fund internal investments made in 2020/21 not covered by additional funding.

- The Trust expects the efficiency CIP of £0.8m to be delivered as a result of on-going work during 2020/21.
  - Rates
  - Estates
  - Agency
  - Procurement

- The further CIP of £1.8m will need further work to be delivered.

H2 CIPs

- H2 will be a further challenge, there will be some FYE but further schemes will need to be developed during H1 to ensure delivery from H2.

- Review of previously agreed business cases to ensure savings are being delivered.

Next Steps

System level

- Continue to work with CCG to confirm funding support for Stroke and Prime Provider
- Continue work started to understand full potential for ERF as a system

Internal review

- Review of phasing including workforce plan
- Review if costs can be reduced, for example identify when some Covid costs can be reduced or removed.
- Review of approved business cases to ensure objectives and savings are being delivered
- Review of costs compared to activity to ensure investment has increased activity as planned.
- CIP development for H2

Appendices

Appendix 1 – Detailed on going COVID and Agreed 2020/21 Business cases)

On Going COVID	WTE	Bottom up Annual £
IT Licences	0.00	12,720
PPE / FIT Testing Team	7.00	288,592
Security	0.00	990,696
Free Staff Car Parking	0.00	563,442
Edith Cavell Ward opened due to covid	34.91	1,368,601
4 x SHO for Edith Cavell and Peale	4.00	242,084
Red & Green Pathway Funding	33.65	1,339,106
First Contact Practitioner (FCP)	10.39	599,877
Ward 20 - Two extra RN on every shift 24/7	10.38	447,226
Peale Ward	36.06	1,307,090
Peale/Edith Cavell	2.00	176,910
Covid Virtual Ward	1.05	52,359
Swabbing Team BC	54.61	0
Temp Check BC	13.33	365,213
Rapid Testing	12.92	0
Catering costs to current average spend	0.00	583,982
Catering income reduction in line with Q3 average	0.00	557,664
Other	0.00	0
Total	**220.30**	**8,895,561**

Other Agreed Business Case	WTE	Bottom up Annual £
FTSU Guardian	0.80	46,699
Delirium Case	1.00	51,468
Enhanced Supportive Care	9.78	469,608
SABR Business Case	2.00	108,947
End Of Life Posts	2.00	107,539
Breast Consultant (6th and 7th)	10.25	1,136,555
EGFR / ROS Business Case	3.00	90,496
QFIT	0.86	99,001
Pharmacy Robot	0.00	58,077
ED Consultant Business Case	4.10	783,425
Sunrise/EPR Go live	11.76	397,702
ID720 Complex Ablation Service	0.00	38,959
ID700 Diabetes Educator	1.00	54,288
ID701 Diabetes Specialist Nurses	2.00	103,058
TB Service	2.25	187,467
Ophthalmology Nursing (6 day Business Case)	3.10	112,865
Obstectrics Theatre Business case	3.17	150,115
ODP Apprentice b/c, started Sept 20, 2 each site	4.00	159,938
B/C 771 new Trainee Breast Fellow	1.00	61,456
Overseas Recruitment	0.00	2,158,151
Cyber Security (Splunk)	0.00	95,000
POCT Business Case	2.00	0
Teletracking	1.00	521,274
ID748 Overseas Nurses	2.00	105,718
Other	7.22	113,535
Total	**74.29**	**7,211,340**

Appendix 2 – Reset and Recovery and Other changes

Recovery and Rest	WTE	Bottom up Annual £
Corporate Changes	14.43	961,928
PPE Team	0.00	148,140
Cancer and Out Patients	29.40	1,572,468
Diagnostics and Clinical Support	7.00	171,880
Medicine and Emergency	19.00	1,423,189
Surgery	32.57	2,131,769
W&CH	8.50	407,228
Operations Restructure	*6.00*	600,000
Other	1.00	149,725
Total	**117.90**	**7,566,328**

R&R Extra Detail:

Surgery – 6 x Consultant posts (1x Emergency, 2 x ENT, 1 x Ophth, 1 x Breast, 1 x Gynae On) plus £200k in full year for Endoscopy

Medicine and Emergency – 7 Day Matron Service and partial 7 days service case (5 Consultants and 6 SHOs)

Corporate – ICC £300k in full year and Site Team Restructure £150k

Other Changes	WTE	Bottom up Annual £
Leadership Programme	0.00	556,645
DBS Checks	0.00	25,906
IVE	0.00	501,547
Band 7 IPC Nurse	1.00	57,238
8d Chief Nursing Information Officer part of Digital Transformtation Strategy	1.00	100,837
New Cancer Alliance	8.80	798
Loss of KCHFT EME Contract	0.00	142,426
Loss of KIMS EME Contract	0.00	82,007
Increase phlebotomy per agreed BC - 7 days services support	5.16	138,308
NHSBT increase of 5% in 21.22	0.00	123,403
Teletracking - Facilities	20.00	568,901
MIU contract increase	0.00	293,749
UTC charges	0.00	446,883
New Matron ENT Pressure	1.00	57,433
Divisional Business Manager	0.40	36,258
DDOO - Posts	2.00	161,006
UIU Manager Pressure	1.00	48,637
Lead Cancer nurse	1.00	57,433
Cancer Drugs - match to M6-12 average	0.00	1,672,729
Homecare Post	1.00	64,364
Medicine Drugs to 21/22 outturn	0.00	242,000
Chief registar role	1.00	77,554
2 x Vascular Nurses	2.00	80,000
Other	-7.93	30,776
Total	**37.43**	**5,566,837**

NHS
Maidstone and Tunbridge Wells NHS Trust

The 'go live' for the Sunrise Electronic Patient Record (EPR) **Medical Director**

Please find enclosed "The 'go live' for the Sunrise Electronic Patient Record (EPR)" report

Which Committees have reviewed the information prior to Board submission?
- Finance and Performance Committee – 25/05/20

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

Executive Summary

This paper is to provide an update to the Finance and Performance committee on the planning that has been put into place in order to prepare for the forthcoming go live of the Sunrise EPR programme of Phase 1 across the Summer of 2021. This includes outlining the proposed timelines, the sign off of the clinical workstreams through user acceptance testing and clinical safety case review. In addition, this paper provides an update on the latest position for training and organisational readiness by Division as well as the outstanding technical tasks to be completed before go live.

Timelines

The Trust's EPR programme is set over a 10-year period, with the initial phases supported by Allscripts. The original phasing and scope were reviewed and revised following the delays due to Covid-19. The table below outlines the timelines proposed for Phase 1 occurring across Summer 2021. Phase 2 which includes Electronic Prescribing and medicines administration (EPMA) and Electronic Discharge Notification (EDN) is planned for later this year but is not covered within this paper.

16th June 21	23rd June	21st Jul 21 (MGH)	18th Aug 21 (TWH)
• Order Comms (Pathology / Radiology and Referrals) • OPD (Gastro & Neurology) • Paediatrics (Hedgehog, Woodlands and Riverbank) • Therapies (TDI flowsheet) • ED (MGH)	• ED (TWH)	• Core Clinical Documentation + Observations • Therapies (Roll out Division by Division)	• Core Clinical Documentation + Observations • Therapies (Roll out Division by Division)

Clinical Workstreams

For each of the clinical workstreams, a dedicated project board was set up, with users from the specific areas alongside the Sunrise EPR team to oversee the 'as is' before desiging the 'to be' processes. As part of this process they had to confirm the scope, identify benefits, highlight risks and mitigating actions, identify dependencies as well as the confirming the final configuration of the system for their workstream.

In addition, the Clinical Design Decision Authority has been involved in taking decisions on Trust wide design issues within EPR, as well as assessing the Clinical Safety case review for Sunrise. This will now be signed off by the Trust Clinical Safety Officers and the Supplier which is due to be completed before the end of May.

User Acceptance Testing (UAT)

In total during the course of the programme five separate rounds of user testing has been completed alongside five data priming exercises between Sunrise and PAS. The last round of UAT completed at the end of March 21, which focused on the Patient Journey. This involves testing different Patient Journey Scenarios across Emergency Department (ED), in-patients (IP) and outpatients. This was designed to concentrated on how patient care is provided across ED to IP by emulating a real-life patient journey across the hospital from admission to discharge. Over 204 individuals attended the UAT5 patient journey sessions held over 2 weeks.

All areas of functionalities in scope for Sunrise Summer go live was tested at the same time during UAT5. Testing was focused on ED, Order Comms (Pathology, Radiology & Referrals), core clinical documents/ e-observations, Inpatient Paediatrics, Outpatients and Therapies. Admission, Discharge and Transfer testing were also included to ensure bed/ ward, consultant/speciality transfer in PAS reflected correctly in Sunrise. All problems found were raised on an issue log and were prioritised for fixing. At the end of April all the identified GLB/ major issues from UAT5 had been fixed. There are still some areas that need to be tested but these are dependent on the live environment becoming available during May are currently scheduled.

Training

In total 5,850 individuals need to be trained on Sunrise for the initial go live. As of 18th May, four weeks after training launched

- 1718 now completed training (29%)
- 1528 on-line in progress (26%)
- 617 people booked into remaining classes (10.5%)
- 67% of classrooms now booked as further classes added this week
- 341 Classroom spaces remain
- 5% DNA rate for classroom sessions (total 92)

The table below provides a breakdown per Division of the numbers trained or in progress / booked

	MEC	Surg	W&C	C Sup	Corp	Cancer
Total to be trained	1512	1399	717	1461	184	511
Staff booked classrooms (future)	328	111	59	68	15	24
Staff DNA classroom (%)	3%	1%	1%	0%	2%	0%
Training in progress (on line)	251	797	104	142	84	104
Total staff completed training (classroom / on-line)	551 (37%)	372 (27%)	108 (15%)	341 (23%)	124 (67%)	112 (22%)

- Of the 5,850 individuals 3,700 staff need to do Order Comms training. As of 18th May only 19% of staff have competed this training. All original classroom spaces are now booked therefore an additional seventeen face to face classes have been arranged providing spaces for another 150 staff and the team is also increasing group training via MS teams to compliment on line training.
- In addition to the above another 1200 staff need to complete the Read only course via e-learning which currently stands at 39%.
- 40% of ED staff have completed their training with another 125 booked which if they all complete would take the department to 71%. 23% of Paediatric staff have completed their training with another 34 booked which if they all complete would take the department to 52%. This is still currently lower than the 80% target for both areas and is focus of the teams to ensure this is improved further in the coming weeks especially within ED as there is a heavy reliance on agency staff at the current time.
- For all courses there is a big push within Divisions for the remaining individuals to complete their training before go live and this being monitored weekly right down to individual department levels
- Training 'Sand pit' (practice computers) is now starting to be rolled out to enable staff to consolidate training and familiarise themselves with the system.

Technical Readiness

Underpinning the implementation of Sunrise is a number of technical activities that the programme team is responsible for coordinating with the support of Allscripts, IT and BI as well as relevant directorates. Progress against each of these is outlined in the table below.

Workstreams	Build	Test	Cutover
Programme Mgt			
ED	Complete		
Order Comms	Complete		
EPR Enablers	Complete		
Windows 10	Complete	Complete	
Core Clinical Docs	Complete		
Paediatrics	Complete	Complete	
Therapies	Complete		
OPD – Pilot Areas	Complete	Complete	
Sunrise PR61 Upgrade	Complete		

- **Detailed Cutover Plan** – Plan continues to be developed and validated with supplier and operational teams as well as IT to reflect any necessary changes / mitigating actions being put into place as required. This includes scheduling decision to proceed (DTP) meetings between now and the 16th June.
- **ED** - further testing of ECDS is planned to continue right up to go live. This will enable users to be involved in data entry and at volume to provide more robust testing of Developed Extracts populated during UAT. Alongside this further testing of Operational Reports and PowerBI will also continue. New ED Clinics have been configured in PAS to replace existing ones on Symphony which also need to be tested with users before being adopted. Depending on this testing, the Division would like to move towards using clinics on PAS before Sunrise goes live. In addition, detailed plans for transition between Symphony / PAS and Sunrise / PAS both technically and operationally continue to be worked through including ensuring Teletracking is not disrupted. It is likely that there will need to be a period of collecting ECDS standards using downtime paper processes to ensure data on Sunrise matches real time activity and performance within the department.
- **Order Comms** - Catalogue Testing is due to be completed on the 18/05/21. There is one known issue relating to a specific Haematology test which needs input from DXC to resolve and they have been made aware. Catalogue testing will continue once loaded into the live system as the Pathology team wish to test ordering volumes as well as label printing and review how results are displayed. Alongside this Allscripts will review the Custom Code Performance. In addition, due to phased go live within ED the ordering of tests for TW ED will require downtime paper processes to be invoked for 1 week. This may also be required in Oncology due to Windows 10 rollout not being completed on time (see below)
- **EPR Enablers** – Almost all label printers needed for Order comms have been installed across the Trust. The transmission policies to support this are ready to be installed into Live environment and then will be tested. The remaining printers are dependant on some additional power sockets being installed particularly at Maidstone as departments have changed in light of COVID and other demands for devices. Business continuity solution also needs to be tested across the organisation including running a mock exercise before go live. In addition, the TIE Migration and upgrade needs to be scheduled following completion of pathology catalogue testing.
- **Windows 10** – Overall is progressing well however there are known issues in four specific areas including Pathology, Maternity, Oncology and Endoscopy. In all cases contingency plans are being put in place to ensure that Sunrise go live is maintained by rolling out selected PC's for EPR use only, bringing extra resources to roll out equipment and prioritising high volume paper order comm areas to be upgraded first to minimise the impact to diagnostic services, if any need to remain on paper ordering for a short period post go live.

- **Mobile Observations Pilot** – Pilot ward has been identified and initial configuration is complete, however this has currently been deprioritised for unit testing to enable the team to focus on June Go-Live priorities for resolution.
- **TDI Replacement** – as with ED, further Report Development and Testing will continue for the next few weeks using additional data being added by users to provide assurance all data required is collected correctly.
- **Patch Release (PR61)** - To ensure the Trust was on the latest version before go live Allscripts advised applying latest patch. Following the application of the patch, regression testing commenced which identified 2 critical issues that needed a fix by Sunrise Global Development team and a further 70 issues which require local configuration. The roll out of PR61 to the live system was delayed until the 2 critical issues were fixed by Allscripts which was completed by 12th May. Out of the other 70 issues, as of 17th May, 38 are left outstanding and are being worked on daily in order to resolve before go live with support of our supplier. PR61 has now been successfully applied to our live environment and now needs to be rolled out to the rest of the organisation which is being to be scheduled.

Organisational Readiness

Alongside the technical component of Sunrise, it is recognised that implementing an EPR requires significant change in the way individuals work. During the last year due to COVID, engagement between the EPR programme with the workforce was reduced, therefore the Trust recently employed two dedicated organisational development leads to join the team to focus on accelerating readiness for change. They have been working alongside the existing business change analysts to assist the Divisions in developing their implementation plans and assessing organisational readiness for Sunrise at Directorate level. The below table outlines the current assessment as of the 17th May.

Criteria	Diagnostics & Clinical Support	Cancer	Women's and Childrens	Medicine	Surgery
Training and knowledge support					
Comms and engagement					
SOP & To-Be Processes signed off				Relating to ED	
Impact, Changes and interventions identified and signed-off:				Relating to ED	
Hardware Requirement and Deployment					
Change Ambassadors					
UAT Testing				Relating to ED	
Sunrise User Access					
Go-Live support					
Behavioural Changes					

- **Training and Knowledge Support -** see earlier section
- **Communications and Engagement – T**he EPR programme has always had a clear communication strategy highlighting the key phases, reasons why the system was being introduced, benefits that staff would see, how they could get involved, and how their roles will change as well as informing them of changes to the rollout due to COVID. Alongside this the business change team within EPR has engaged regularly with staff from all the clinical workstreams and key departments to keep them engaged. From the beginning of Nov 2020 a 'Sunrise go live' implementation group was started with named individuals from each Division consisting of a doctor, senior nurse and manager with a focus on clear action plan to ensure departments were ready. Initially this group met monthly increasing to fortnightly from Feb and is now meeting weekly from the start of May. Alongside this each Division has its own implementation group where they go through their plans and review organisational readiness as part of this assessment. In addition, at the beginning of April a ten-week countdown of intense

engagement and communications started. This has themed weeks and involves members of the EPR team working alongside Divisional teams visiting wards / departments raising awareness as well as running pop up sessions**.** Sunrise corners have been created in many areas displaying important information for staff relevant to their area.

- **Standard Operating Procedures and to be processes –** all divisions / departments are reviewing their standard operating procedures in light of any changes to their future processes. This will continue up until go live and in some instances may require further changes as system beds in. The EPR team is involved and offering advice and guidance as the teams review their systems. Due to the impact of Sunrise on ED (see next section) there are a significant number of standard operating procedures and to be processes that to be reviewed. Extra support is being provided by the EPR team to ensure that these are all completed before go live but some are dependant on the testing that is continuing, hence why ED shows as red.
- **Impact, Change and Interventions –** Every area has devised a risk log which they are working through as part of their implementation plans with support of EPR team. Trust wide Quality Impact Assessment has been done for Order Comms and ED and signed off. Each department has slightly different impact, change and interventions required depending on the functionality that is going live i.e. in most areas with exception of ED and Paediatrics this initially is limited to only ordering tests, reviewing results and making referrals. Within outpatients' operational teams are planning to reduce activity for the first 2 weeks to enable staff to use and embed ordering tests electronically within clinics. Additional staff are being brought in to support administrative changes in process within ED and plans are being put in place to improve flow across the sites to reduce pressure generally. Within ED there are additional items to consider such as reporting, decommissioning their Symphony IT system in a phased way, and ensuring Teletracking is maintained throughout. A specific team is working through all these issues as part of the detailed cut over plan. ED are also having to plan for using downtime paper processes for ordering tests for one week at Tunbridge Wells, during the transition as part of phasing the two ED go lives, in order to continue with Symphony on one site and provide as much senior management support as possible on the other for this key service. As mentioned earlier a lot of work continues to test the reporting needed for ECDS and this will continue up until go live. ED is also reviewing staffing numbers to ensure that there are extra staff on duty to help flow whilst they get used to the new system. Oncology is also having to put plans in place in response to Windows 10 roll out which may not be complete by the time Sunrise goes live as mentioned earlier. This will also mean in some areas activity has to be prospectively added to PAS rather than retrospectively which will mean changes to current administrative processes. In addition, all off sites will need to continue ordering on paper as initial these were out of scope of the original business case. As discussions continue with Divisions and departments issues are captured and mitigating actions are agreed. In addition the team is proactively identifying any areas that will need to be prioritised to be reviewed as part of the optimisation post go live.
- **Hardware deployment –** almost all label printers are now installed but they still need to be tested in terms of Order Comms. A number of additional power sockets are also required particularly at Maidstone given the general increase in equipment, rather than solely because of Sunrise implementation. A further 161 COWs are due to be delivered in batches across June and July starting from the 2nd June. See earlier section relating to Windows 10 deployment
- **Change Ambassadors / One Team Runners –** 420 ambassadors have been identified across the organisation and are currently undergoing specific training as well as being asked to attend on-boarding sessions so they are clear about what to do at go live and beyond. Many of these will be clinical and will be supported by the EPR team and floorwalkers as well as the IT helpdesk. In addition, the team is looking at utilising existing one team runners to support wards across the summer and a provisional rota has been devised which is being progressed.
- **UAT Testing –** has been competed centrally as reported earlier in this paper, however testing within ED will continue right up until go live focused on the operational reporting.
- **Sunrise User Access** – Sunrise access is determined by Windows 10 account. As users are upgraded this information is being passed over to the EPR team and once training confirmed these will be loaded and activated within Sunrise. In addition, the EPR also has security settings relating to role-based access. These have been agreed by the Clinical Design Decision Authority and will be individually checked by Divisions before go live to reduce any issues surrounding access.

- **Go live Support –** All divisions are currently working through their rotas for go live support. In addition, discussions are in progress about setting up a Sunrise command to work alongside the Incident Command Centre. In addition, there will be two Sunrise operational hubs one on each site to co-ordinate the support available and mobilise staff to where they are needed as well as keep in regular contact with the Ambassadors who are working clinical shifts. Non-essential meetings are being cancelled to free up staff. IT team are also reviewing the capacity of the service help desk to manage higher call volumes and direct calls to the relevant team depending on the nature of the issue raised. Alongside this the wellbeing of staff both in clinical areas and those providing support is being considered including break out areas, refreshments and catering as this will be needed 24/7 for initial go live. In addition there will be specific metrics focused on the number of users, tests being ordered, documents created and issues being raised.
- **Behavioural change –** the EPR team have provided a day in the life of series which helps explain how individuals' behaviours will need to change with Sunrise being introduced. These are being communicated to all impacted individuals and reinforced to ensure readiness for Go-Live. Additional support will be provided for known services with high volumes of activity or where staff will see a significant shift from paper to electronic systems such as ED and Paediatrics. Any concerns not already known or covered are being flagged and the EPR team will continue to work with teams all the way up to go live to help raise awareness, reduce anxiety, provide additional demonstrations as required, attend clinical governance, staff meetings etc. This support will continue past the initial go live and will form part of the optimisation phase where workshops will be held to respond and amend the system to further enhance functionality.

As part of the organisational readiness assessment there will be a number of Decisions to Proceed meetings (DTP) to check progress in all areas outlined within this paper, as well as considering any operational pressures on the organisation before going live. These DTP involve Executives, EPR programme team and Allscripts.

Risks

The main risks identified within the EPR programme are outlined within the Appendix and over the next four weeks these will be constantly reviewed alongside the Divisional plans and outstanding actions. These will also be discussed as part of the DTP meetings consideration in whether to go live.

Appendix 1

EPR Programme Risks rated 12 and above unadjusted and adjusted – mitigating actions

These are currently under review with the operational teams and maybe added to as required- full EPR risk register is available on request

Description of Risk	Impact	Probability	Unadjusted risk	Mitigation / Actions	Impact	Probability	Mitigated risk
Trust's Capacity and Capability to manage the volume of change required for EPR alongside other high priority initiatives.	4	4	16	• Sunrise go live implementation group set up • Divisional / Directorate implementation groups in place to review actions / risks with support from EPR team • Review of all other high priority initiatives to see which can be delayed / suspended during go live phase • Set up of Sunrise command centre • Review existing Incident command centre to work alongside EPR team to provide support and also monitor operational impact • Provide weekly Executive Team updates on progress and issues • Feedback to weekly DTP meetings • Review at EPR programme board	4	3	12
Operational pressures contributing to the Divisional lack of readiness to implement EPR and support Trust wide Transformation.	4	4	16	• Sunrise go live implementation group set up with Divisional and Directorate representation • Divisional / Directorate implementation groups in place to review actions / risks with support from EPR team to review organisational readiness and agree actions • Provide weekly updates on progress and issues to Senior Ops team and COO • Feedback to weekly DTP meetings • Provide weekly Executive Team updates on progress and issues	4	3	12
Operational pressures may reduce the ability to release enough staff for training before go live	4	3	12	• On line training being provided to allow people to complete training flexibility • Group on line training being provided via MS teams • Extra training course being organised from mid-May onwards • Backfill available to book staff to release others to attend classroom training • Exploring potential of using Clinical Systems Management team to help support more Order comms training	3	3	9
Unknown / Unexpected issues emerging as we approach Go-Live that we are unable to resolve within Timescales.	4	3	12	• Daily meetings being held between EPR team, IT and supplier to go through technical issues as raised • Discussions taking place to utilise existing ICC structure to support Sunrise command to ensure operational issues are being addressed	4	3	12

				• Utilise Allscripts support to address any technical issues as soon as they are raised • Weekly implementation meetings being held Trust wide so Divisions and departments can escalate issues to central EPR team • In addition, local implementation meetings are being held with support from EPR team to look at local issues for resolution seeking support more centrally if required			
Due to operational pressures and competing priorities engagement of staff to increase their awareness of the impact and changes to working practice may be affected and so they may not use the system at go live	4	3	12	• Undertake walk the floor events to meet staff and discuss concerns • EPR team to provide pop up sessions to raise awareness and attend governance meetings / staff briefings within departments • Offer demos and sand pit computers so that staff can consolidate training • Ensure FAQ and day in Life materials are accessible by staff • Ensure Senior managers within Operations are engaged and have had training / support they need to cascade to their teams • Ensure senior managers are released to encourage and support individuals who are not keen to use Sunrise • Utilise dedicated organisational development resource to EPR to support Divisions • Provide clear information on cut over plan, support structure to be put into place including command centre and operational site hubs • Provide clear information on how to report issues to IT helpdesk	3	3	9
Due to current shortages of staff it may not be possible for Ambassadors or One team Runners to be released to support staff as originally planned	4	3	12	• Divisions to review rotas highlighting Ambassadors on a clinical shift are identified to EPR team so they can provide support if required • On boarding sessions provided to help support Ambassadors • Review whether other non clinical areas can temporarily reprioritise work so they can assist • Encourage more individuals to put themselves forward as Ambassadors and One team runners • Identify priority areas for support which have high volumes of activity in advance	3	3	9
Due to current shortages of staff there is an increased reliance on locums, agency nurses, and temporary staff who need to be trained to access all clinical systems including Sunrise	4	3	12	• Ensure agency / locum staff who are used regularly know how to access training – backfill to release in advance where possible • Ensure all substantive staff are aware of policy that outlines process to give access agency / locum staff that are booked for shifts at short notice • Review rotas so that there is always at least 50% of substantive staff who have had training on Sunrise can use the system	3	3	9

NHS Maidstone and Tunbridge Wells NHS Trust

Strategy Deployment – corporate objectives for 2021/22	**Director of Strategy, Planning and Partnerships**

Please find enclosed the Strategy Deployment – corporate objectives for 2021/22

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

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

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

Corporate Objectives

MTW

NHS
Maidstone and
Tunbridge Wells
NHS Trust

This document covers our corporate projects for 2021/22, to be successful we must deliver both these, our breakthrough objectives and the goals of our strategic themes for the year ahead.

Strategic Themes

Strategic Themes		Strategic Goal	Current Target
Sustainability	Living within our means providing high quality services through optimising the use of our resources	Continued delivery of financial plan, with a modern and fit for purpose environment and infrastructure	Delivery of financial plan, including operational delivery of capital investment plan
People	Creating a genuinely great place to work where I can come to work and be my best self	We will be the best place to work in the NHS when benchmarked against others, using the NHS Staff Survey as our benchmark.	We will be the top performing acute Trust for recommending MTW as a place to work
Patient Experience	To meet our ambition of always providing outstanding healthcare quality we need people to have a positive experience of care and support.	We are consistently recognised by patients as outstanding through FFT positive response rates nationally.	Achieve the national FFT response rate target and maintain the positive response rate.
Quality	Working together to put quality at the heart of all that we do. Achieving outstanding clinical outcomes with no avoidable harm.	Zero harm episodes	A reduction in harm (target to be determined) by March 2022
Access	Ensuring all of our patients have access to the care they need to ensure they have the best chance of getting a good outcome	To ensure we are achieving all constitutional patient access standards	We will achieve a 50% reduction in 52 week breaches by September 2021 and by April 2022 we will achieve the RTT standard whilst also ensuring no patient waits longer than 52 weeks for treatment.
Systems & Partnerships	Working with partners to provide the right care & support, in the right place, at the right time.	No patients who could be treated in our community are transferred to our hospital or who could be treated in West Kent are transferred out	The target is to reduce non-elective bed days to a monthly average of <880 an (approx. 10% reduction)

Exceptional people, outstanding care

Breakthrough Objectives

True North	Breakthrough Objective
Sustainability	Temp staffing continues to rise, even though substantive staffing is increase. Temp staff in use across all staff groups.
People	Each department and team improves their "recommendation as a place to work" by X percent.
Patient	Increase response rates across all our FFT domains to meet the national target
Quality	Reduction in slips, trips and falls
Access	Ensure activity levels for theatres , diagnostics and outpatients match those pre-Covid
Systems & Partnerships	Decreasing the volume of high and very high AEC sensitive conditions being admitted to our bed base as NEL admissions

Strategic Initiatives

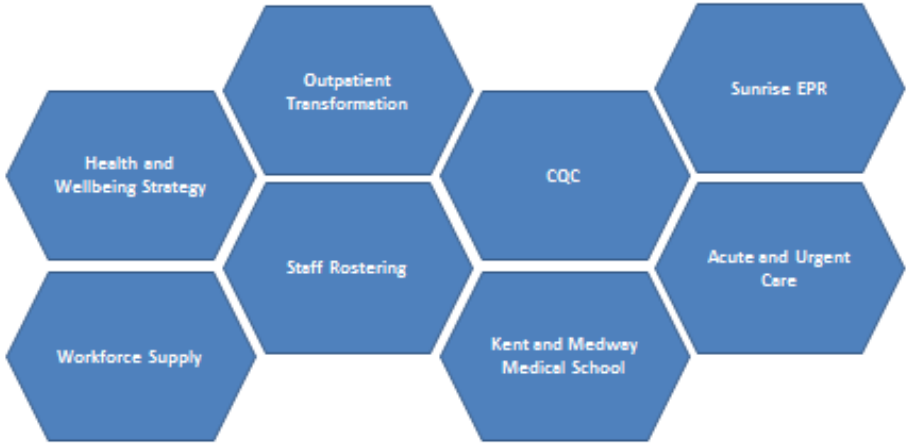
"Must Do Can't Fail" strategic programmes of work to drive forward and support delivery of True North.

Sustainability	People	Patient	Quality	Access	Systems & Partnerships
Continued delivery of our financial plan, allowing us to invest sustainably in high quality services and infrastructure, improving patient experience and outcomes, and providing staff the tools they need to do their job.	*We recruit, support and develop exceptional people and create the conditions for success so that they can deliver outstanding care.*	*We take every opportunity to hear, and act upon the voice of patients, always providing outstanding, compassionate & personalised care.*	*An organisation which has a blame free reporting and learning culture, delivering harm free hospital care*	*All of our patients should be able to access the highest quality care and treatment when they need it, whether it's as an emergency, waiting for a cancer diagnosis or waiting for elective surgery*	*We want to have people receiving the right care in the right place as close to home as possible from the right person in order to allow our clinical staff to operate at the*

Clinical Strategy | Culture and Leadership Programme | Facilities and Estates | ICP | Informatics Refresh | Equality Diversity and inclusion Strategy

The strong STRATEGIC FOUNDATIONS through which we will support the delivery of our True North strategy and objectives

Corporate Projects



CP **Project Charter:** Acute and Urgent Care | **Date Charter Agreed**

Problem Statement

In December 2020 NHSE and NHSI launched its proposed changes to measuring urgent and emergency care activity aligned to the NHS Long Term Plan programme with the aim of transforming urgent and emergency care for patients, drawing on the learning from the coronavirus pandemic and building on the findings of the Clinically-led Review of Standards (CRS) that was undertaken in 2019. It was the view of the CRS that these proposed measures would provide far greater assurance that Urgent and Emergency Care systems function efficiently and effectively for service users than the existing four-hour standard.
In addition, with Teletracking now implemented and ED attendances increasing, working closely with the community to reduce length of stay (LOS), using SDEC and community discharge pathways continues to be a top priority at MTW.

Scope

In scope
- A&E Performance, including the new ED standards
- Boards rounds – LOS, super stranded
- Community pathways
- Same Day Emergency Care (SDEC)

Out of scope
- Elective Care

Project Goal

- To work with the speciality teams across the hospital to improve acute patient pathways for all specialities, maximising the use of community pathways and SDEC pathways .
- To improve flow with the Emergency Department
- To maximise the number of 'green days' for our inpatients, by providing senior clinical review 7 days per week
- To build upon existing SDEC pathways to improve patient experience and access to acute care across all specialties, working with primary care to avoid these patients having to go via ED.

Exit Criteria

1. TBC

Sponsor & Project Team

Sponsor – Sean Briggs (COO)
Programme Director – Claire Cheshire (Director of Ops, Medicine & Emergency Care)
Core Delivery team – Sally Foy, Fiona Redman, Jim Reynolds, Claire Philips, Dawn Hallam, Nick Sinclair, Kelly Cushman

Governance Structure

- Weekly Access meetings with GMs to cover all national standards
- Weekly PTL meeting for RTT
- Daily PTL meetings for cancer
- Monthly Theatre Utilisation Board
- Weekly 6 – 4 – 2 theatre scheduling meeting

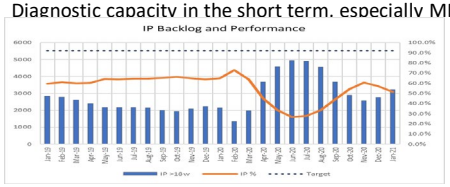
Project Roadmap & Timescales

Project method and timescales can be clarified once PMO support is allocated to ED project charter.

Aim to clear 52 week breaches by September 2021.

Critical Success Factors & Key Risks

Risks
- Risk of cancelling electives again in another Covid wave
- Risk to theatre utilisation due to retention problem following ITU redeployment
- Diagnostic capacity in the short term, especially MRI



Project KPI's (Target)

- Reducing number of 52 week breaches back to zero
- Increasing RTT performance against 18 week standard to meet the 92% standard
- Maintaining 62 day cancer performance and 14 day time to first seen for cancer referrals
- Implementing 28 day Faster Diagnosis Standard
- Improving diagnostic 6 week target

Benefit Realisation

Direct
- avoid unnecessary admissions
- reduced ED waiting times
- So that patients are triaged quickly and treated in the most appropriate place with the best quality of care
- Reduction in delayed discharged

Economic

CP **Project Charter:** Outpatients | **Date Charter Agreed** | May 2021

Problem Statement

Prior to June 2020, the Outpatient directorate did not have a senior management triumvirate, clear KPIs or standard operating procedures. Furthermore, services could not easily be and were not held to account on their Outpatient activity or use of the Outpatient services. Following the recruitment of a management team, there has been the opportunity to 'take stock' of the current issues and identify clear areas for improvement. These fall under clear sub-groups of Environment, Clinic templates and Utilisation, Virtual, Room booking and flow, CAU processes, SOPs and processes and Nursing and Quality. Through the introduction of a robust governance structure and inclusion of key stakeholders both internal and external, the Outpatient services will adhere to the NHS Long term plan whilst transforming Outpatient services which will be co-designed using the experience of our current and previous patients, which in turn will improve the quality of care we provide and the experience our patients receive.

Scope

In scope

- Outpatient clinics and utilisation
- room booking and space management,
- Outpatient flow,
- call performance and communication,
- virtual appointments and
- staffing and leadership.

Out of scope

CAU theatre bookings, RTT and theatres

Project Goal

- Implement a robust patient flow system , 6:4:2 clinic/room booking and cancellation process
- Review/redesign clinic templates
- Pilot a telephone triage system to improve call response time and meet <1min KPI
- Development of business case looking at patient communication
- Introduce robust reporting platform using power BI
- Improve outpatient environment across both sites
- Increase utilisation of virtual software with clinical champions
- Create centralised outpatient team including reception staff, communication centre and clinic builders
- Co-design services using patient feedback from Outpatient voice group
- Introduce patient initiated follow up model within all Directorates

Exit Criteria

- Achieve an outstanding CQC rating for outpatients in subsequent inspections

Sponsor & Project Team

Sponsor – Sean Briggs (COO)
Programme Director – Katie Goodwin (DDO Cancer Services)
Core Delivery team – Grace Mitchell (Outpatient GM), Sara Pizzy (Outpatient Matron), Tuck-Kay Loke (Outpatient CD), Outpatient nursing team, DDO's, Directorate triumvirates, CSMT, IT, Estates and Facilities, IPC, Comms

Governance Structure

- A fortnightly outpatient programme board commencing on the 17th March 2021
- A monthly clinical steering group commencing on the 28th April
- PMO/Transformation will support with the production of reports and supporting documents as required.
- Working groups leading on key aspects of the project goal will feed into the programme board
- The programme board will provide a monthly update to the Executive board

Project Roadmap & Timescales

Agree and begin CAU telephone pilot	May 2021
Roll out Power BI system	May 2021
Scope and begin PIFU pilot	May 2021
Create consultation document	Jun 2021
Work with patient experience team to coordinate 'Outpatient voice' group	Jun 2021
Complete cosmetic work at Tunbridge Wells and Maidstone	Jul 2021
Begin roll out of Room booking system	Aug 2021
Present call centre pilot review to execs	Aug 2021
Scope further functionalities of NetCall system	Sept 2021
Scope patient portal system	Sept 2021
Submit BC for trust wide Communication centre	Oct 2021
Complete clinic template review	Oct 2021
Roll out trust wide Communication centre	Oct 2021
Begin roll out of patient flow system	Oct 2021

Critical Success Factors & Key Risks

Critical Success Factors

- Stakeholder engagement
- Clinical Engagement to ensure successful delivery
- Space in relation to Clinic space, waiting room space and administrative space
- **Risks**
- Risk – Operational pressures may mean staff are not as engaged
- Risk – Covid 19 – further surge
- Risk – lack of funding
- Risk- sickness/vacancy rate
- Risk- Poor clinic redesign
- Risk- Reporting platform not fit for purpose

Project KPI's (Target)

Achieve an outstanding CQC rating for outpatients in subsequent inspections

KPI	Target
% of calls answered under a minute	95%
% of call abandoned	0%
% of virtual (video and telephone) appointments	60%
% of VCA appointments	20%
DNA % - news	5%
DNA % - follow-ups	5%
% of total outpatient clinics utilised	85%
% of available satellite clinics utilised	85%
% of clinic rooms utilised	95%
% of clinics delayed	<10%

Benefit Realisation

Direct

- Improved patient experience and therefore patient feedback, reduction of pressure on Admin teams and achieving KPI
- Improve utilisation
- Improve patient experience
- Improved response times

CP **Project Charter:** CQC | **Date Charter Agreed** | May 2021

Problem Statement

Background: At the last CQC inspection in 2017 the Trust was rated 'Requires Improvement' over all. This is currently how our services are 'formally' rated and therefore externally viewed by service users and stakeholders as a benchmark of our patient safety and clinical effectiveness. As an organisation and through the continuous quality improvement work undertaken since the last formal inspection in 2017, there has been significant improvements; self assessments have indicated that our services have improved and the current RI rating does not reflect the care we currently provide and ongoing innovations, the ongoing innovations and the work to transition to a proactive (BAU) approach to CQC monitoring and inspections. Additionally, Covid-19 has directly resulted in a delay to the Trusts planned inspection cycle and whilst we fully expect an inspection this year, the inspection process remains unknown and is still to be defined by the CQC following consultation.

Problem: Whilst there are pockets of good practice there is currently no consistent or sustainable organisational approach to embed continuous quality improvement which aligns to the KLOES to deliver outstanding services outside of the core project team. There is no clarification for the new model of inspection regimes and MTW remains rated as Requires Improvement. Requires wider engagement across all multi professions, current tendency can be for Nursing and Midwifery to lead on CQC preparedness within services.

Impact: MTW remains rated as requires improvement. We are not recognised as having a culture of continuous improvement delivered by exceptional people. Organisational development opportunities are potentially limited due to the RI rating. Impact on organisation reputation being externally viewed by patients, service users, external stakeholders as an RI organisation.

Scope

In scope:
The Trust Board, *all services and staffing groups within MTW use the Key Lines of Enquiry (KLOE) as a framework for quality improvement each service can identify areas for improvement to reach the Trusts goal to be 'outstanding.'*

Out of scope: The project will not focus on services outside of the organisation currently but will be prepared to adapt scope to reflect any change in an inspection regime which may incorporate a pathway / system approach.

Project Goal

MTW is rated as Good/Outstanding at next inspection.
Embedded culture of continuous quality improvement methodology in alignment to the CQC KLOE's , and our Trust PRIDE Values. Clear outline for the services to achieve an outstanding CQC rating.

To ensure MTW is in a state of preparedness for future inspection using the methodology of the CQC but embedding a BAU approach which recognises quality improvement as "the right thing to do" aligned to MTWs PRIDE values and the Exceptional leaders programme empowering ownership of this.

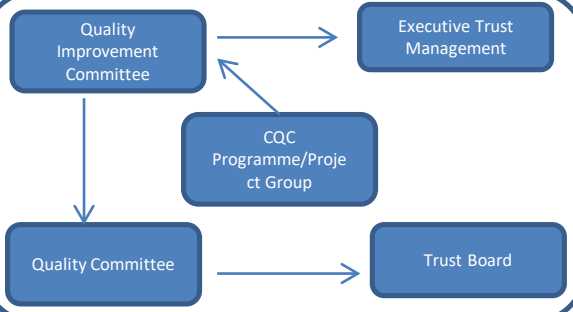
Exit Criteria

MTW is rated as good / outstanding.
MTW sustains the good / outstanding.

Sponsor & Project Team

Sponsor – Claire O'Brien
Workstream Lead – Gemma Craig
Transformation Programme Manager - Lisa Urquhart
Transformation Programme Coordinator – Lisa Bonifacio
Key Stakeholders – Judy Durrant/Aoife Cavanagh/Divisional leads/
Focus area leads

Governance Structure



Project Roadmap & Timescales

Planned gateways and milestones

Define: reset of service peer reviews and full reviews of all services current self- assessment status, following 2nd wave of Covid (June 1st 21)
Measure: Service analysis of improvement trajectory with key improvement priorities identified against the KLOE framework (July 1st 21)
Analyse: Implementation of monthly oversight clinics to track improvement progress and identify change (ongoing)
Improve: Establish new self-assessment cycle against improvement plans
Control:

Critical Success Factors & Key Risks

Critical Success Factors
MTW is rated as Good/Outstanding
MTW remains in a state of preparedness for future inspection based on the KLOEs. This is an embedded quality improvement / BAU approach which recognises the importance of learning, sharing and delivering of outstanding care as "the right thing to do". This is aligned to MTWs PRIDE values and the Exceptional leaders programme empowering ownership of this.

Risks– *unknown new inspection methodology*
Conflicting priorities for key stakeholders (Covid/reset and recovery)
Operational pressures
Ability to have a central repository for evidence storage / gathering

Project KPI's (Target)

% of Peer reviews completed
New Self assessment cycle completed with trajectory to outstanding identified
CQC Audit outcomes
Engagement Events
% conversion of services from good / outstanding
Focus areas moved to monitoring tracker
MTW rated as good/outstanding

Benefit Realisation

Direct
Organisation reputation – recruitment / retention
Patient and staff / stake holders
Research and development increased opportunities

Economic
Effective and sustainable services
Financial sustainability.
Potential for reduction in legal costs / patient safety
Costs associated with R+R.

CP **Project Charter:** **Workforce Supply** | **Date Charter Agreed** | May 2021

Problem Statement

MTW has a limited oversight on future workforce needs and has a traditional reactive approach to workforce supply. There are a number of key roles which are hard to fill due to national supply, competitive market, changing skills and general turnover in the sector. Real time data and oversight of future workforce planning and development of talent pipelines is required to develop alternative routes into roles and increase the diversity of workforce supply.

Scope

In scope:

- All roles across the Trust - key focus on hard to fill/competitive in the market potential for alternative career pathways and routes to develop.
- Exploring adaptive workforce models including multi disciplinary team working, nursing associates and apprenticeships.
- Reducing the reliance on overseas recruitment and building a domestic workforce that is adaptable to future needs.
- Including aspects of recruitment; education; professional development; retention and pay; reward systems; pensions and end of career options

Out of scope:

- Corporate and non clinical/medical staffing to enable focus on front line delivery.

Project Goal

- To deliver an adaptable and agile workforce that is designed for the health care needs of the future enabling multi disciplinary working and alternative career options.
- Identifying alternative routes into health care and optimising apprenticeships and development opportunities.
- Less reliance on overseas recruitment and building a domestic supply of health care workers.

Exit Criteria

1. Reduction in temporary staffing
2. Staff Turnover reduced
3. Implementation of new workforce models
4. Implementation of alternative career pathways

Sponsor & Project Team

Sponsor - Chief People Officer – Sue Steen
Head of Recruitment – Liz Parker
Head of L&D – Haylie Usher
Champion - Chief Nurse - Jo Haworth
Programme Manager – Lisa Urquhart
Core Delivery Team to include:
HR, Finance, DDO Cancer Services, DDNQ Quality, Deputy COO, Deputy Chief Nurse

Governance Structure

- Monthly Workforce Supply Steering Group
- Weekly Implementation targets
- Communication with stakeholders
- Resource team established to lead on key delivery

Project Roadmap & Timescales

Objective delivered using Programme Management methodology.

May 21 -Programme timescales to be scoped and established
May 21 – Programme Board set up
June 21 – Workshop to assess scope and workstream leads

Critical Success Factors & Key Risks

- Stakeholder supported programme plan.
- Clinical Engagement to ensure successful delivery.
- Investment in alternative career pathways including lead in time for new ways of working
- Risk – Operational pressures may mean staff are not as engaged or able to undertake training
- Risk – Covid 19 – further surge

Project KPI's (Target)

- % decrease in agency and temporary staffing spend
- Improvement in MTW as a place to work and employer of choice

Benefit Realisation

- Alternative career pathways introduced
- Reduced reliance on overseas recruitment
- Improved engagement and reduced attrition

CP **Project Charter:** **Health and Wellbeing Strategy** | **Date Charter Agreed** | May 2021

Problem Statement

The People Strategic Theme in our organisation is 'Creating a genuinely great place to work where I can come to work and be my best self.' The NHS People Plan identifies people are our biggest asset and we need to do all we can to support them and provide good quality Health and Wellbeing offers fit for the future. In response to the pandemic our staff have gone above and beyond but feedback highlights staff are exhausted and at risk of burnout, some are fearful of further Covid waves, staff on the frontline often experience incivility from patients, there are inconsistencies on how our people are looked after and wellbeing conversations often do not happen. We also will have colleagues physically and mentally impacted by the pandemic and will require support to recover. We cannot categorically say that all of our staff; irrespective of where they work have a consistently exceptional experience at work.

Scope

In scope
- All staff groups
- Substantive and Bank

Out of scope
- Agency staff

Sponsor & Project Team

- Exec Sponsor – Sue Steen/Chief People Officer
- Champions – Andrea Vigille, John Weeks
- Clinical Leads – tbc (based on prioritisation).
- Continuous Improvement Leads – Kathryn Brown and Emma Bray
- Team – Jo Garrity, Christian Lippiatt, Hayley Usher, Dan Butcher
- Senior Finance Champion - John Coffey
- Exit Process Owner – Clinical Leads
- Divisional Voices – Steve Williams, Claire Manneh, Theresa Welfare,

Project Goal

- We will look after our people – with quality health and wellbeing support for everyone
- Deliver Team Away Days for all our staff to build resilience and support each other in teams
- Continue to deliver multi-level psychological support
- Deliver development opportunities on coaching in Crisis Management and Disruptive Patient Training
- Improve Physical Wellbeing of our staff
- Improve quality and health of our food offering
- Provide safe spaces for staff to rest and recuperate
- Deliver communication activity to increase awareness and to enable our staff to actively undertake self-care
- Listen to our people through the Climate Survey and Divisional Voices

Governance Structure

1. Monthly Health and Wellbeing Committee led by CPO
2. Weekly Health and Wellbeing Working Group
3. Fortnightly Health and Wellbeing Divisional Voices

Exit Criteria

1. People Directorate structures recruited to with team in place
2. Mature governance in place with roles and responsibilities clear
3. People and OD Strategy completed
4. Health and Wellbeing plan completed, implementation commenced with offer being perceived as fair, consistent and easy to access
5. Clear governance structure for communication in place with Divisional Voices from Governance Committee, Divisional Board to staff on Wards

Project Roadmap & Timescales

Breakthrough Objective delivered using Lean Six Sigma Improvement methodology and DMAIC framework -

Indicative timescales

Define	May 2021
Measure	June 2021
Analyse	June 2021
Improve	July 2021
Control	March 2022

Critical Success Factors & Key Risks

Critical Success Factors
- Health and Wellbeing offer must be deliverable, fair and consistent across MTW, easy to access and sustainable over time to have the desired impact
- We need to ensure our approach reflects broader factors such as equality, diversity and inclusion that can impact on overall wellbeing.

Risks
- Lack of funding

Project KPI's (Target)

TBC – to become defined in more detail as project progresses

1. Health and well being offer being perceived as fair, consistent and easy to access
2. Increase in Climate Survey engagement
3. % increase in staff feeling supporting in their role
4. % increase in staff who feel the Trust has a genuine concern for their safety
5. % increase of staff who feel able to cope with the demands being placed upon them
6. Improvement in MTW as a place to work and employer of choice

Benefit Realisation

Direct
- Increased staff satisfaction
- Health, flourishing and engaged staff
- Improved presentism
- Staff feel motivated
- Improved resilience
- Staff feel supported in teams

Economic
- Reduction in sickness absence rate

Project Charter: Digital Transformation - Implementation of Sunrise EPR

Date Charter Agreed: May 2021

Problem Statement

MTW does not have a consistent system for managing patient records electronically across the organisation with a heavy reliance on paper based systems and stand alone clinical IT systems which results in clinical staff not being able to always access real-time, up-to-date patient records to support efficient and safe patient care. As part of MTW aspiration to deliver outstanding care the aim of our EPR programme is to help treat patients more effectively by giving healthcare staff easier access to a single version of up-to-date information, to improve care through decision support tools, giving healthcare staff the functionality and data needed to be safer and more efficient. It also opens opportunities for the sharing of patient data across boundaries, to improve care where services are provided by different teams across organisations as part of our wider strategy for digital transformation within the Trust

Scope

In scope Interface to Allscripts, PAS, TelePath LIMS and Soliton RIS, Tab Integration (3rd Party Application Launch) within Sunrise EPR enotes, GE PACS and MTW KOMS, Core Clinical Documentation, eObservations, OPD Pilot (Gastro and Neuro clinics), Paediatrics, APAS Order Comms replacement, Therapies, EPMA, eDN (Teleologic replacement), ED and EDCS reporting, Symphony replacement, Hardware Deployment including digital infrastructure and End User devices such as Label Printers and COWs

Out of scope

Maternity services, Outpatients Department (exception of Gastroenterology and Neurology), SCUBU and Neonates, Issuing Blood Transfusions, Histology Ordering (results will be received on Sunrise), Sexual Health Clinic, Occupational Health, Breast Screening Clinic, Satellite Sites, Nervecentre's Clinical Handover, RTT and Off-site Clinics, Pre-assessment, Interventional Radiology, Cath Lab, Endoscopy, UIS, Colposcopy, Pain Management, ITU, Theatres and Surgery including Day Case, Community Services

Project Goal

- *Delivery of Allscripts' EPR solution "Sunrise"; aligning and supporting the wider strategic objective of digitally transforming MTW to improve patient outcomes through providing safer and more efficient care.*
- *This will include rolling out functionality for ED, Order Comms, Paediatrics, Core Clinical documentation and Therapies across the Summer 2021 and subsequently EPMA before the end of the financial year across both sites.*

Exit Criteria

1. x

Sponsor & Project Team

Sponsor – Pete Maskell (medical Director and SRO)
Champions – Alex Slack (CCIO and Trust CSO) + Liz Champion (Deputy CCIO Nurses/AHP and Midwives)
Programme Director – Jane Saunders Programme Director for EPR and Digital Transformation
Core Delivery team – Business change, EPR configuration, EPR testers and training
IT enablers lead – Sue Forsey Director of IT

Governance Structure

- Daily project team huddles .
- Monthly EPR Programme board
- Monthly EPR update at ETM
- Bimonthly update and F&PC
- Weekly Implementation Divisional / department meetings
- Monthly EPMA project Board
- Gateway Reviews at end of each stage for approval to move to next stage of project with supplier.
- Communications with stakeholders as per go live plan

Project Roadmap & Timescales

Objective delivered using Programme Management methodology and Allscripts commercial framework

	Summer 21 go live	Winter 21 go live
Start out	July 2018	July 2019
Define & Scope	Completed	In progress
Measure & understand	completed	In progress
Design & Plan	In progress	Q2 & Q3
Pilot and Implement	Q2	28th Nov 21
Sustain and Share	Q3 and Q4	Q4 21/22

Critical Success Factors & Key Risks

- Stakeholder supported programme plan.
- Clinical Engagement to ensure successful delivery.
- Risk assessed system Interface issues
- Visibility of end to end service /specialty new ways of working more effectively
- Optimisation brings added benefits or new areas of development within existing functionality
- Risk – Operational pressures may mean staff are not as engaged or able to undertake training
- Risk – Covid 19 – further surge
- Risk – W10 rollout dependancy

Project KPI's (Target)

1. Reduction on print costs so less paper clinical notes are generated reducing cost of printing and improving legibility and accuracy of information recorded

Benefit Realisation

- Staff efficiency and improved patient outcomes - Single source of truth as clinical information captured once, and made visible to multiple consecutive user
- Reduced maintenance - As more paper documentation and systems are re-designed on the EPR, there will be less paper notes and a smaller footprint on the IT estate
- Reduction on print costs so less paper clinical notes are generated reducing cost of printing and improving legibility and accuracy of information recorded
- Patient Safety is improved whilst cost of delivering care is reduced by introducing EPMA
- There are over 100 benefits currently identified and detailed against the EPR programme which are available on request

CP **Project Charter:** Kent and Medway Medical School (KMMS) | **Date Charter Agreed** | May 2021

Problem Statement

MTW has a strong history of delivering excellent postgraduate and undergraduate teaching and education. The lack of adequate residential accommodation for undergraduate students has greatly impacted on the number of undergraduate placements we have been able to offer. The Kent and Medway regional programme for the new Kent and Medway Medical school has provided a unique opportunity to realise our undergraduate teaching potential. It has driven the investment to develop a 'campus style facility' of 145 rooms at our Tunbridge wells hospital site together with the new accommodation at Maidstone. A detailed planning exercise has confirmed that MTW has the clinical structure capacity and the new accommodation facilities increases the accommodation capacity to provide significantly more placements to Year 3, 4 and 5 Kent and Medway Medical School students.

Scope

In scope:
- Clinical placements for Year 3, Year 4 and Year 5 Kent and Medway medical Students
- Residential accommodation and learning hubs for Medical students
- Stakeholder engagement to support delivery of placement programmes, student pastoral care and the appointment of Faculty and Speciality leads

Out of scope:
- Clinical placements for Year 1 and Year 2 medical students

Project Goal

Develop and appoint Faculty and Speciality leads with stakeholder engagement to deliver placement programmes

By Sept 22:
- Student accommodation at Tunbridge wells
- Faculty, Year 3 placements and curriculum delivery programmes in place for 40 students

By Sept 23:
- Faculty, Year 4 placements and curriculum delivery programmes in place for 40/50 students

By Sept 24:
- Faculty, Year 5 placements and curriculum delivery programmes in place for 40 students

Exit Criteria

1. Year 3, 4 and 5 students placements commenced at MTW
2. Year 3, 4 and 5 Curriculum in place
3. All appointments within Faculty in place with speciality lead
4. Residential and academic estates and facilities in place to support teaching and student welfare

Sponsor & Project Team

- Sponsor (SRO) – Peter Maskell (Medical Director)
- Champion - Garth Sommerville (Director of Medical Education)
- Programme Lead – Valentina Ideh (Senior Business and Delivery Manager)
- Core delivery team: **Garth Sommerville** (Director of Medical Education, **Amanjit Jhund** (Director of Strategy, Planning and Partnerships), **Pamela Leventis** (Undergraduate Curriculum Lead)
- Senior Finance – Steve Orpin (CFO)
- Exit Process Owner – Garth Sommerville (Director of Medical Education)

Governance Structure

- KMMS project consists of 3 Workstreams, Estates & Facilities, Placements and an Engagement Workstream with associating work groups.
- Each Workstream reports to a KMMS Steering Group, meets bi-monthly chaired by the Medical Director.
- In addition, the Estates & Facilities Workstream reports to a NED Oversight Group on a fortnightly basis attended by NEDs and chaired by the Trust Board Chair.
- Once planning permission in approved the Estates & Facilities group will report into Finance and Performance Committee monthly.
- Educational leads report to the Director of Undergraduate Medical Education

Project Roadmap & Timescales

Stage 1: **Dec 20** BC approved for accommodation build, Governance/Scope/Stakeholder Engagement/detailed project /Risk & Issues for placement and engagement workstreams
Stage 2: **MAR 21** Faculty Structure defined with plan for appointment, Engagement with key stakeholders, High level definition of curriculum.
Stage 3: **June 21** Build commences, Appointment of Director of Undergraduate Medical Education.
Stage 4: **Dec 21** Resource and capacity analysis by speciality, Development of curriculum delivery, Appoint Head of Year 3
Stage 5: **Jan 22** Year 3 Speciality lead appointed
Stage 6: **Sept 22** Year 3 students arrive , Build Completed
Stage 7: **Dec 22** Resource and capacity analysis by specialty, Development of curriculum delivery, Appoint Head of Year 4
Stage 8: **Jan 23** Year 4 Speciality lead appointed
Stage 9: **Sept 23** Year 4 students arrive
Stage 10: **Dec 23** Resource and capacity analysis by specialty, Development of curriculum delivery, Appoint Head of Year 5
Stage 11: **Jan 24** Year 5 Speciality lead appointed
Stage 12: **Sept 24** Year 5 students arrive

Critical Success Factors & Key Risks

Critical Success Factors
- Completion of Student accommodation by Sept 22
- Appointment of Faculty
- Development of student placement programmes
- Equivalent academic facilities available on both sites
- Student Satisfaction

Risks
- KMMS reducing or withdrawing placements for their Medical Students
- Delays impacting accommodation and academic facilities timeline

Project KPI's (Target)

- Students feedback through satisfaction scores via End of Placement surveys (EOPs) carried out by KMMS
- Quality of teaching programme
- Quality of Induction

Benefit Realisation

- Improve status of MTW as a teaching hospital
- Attraction of different staff groups to MTW
- Improve medical academia and research standing within the Trust
- Contributes to increasing the quality of care for our patients
- Enhance post graduate training
- Address local medical workforce needs particularly under-subscribed specialties in Kent
- Widening participation in medical training from diverse local communities

CP **Project Charter:** **Staff Rostering** | **Date Charter Agreed** | May 2021

Problem Statement

Background: MTW has an e-rostering system across the non medical workforce, however due to lack of change management and consistency in use there is no accurate and up to date central view of all staffing across the Trust. At this time there is no accessible provision therefore of live information or forecasting capability on staffing..
In 2019 the Trust purchased the medical rostering capability from Allocate however due to the Covid-19 pandemic this was not implemented. At this time there are multiple systems and processes in place to manage medical rosters. No central dataset for Medical staff.
Ensuring a consistent fill-rate target across the all shifts with adequate planning will reduce agency spend and improve the ability to confirm safe staffing levels.
Problem: Unable to have a central view of staff to ensure the safe delivery of care. This is as there is no consistent, accurate process in place to manage staff. This leads to a higher dependency on temporary staffing usage. There is a perception that there is a lack of accessible support for rostering
Impact: Inability to provide efficient decision making and management of staff. Without this data and automated real time staffing reports it is challenging to understand our current staffing issues and manage performance, unable to forecast and plan effectively and also embed a consistent change/vacancy control process throughout the Trust

Scope

In scope:
- AFC health roster; control processes, medical health rostering and appropriate temporary staffing solution trust wide.
- Workforce systems infrastructure
- Trust wide solution for delivery of an effective and timely provision of temporary staffing to ensure rosters are filled.

Out of scope:
- Workforce Planning and workforce supply

Project Goal

- Provide efficient management of staff and decision making through accurate, timely and accessible data.
- A move to a single and consistent rostering system.
- Reduction in agency and temporary staffing spend and improved levels of forecasting and planning.

Exit Criteria

- Accurate data
- Access available to all staff required
- Staff upskilled in rostering and compliant
- Full functionality used

Sponsor & Project Team

- Chief People Officer – Sue Steen
- Head of Temporary Staffing – Nicky Sharpington
- DDO Flow – Nicky Sinclair
- Head of Employee Services – Tracy Karlsson
- Programme Manager – Lisa Urquhart
- Deputy COO - tbc
- DDNQ For Quality – Sally Foy
- Consultant Lead - TBC
- Deputy Chief Nurse – Gemma Craig

Governance Structure

- Fortnightly Staff Rostering Programme Board
- Fortnightly Medical Rostering Governance Group
- Fortnightly Workforce Systems Infrastructure Working Group
- Weekly Implementation targets
- Communication with stakeholders
- Resource team established to lead on key delivery

Project Roadmap & Timescales

Objective delivered using Programme Management methodology. PDSA
- *ESR Self Service – July – August 2021*
- *Establishment Control - Cleanse data with divisions – July to August*
- *Division and Finance signoff – August 2021*
- *ESR emails and data cleanse – June 2021*
- *Health roster embedding – eRoster Healthhceck – June 2021*
- *Rebuild all units for interface – September 2021*

Critical Success Factors & Key Risks

- Stakeholder supported programme plan.
- Clinical Engagement to ensure successful delivery.
- Risk assessed system Interface issues
- Visibility of end to end service /embedding new ways of working more effectively
- Risk – Operational pressures may mean staff are not as engaged or able to undertake training
- **Risk** – Covid 19 – further surge
- **Risk** – implementation of Sunrise solution, competing priorities for staff
- **Risk** – inability to differentiate savings alongside other workstreams (workforce/STP)

Project KPI's (Target)

- % decrease in agency and temporary staffing spend
- Rosters agreed 6 weeks in advance
- Roster support available (SLA tbc)

Benefit Realisation

- Real time data reporting and staffing levels
- Additional clinical time available for patient care
- Consistency in roster management
- Availability of data to inform resourcing and recruitment planning
- ESR data to inform effective establishment and roster planning

The metrics from our strategic theme goals, breakthrough objectives and corporate projects will all be reported through an integrated scorecard

	PF Domn.	Scope Division or Trust	Status Watch / Driver/ Information	Ref	Metric	Most recent position	Date of Most recent position	Trust Target 20/21 21/22	Divisional 20/21 21/22 Target
True North Goals/ Targets	People	Trust	Driver	TNP.1	We will be amongst the top performing acute Trusts for recommending MTW as a place to work.	71.2%	Feb-21	70%	n/a
	Patient safety & Clinical Effectiveness	Trust	Driver	TNPS.1	A reduction in harm (target to be determined) by March 2022. - Incidents resulting in Harm	148	Mar-21	100	n/a
	Access	Trust	Driver	TNA.1	We will achieve a 50% reduction in 52 week breaches by September 2021.	435	Apr-21	0	n/a
	Access	Trust	Driver	TNA.2	By April 2022 we will achieve the RTT standard whilst also ensuring no patient waits longer than 52 weeks for treatment.	62.6%	Apr-21	86.7%	n/a
	Patient Experience	Trust	Driver	TNPE.1	Achieve the national FFT response rate target and maintain the positive response rate: Inpatients	98.5%	Apr-21	95.0%	n/a
		Trust	Driver	TNPE.2	Achieve the national FFT response rate target and maintain the positive response rate: A&E	96.0%	Apr-21	87.0%	n/a
		Trust	Driver	TNPE.3	Achieve the national FFT response rate target and maintain the positive response rate: Maternity	100.0 %	Apr-21	95.0%	n/a
		Trust	Driver	TNPE.4	Achieve the national FFT response rate target and maintain the positive response rate: Outpatient	83.5%	Apr-21	84.0%	n/a
	Systems	Trust	Driver	TNS.1	The target is to reduce non-elective bed days to a monthly average of <550 an approx. 10% reduction).	499	Apr-21	550	n/a
	Sustainability	Trust	Driver	TNSU.1	Delivery of financial plan, including operational delivery of capital investment plan.	£727,114	Apr-21	0	n/a

	PF Domn.	Scope Division or Trust	Status Watch / Driver/ Information	Ref	Metric	Most recent position	Date of Most recent position	Trust Target 20/21 21/22	Divisional 20/21 21/22 Target
Breakthrough Objectives	People	Trust	Driver	BTP.1	Each department and team improves their "recommendation as a place to work" by X%.	74.52%	Nov-20	70%	n/a
	Patient safety & Clinical Effectiveness	Trust	Driver	BTPS.1	Reduction in slips, trips and falls (Rate per 1,000 Occupied Beddays)	117	Apr-21	118	n/a
	Access	Trust	Driver	BTA.1	Ensure activity levels for theatres match those pre-Covid - Total Elective	91.6%	Apr-21	88.0%	n/a
	Access	Trust	Driver	BTA.2	Ensure activity levels for outpatients match those pre-Covid - First Outpatients	95.0%	Apr-21	95.0%	n/a
	Access	Trust	Driver	BTA.3	Ensure activity levels for outpatients match those pre-Covid - Follow Up Outpatients	116%	Apr-21	102%	n/a
	Patient Experience	Trust	Driver	BTPE.1	Increase response rates across all our FFT domains to meet the national target: Inpatients	9.2%	Apr-21	25.0%	n/a
		Trust	Driver	BTPE.2	Increase response rates across all our FFT domains to meet the national target: A&E	2.4%	Apr-21	15.0%	n/a
		Trust	Driver	BTPE.3	Increase response rates across all our FFT domains to meet the national target: Maternity	15.3%	Apr-21	25.0%	n/a
		Trust	Driver	BTPE.4	Increase response rates across all our FFT domains to meet the national target: Outpatients	17.3%	Apr-21	68.0%	n/a
	Systems	Trust	Driver	BTS.1	Decreasing the volume of high and very high AEC sensitive conditions being admitted to our bed base as NEL admissions.	43.02%	Apr-21	60%	n/a
	Sustainability		Driver	BTSU.1	Reduction in temporary staffing. Temp staffing continues to rise, even though substantive staffing is increase. Temp staff in use across all staff groups.	To Folllow	To Folllow	To Folllow	n/a

NHS Maidstone and Tunbridge Wells NHS Trust

Annual approval of the Trust's Green Plan **Director of Estates and Facilities**

The enclosed report contains the Trust's annual Green Plan (formally the Sustainability Development Management Plan (SDMP)) which is required to be approved by the Trust Board annually.

Which Committees have reviewed the information prior to Board submission?
- Executive Team Meeting – 11/05/21

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

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

Maidstone and Tunbridge Wells NHS Trust

Green Plan

(Formerly Sustainable Development Management Plan)

Contents

1. Vision, Strategy and Scope

1.1. Sustainability Vision

The Sustainability Vision of the Trust is “The provision of Sustainable and Resilient Healthcare and Buildings to ensure Healthy People and Places in Maidstone and Tunbridge Wells NHS Trust”

1.2. Sustainability Strategy

The Trust recognises that in delivering healthcare services its sites and operations may have adverse impacts on the environment and it is essential that these are minimised and maintained as such through continuous monitoring, mediation and changing culture around the environment and sustainability. The trust is committed to providing healthcare and services to the populations of today without compromising the opportunities of the populations of tomorrow.

The Trust recognises that, to deliver sustainable healthcare, it must achieve positive social impacts, must mitigate its impacts on the environment and must achieve a level of financial efficiency and effectiveness.

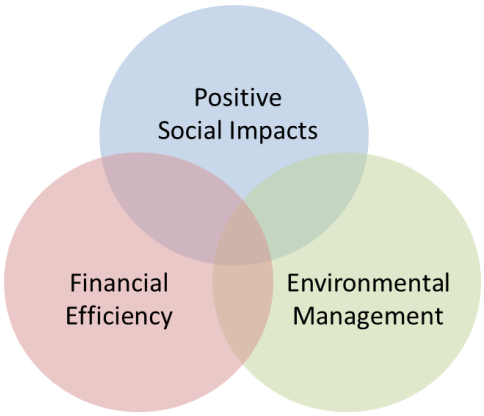


Figure 1: Components of Sustainability

The Trust has developed a Sustainability Strategy that will be implemented through a Green Plan that comprises of 6 key areas of focus:

- Corporate Vision and Governance
- Leadership, Engagement and Development
- Healthy, Sustainable and Resilient Communities
- Sustainable Clinical Care Models
- Commissioning and Procurement
- Operational Management and Decarbonisation

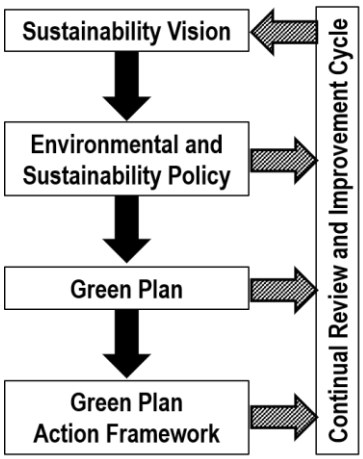


Figure 2 shows the relationship between the Vision, the Policy, the Green Plan and the Green Plan Action Framework to form the sustainability strategy.

Figure 2: Relationship of the components of the Sustainability Strategy

1.3. Scope of the Plan

This Plan is applicable across the entire geographical extent of the Trust where the Trust has direct operational responsibility

2. Drivers for Change

The key drivers for producing a green plan can be divided into 4 categories, financial, environmental, legislative and social:

2.1. Financial Drivers

- **NHS Long Term Plan**
  The NHS Long Term Plan sets out the expectation that by 2023–24 no trust will be reporting a deficit.

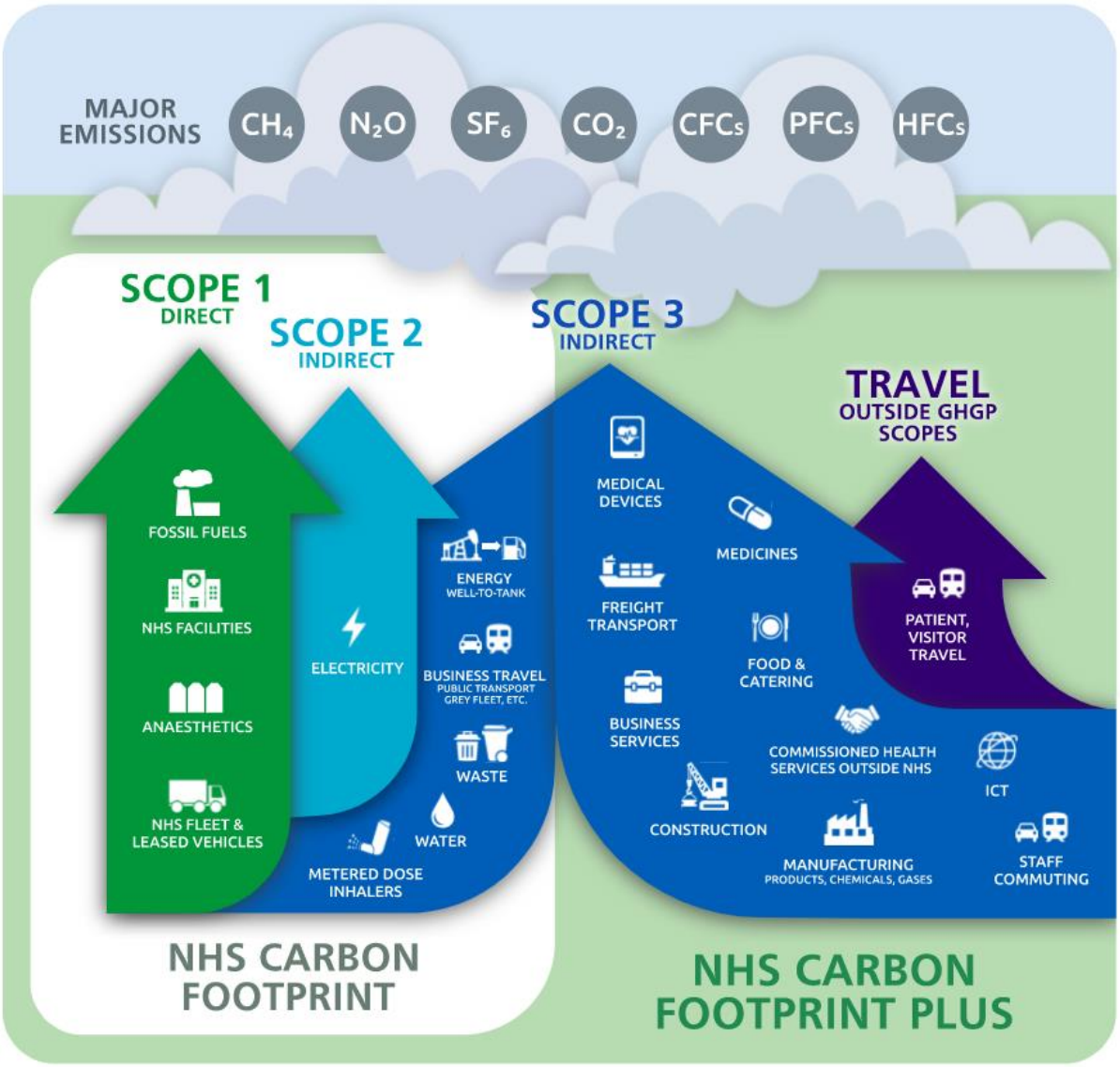
- **Energy and Water Costs**
  The costs of using energy, water and emitting carbon are predicted to rise in the medium to long term. The wholesale energy price is dependent upon many natural and geopolitical variables, none of which are within the immediate control of the Trust.

- **Funding Deficits and the need to generate savings**
  Trusts are under ever increasing pressure to reduce costs, generate savings and close the gap between the increasing demand for service and the funding available.

2.2. Legislative Drivers

- **Climate Change Act 2008 (2050 target amendment) order 2019**
  The Climate Change Act (2008) was introduced to ensure the UK cuts its carbon emissions by 80% by 2050. The 80% target was set against a 1990 baseline.
  The act was amended in 2019 to give a 100% target by 2050 against the same baseline.
  The act enables the UK to become a low carbon economy. It sets in place a legally binding framework allowing the government to introduce measures which will achieve carbon reduction and mitigate and adapt to climate change.

- **NHS Carbon Reduction Target**
  As the largest public sector emitter of carbon emissions, the health system has a duty to respond to meet the targets which are entrenched in law.
  The NHS has responded to the amended Climate Change Act by committing to be net zero by 2040 for the emissions that are directly controlled, called the NHS carbon footprint, and the net zero by 2045 for the emissions that are influenced, called the NHS carbon footprint plus.



- **Public Services (Social Value) Act 2012**
  The Public Services (Social Value Act) was passed at the end of February 2012 and came into force in January 2013. Under the Act, for the first time, all public bodies in England and Wales are required to consider how the services they commission and procure might improve the economic, social and environmental well-being of the area.

2.3. Environmental Drivers

- **Natural resources**
  Natural resources are essential to human life and civilisation, their loss threatens human wellbeing and economic stability and development

- **Threats to Public Health**
  Public health is adversely affected by pollution to air, land and water as well as being jeopardised by extreme weather events associated with Climate Change.

2.4. Social Drivers

- **Changing Demographics**
  Using resident populations for the districts of Maidstone, Sevenoaks, Tonbridge & Malling and Tunbridge Wells, the following changes are predicted over the next 20 years:
  The overall population of the four districts is expected to increase, with the highest increases in Maidstone for 65 years or over (11% increase) and Tonbridge & Malling for people aged over 85 years (26%).

  This population increase has serious implications for health and care delivery from both a financial and activity perspective.

  Older people have the greatest risk of their health being affected by cold temperatures. The majority of excess winter deaths are in people 75 years old

  The prevalence of multi-morbidity increases substantially with age

  The prevalence of dementia increases with age and these patients need additional elements in their care

- **Public Opinion**
  There is a large and growing expectation amongst the public and staff members that the NHS should do more to address its environmental impacts and take action to reduce them.

3. Specific Areas of Focus and Related Targets

3.1. Corporate Vison and Governance

Focus Aim

The Trust will make carbon reduction and sustainable development corporate responsibilities and will ensure that they are integrated into the governance and reporting mechanism.

The Trust will have a clear vison of its Sustainability Goals and will ensure that responsibility and accountability for sustainable development is clear within its organisational structures.

The Trust will produce evidence of its progress towards targets to satisfy the requirements of its regulators and commissioners. In addition the Trust will publish performance information to provide assurance to its stakeholders that the Trust is managing its corporate responsibility commitments.

Related Targets and Current Progress

1 The Trust has a clear vision of its Sustainability Goals

2 Responsibility and accountability for sustainable development is clear in the Trust

3 Leadership has engaged widely and developed a narrative for sustainable development that aligns visions, priorities and delivery

3.2. Leadership, Engagement, Partnership and Development

Focus Aim

The Trust aspires will be a demonstrable leader within the provision of sustainable healthcare and is committed to engaging and partnering at all levels, both locally, regionally and nationally to deliver this ambition. The Trust will ensure that the Green Plan is adopted by Heads of Department and Senior Management Team members and is cascaded through the lines of control

The Trust will engage with local stakeholders to ensure that its approach is dovetailed to local initiatives and activities as well as to seek endorsement of and support for its sustainability strategy and actions. The trust is committed to ensuring that local feedback and opinion is recognised within its decision making and that local community assets and initiatives are embedded within its care provision. The trust is committed to communicating its vision, goals and strategy to local stakeholders and will put in place a communications plan to ensure the openness and transparency of its programmes. The approach is one of

supporting and enhancing local activities where they exist and working in partnership with local groups to achieve a common aim.

The Trust is committed to engaging in local, regional and national forums and platforms, both internal and external to the NHS to ensure that it maximises on all potential leverage that is available and benefits from and demonstrates best practice to the wider stakeholder community.

The trust recognises its own staff members are essential and intrinsic to the delivery of sustainable healthcare and is committed to supporting and developing its staff to have the competencies and skills to deliver sustainable healthcare within their specific areas of operation and to challenge and rectify practices that are not complementary to this aim. This will be achieved through the mainstreaming of sustainability into the recruitment process, into job descriptions and daily activities and operations through a comprehensive review of operational procedures and policies.

Related Targets and Current Progress

4 The Trusts approach to environmental and social responsibility is supported and owned by local people.

5 The Trust has consolidated partnerships and makes use of its leverage within local frameworks.

6 All staff are aware of the benefits of acting sustainably, have the competencies and skills to implement sustainability initiatives and are empowered to challenge unsustainable behaviour

3.3. Healthy, Sustainable and Resilient Communities

Focus Aim

The Trust recognises the inherent value of a healthy community and will actively support programmes and schemes to improve the health and fitness of its local community, stakeholders and staff through direct activities, the use of volunteers and the partnership with local organisations.

The Trust recognises that investing in volunteers is investing directly in its stakeholders and seeks to capitalise on positive experiences and feedback to expand the scale and role of volunteers within the operation of the sites.

The Trust is committed to improving the health and welfare of its staff, both in and outside of the workplace, through the promotion of healthy living options, support services and the partnership with organisations that provide specialist services.

The Trust recognises that its grounds and green spaces are an asset, both due to the natural capital that they represent as a habitat and ecosystem but also as a resource for local communities to utilise and enjoy. The Trust will improve access to its green spaces and natural environments for stakeholders and will maintain and enhance the biodiversity capacity of its managed estate. The Trust will develop and publish a Biodiversity Management Strategy for its entire estate and will engage with local ecological partners and volunteers in its preparation.

The Trust recognises that its buildings and facilities have a significant impact on the environment, both due to the embedded carbon and resource depletion involved in their construction and in the energy consumed and carbon produced in their operation. The Trust will ensure that any refurbishment, redevelopment or new development seeks to minimise the environmental impact and associated carbon footprint of the construction process, the materials used and the subsequent operation of the facility through the use of appropriate technologies and strategies.

The Trust will ensure that any redevelopment or new development of its facilities appraises the potential changes to the climate, the potential effects of those changes on the facility and seeks to mitigate them at the design stage.

The effects of climate change to the Trust have the potential to be severe, and the organisational risk register will be updated to include the appraisal of the legal, financial, infrastructure and service related risks and action plans will be developed to manage the risks that have been identified. The Trust will use standard risk assessment tools and externally available guidance and support to assist with the risk assessment process.

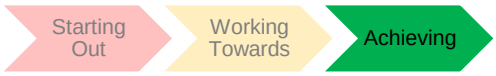
The Trust recognises that the process of climate change is leading to the normal patterns of weather changing and severe weather events becoming more frequent and prolonged. These include heatwaves, drought and water shortage, extreme cold events and associated snowfall, extreme rainfall and associated fluvial (surface water) flooding, changes to groundwater levels and associated groundwater flooding, severe storms and high winds.

The Trust will prepare plans for the risks identified and will integrate the process of planning with the existing processes for Emergency Planning and Business Continuity.

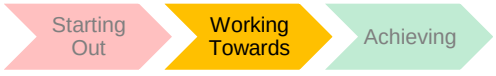
Related Targets and Current Progress

7 The Trust actively supports programmes and schemes to improve the health and fitness of its stakeholders and staff

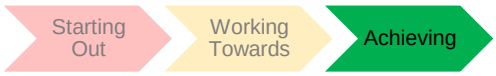
8 The Trust has a network of engaged and enthusiastic volunteers form the local community who capitalise on positive experiences and support the operations of the Hospital



9 The entire environment in which the Trust delivers care will promote wellness, will minimise emissions and will be resilient to changes in climate



10 The trust understands and minimises the current and future risks to the organisation from climate change



11 Adaptation plans are in place that link to business continuity and emergency planning processes

3.4. Sustainable Clinical Care Models

Focus Aim

The Trust is committed to the transformation of its service to deliver improved health outcomes coupled with social and environmental benefits.

The Trust recognises that the way that healthcare services are delivered will need to change to accommodate the changes associated with rising costs, changing population intensities, demographics and locations. Financial and budgetary pressures will continue to challenge the service provision as well as the ever changing and evolving structure of NHS services within the local and regional setting.

The Trust will ensure that environmental and social sustainability assessments are included as a standard within the templates for business case and service redesign templates and will review the models of care and patient pathways to take into account the overhead use of resources and carbon footprint.

The Trust will consider the most appropriate locations of services and facilities to minimise internal travel and will seek to maximise the opportunities presented by technology to facilitate remote and distance meetings.

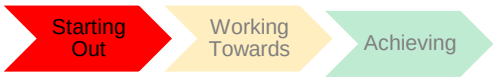
The Trust will work in partnership with NHS stakeholders to ensure the realisation of the Health and Social Care Sustainability and Transformation Plan (STP) and the integration and redesign of services across Kent and Medway to deliver better standards of care, better health and wellbeing and better use of staff and funds.

The Trust recognises the high carbon impact of anaesthetic gasses and inhalers and will work to reduce these where clinically viable.

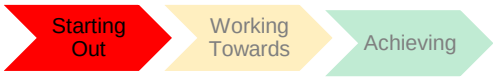
Related Targets and Current Progress

12 Transformation of the Trust services deliver improved health outcomes coupled with social and environmental benefits.

13 Switching to lower carbon asthma inhalers



14 Reducing the carbon footprint of Anaesthetic Gasses



3.5. Commissioning and Procurement

Focus Aim

The Trust aims to fully assess the environmental, social and financial impacts of its procured goods and services whilst remaining compliant with the systems and procedures established.

The Trust will minimise procurement of new items and will seek to reuse existing equipment where this is operationally viable. The sharing and internal recycling of resources will be promoted and encouraged to all staff and departments

Where procurement is required the Trust will develop tools to assess the lifetime financial and environmental impact of the required item, to include the manufacture, delivery, operational usage, consumable requirement, maintenance, decommissioning and disposal and will seek to use the assessment to influence the outcome of tender review decisions.

The Trust is committed where possible to sourcing all products from certified sustainable and renewable sources and will specify this as a requirement of its supply chain.

The Trust is fully committed to working within the NHS Procurement and Commercial standards and using the standards as a vehicle for improving the efficiency of the systems it operates and the sustainability of the services it provides.

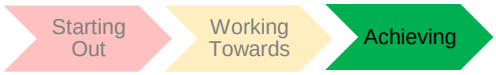
The Trust is committed to fully complying with all relevant aspects of the Public Services (Social Value) Act 2012 and the Modern Slavery (2015) Act and will publish clear statements and guidance for its partners and supply chain.

The Trust is committed to maximising the local economic benefit of its activities through the use of local suppliers and local labour where the skills and experience are available to undertake the required tasks and where the local selection is permissible under procurement guidelines.

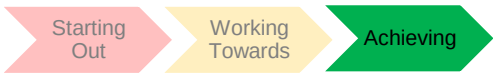
Related Targets and Current Progress

13 Procurement is undertaken in a compliant manner that takes into account the social, environmental and financial impacts of the service

14 The systems and processes for procurement are streamlined and consistent to ensure Trust Wide best value and efficiency



15 Materials are controlled, issued, reused and replaced in an efficient manner that minimises loss and the generation of waste



3.6. Operational Management and Decarbonisation

Focus Aim

The Trust is committed to operating in a manner that eliminates unnecessary energy and water use, utilises equipment and materials effectively, reduces waste production, maximises waste recycling, accurately assesses and mitigates impacts to the environment and causes no environmental damage through accidental discharges or spills.

The Trust will monitor and report upon its energy and water usage and its Scope 1 and Scope 2 emissions on an annual basis and will set internal targets with the aim of reducing the carbon emissions associated with its activities in line with the NHS Carbon Reduction Target of 10% by 2050.

The Trust will create a tangible culture that is intolerant of energy and water wastage, will optimise equipment and systems for efficient operation and will monitor, record and report on the energy and water performance of different geographical areas and departmental zones.

The Trust will identify opportunities for capital replacement and upgrade of equipment and infrastructure that will have an energy and water saving benefit and will prepare relevant business cases and justification.

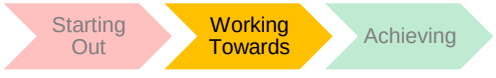
The Trust is committed to reducing the emissions associated with transport and providing efficient low carbon transport services across its operational environment and will document this through the publication of a green travel plan.

The Trust is committed to applying the waste hierarchy in all aspects of its operation, including those of subcontractors, to ensure that none of its waste is send to landfill and to maximising the recycling of waste that is produced.

The Trust will regularly assess the environmental aspects and impacts of its operation and will have in place suitable procedures and processes to prevent any unplanned or uncontrolled discharge to the environment. The Trust will maintain and practice emergency response procedures to intercept any spillage or environmental incidents that may occur to ensure that any potential impacts are mitigated.

Related Targets and Current Progress

16 The Trust operates an environment where non-essential energy use is eliminated



17 The Trust delivers efficient low carbon transport services

18 The Trust is operates an environment where non-essential water use is eliminated

19 The trust applies the Waste Hierarchy in all aspects of its operation, diverts 100% of waste from Landfill and maximises recycling

20 The Trust operates in a manner that assesses the environmental aspects of its activities and mitigates any impacts associated with them

Specific actions associated to the objectives are tracked through the Sustainable Development Management Plan Action Framework (appendix 1)

4. Numerical Scope 1 and 2 Emissions Target

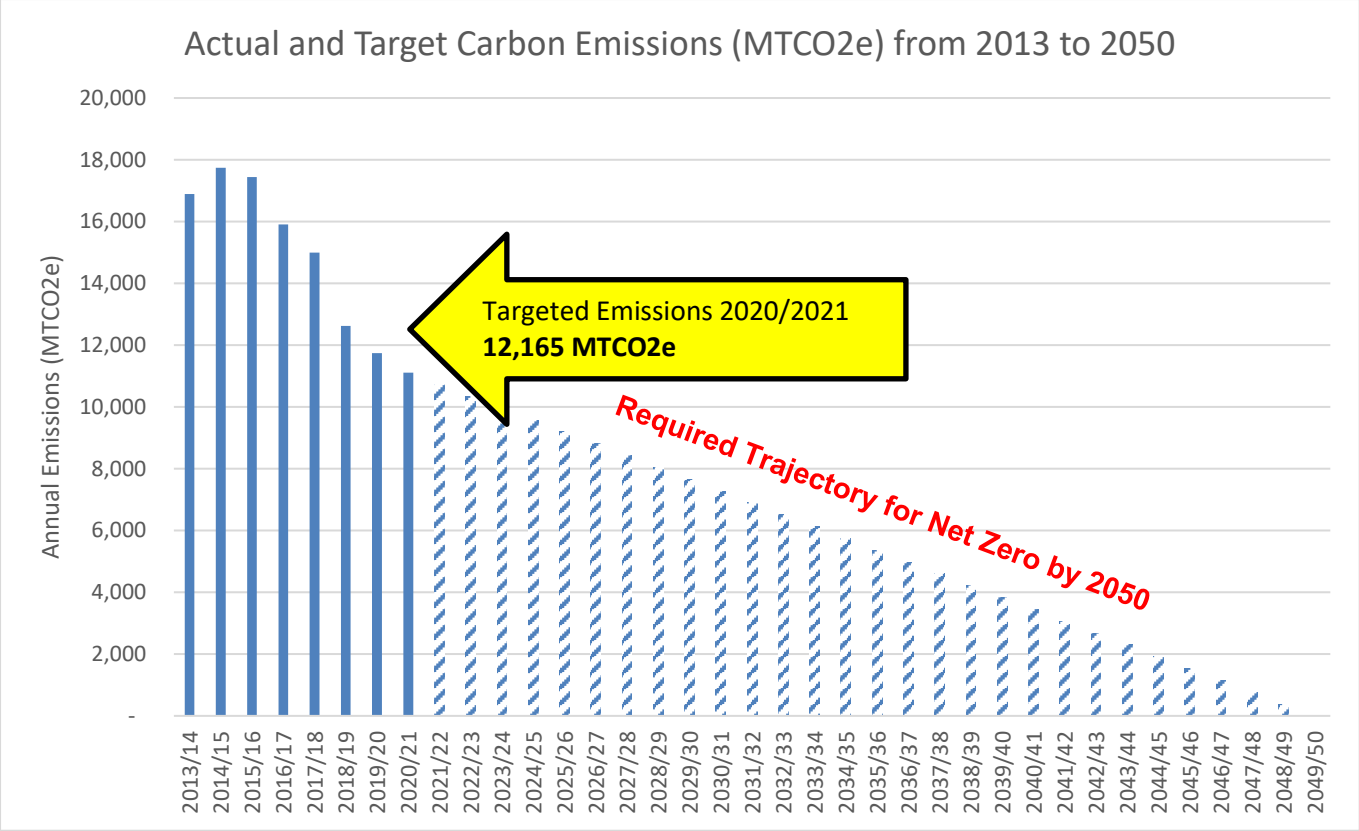
In 2016 the Trust set a target of a 28% reduction in scope 1 and 2 carbon emissions by 2020/2021 against a 2013/14 baseline.

The Trust exceeded this target a year early, in March 2020.

The Graph below shows the scope 1 and 2 emissions of the Trust since 2013/14, the progress to date and the required decarbonisation trajectory to meet the NHS targets of zero emissions by 2050. The graph clearly shows that the current emissions trajectory of the Trust is highly favourable.

The Trust has undertaken a significant number of projects and initiatives since 2016 and the scope 1 and 2 emissions have reduced by 36.3% in the last 5 years since the 2015/16 period.

The future targets for carbon reduction have been set in line with the path to zero emissions by 2050, and this equates to an annual reduction of circa 3.5%.



5. Green Plan Action Framework

Specific actions arising from and related to this Green Plan will be tracked through the Green Plan Action Framework.
All actions within the framework will have a member of the committee assigned as lead for the action and will have timeframes for implementation and review timeframes established and recorded.
Progress against actions contained within the framework will be reviewed by the Sustainable Development and Environmental Committee on a quarterly basis.

6. Review

This plan will be reviewed and ratified on an annual basis by the Sustainable Development and Environmental Committee and the Trust Board

7. Conclusion

The Trust has made significant progress in reducing its scope 1 and 2 emissions in the last year and continues to prioritise the delivery of sustainable healthcare in its actions and endeavours.

To approve the proposal for a Maggie's Centre to be built at Maidstone Hospital	**Divisional Director of Operations, Cancer Services / Chair of the Charitable Funds Committee**

The Trust has, for several years, been exploring a potential partnership with Maggie's to build a Maggie's Centre at the Trust. Maggie's is a charity that provides free cancer support and holistic care for patients, families and carers in Centres across the UK and online. The Charitable Funds Committee has been kept updated on developments but had been informed that the proposal had stalled because of the COVID-19 pandemic. However, the situation has recently changed, and Maggie's have stated that they are now able to financially support a Centre at the Maidstone Hospital site.

The proposal to build a Centre was supported when it was considered at the Executive Team Meeting (ETM) on 04/05/21, and the Charitable Funds Committee on 07/05/21, although some questions were posed at both forums.

The Trust Board is therefore asked to:

1. Approve the proposal in order to allow next steps to progress.
2. Provide permission to agree a suitable area of land at the Maidstone Hospital site, aligning with the site's Development Control Plans.
3. Subject to step 2 above, agree for this item to return to the Trust Board July 2021 to approve the Heads of Terms.

This report includes the following documents:

- An Executive Summary of the proposed partnership with Maggie's Centres (a previous version of this was submitted to the Charitable Funds Committee on 07/05/21).
- A "Q&A with Maggie's" document (which responds to the queries raised at the Executive Team Meeting (ETM) on 04/05/21 and the Charitable Funds Committee on 07/05/21.
- A "Becoming part of Maggie's" presentation.
- The "Living with and Beyond Cancer Health and Wellbeing Centre" Business Case that was first considered by the Charitable Funds Committee in March 2019.
- The draft Heads of Terms.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting (ETM), 04/05/21
- Charitable Funds Committee, 07/05/21

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

To approve a proposal for a Maggie's Centre to be built at Maidstone Hospital

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

EXECUTIVE SUMMARY FOR THE PROPOSED PARTNERSIP WITH MAGGIE'S

NHS Maidstone and Tunbridge Wells NHS Trust

Briefly describe the Business Case objectives

- There has been an incredible improvement in long term survival for people diagnosed with cancer over the last 10 years. There are many more treatment options available today and patients are living beyond a cancer diagnosis for many years. Macmillan, the cancer support charity, has developed a toolkit known as the "recovery package" that provides practical actions designed to support patients through the transition from active treatment to living with cancer and beyond.
- The Cancer Division has been approached by Maggie's to fund a Health and Wellbeing Centre at the Maidstone Hospital Site. Maggie's is a charity that focuses on Health and Wellbeing centres which are designed to be architecturally interesting and have won many awards. Maggie's would undertake all the fundraising required to obtain the funding to build a centre at Maidstone Hospital. They would run and staff the centre in perpetuity with no cost to the Trust. Maggie's asks for the land for the centre to be built on to be donated or leased for a peppercorn rent in order to enter in to a partnership.
- It is important that we are continually striving to improve and develop our services in collaboration with the local community. A Maggie's Centre will enable every person to be treated as an individual with a holistic approach that empowers them and helps them regain some of their control that can be lost of part of their cancer diagnosis. Maggie's Centres are designed on the principle of being non-clinical looking and set away from the main hospital site. The purpose of the centre will be to provide a supportive environment, holistic treatment and signposting services for patients, family and carers, even after cancer treatment has been concluded and the patient would normally be discharged from secondary care. This is to meet the recommendations in the Cancer Taskforce report and the NHS Long Term Plan and is in line with Macmillan's Living with and Beyond Cancer guidance.

Changes since the last update to the Charitable Funds Committee

- Since the last update to the Charitable Funds Committee in March 2020, Maggie's informed us that they would be unable to come up with suitable funds to progress with funding a Maggie's Centre on the Maidstone Hospital site. This was due to fundraising issues which were heightened by the pandemic last year. However, over the past 6-months Maggie's have received significant donations and are now able to financially support a proposed Maggie's Centre for Kent and Medway. Maggie's have indicated the projected donation is sizeable but have not given the specific amount.
- In the previous business case proposal submitted in 2019, the Maggie's Centre was to be built on the land next to the Academic Centre. However, due to significant changes with spacing and social distancing requirements throughout the pandemic, that plot of land is now being used for other purposes. Subsequently, the aim of this meeting is to agree to the Heads of Term which outline that we will provide Maggie's with a plot of land approximately 450m^2 which is yet to be specified. This plot of land can be agreed upon in due course once Maggie's further fundraising has been completed and an architect has been hired for the project.

Briefly describe the expected benefits

- Fundraising would be undertaken by a proven charity with the skills, donor database and knowledge to be successful in raising the amount of money a project of this size requires
- Charity commits to run and staff the Centre in perpetuity with no cost to the Trust
- Health and wellbeing centre for Kent & Medway that can provide extra on-going support to those with and those affected by cancer. Additionally, these services will be available after traditionally they would cease to be supported by secondary care
- A common access point for patients to be able to self-refer back in to secondary care
- A calming and non-clinical space, away from the main hospital and Oncology Centre, where patients, relatives and carers can visit for support or peace and quiet (and for staff too)
- A non-clinical space that can be utilised for information giving sessions and holistic support and therapies to patients actively being treated and following active treatment
- A place for patients and relatives to make connections with other people going through similar experiences to them and gain support organically
- The Trust and Kent Oncology Centre will be able to meet the recommendations of the Cancer Taskforce report and NHS Long Term Plan in terms of supporting those with and affected by cancer living with and beyond cancer
- Patients treated at the Kent Oncology Centre will have a better experience and the Trust will be able to support a broader range of complementary and holistic treatments and support with a Health and Wellbeing Centre

Briefly describe high-level risks and mitigations

- Unable to raise sufficient charity funds within an appropriate time frame may significantly increase cost of the project or cause it to fail.
- Unable to identify an appropriate plot of land to suit the requirements. The purpose of this meeting is to ascertain we will be able to provide Maggie's with the appropriate plot of land.
- Damage to future relationship with Macmillan and other local cancer charities as Maggie's is a competing charity. Conversations have previously been had with senior Macmillan representatives to mitigate this risk and it was concluded that Macmillan offer a differing service to Maggie's. The Trust will remain in conversations with Macmillan to ensure the relationship is maintained.

What is the overall cost of the Business Case? £0.00

Has the funding been identified and agreed? Yes ✓ No ☐

If "No", please explain why the Business Case is still being submitted

Q&A with Maggie's

The following questions were raised at the Executive Team Meeting on 04/05/21 and the Extraordinary Charitable Funds Committee on 07/05/21, and were actioned to be discussed with Maggie's. The Assistant General Manager in Cancer Performance duly met with the Business Development Manager at Maggie's on 12/05/21 to discuss the following points.

Does the building need to be located on-site or can it be a neighbouring site?

- Ideally, the Centre would be located on-site due to the nature of the Support Centre and Maggie's philosophy. The Centre can also be located on the periphery of the hospital site. If the Trust has severe site pressures which mean it cannot be located on-site, Maggie's could look into neighbouring space, it is not completely ruled out.
- Visitors of the Centre tend to come after they have had an appointment or treatment at the hospital. If the Centre is on-site then visitors do not have to make another journey and can just stay in the same car park for longer, making it a more convenient visit.
- Every hospital Maggie's has previously worked with has had the same site anxieties. The project has only failed once out of 24 times which was due to considerate site changes and construction works happening alongside.
- Moving a helipad by 10m was built into the project scope for the Dundee Centre. Moves such as this can be incorporated into and funded by the Maggie's project. This would only be the case if there were no other viable options.
- Maggie's will not go forward with any plans that MTW do not 100% agree with and will include future construction and expansion plans within all stages of the project.

Next steps: The Assistant General Manager in Cancer Performance will arrange an initial walkaround over the coming months with the Maggie's project team & MTW's Cancer DDO & Estates team, to show Maggie's around MTW and get their views & ideas on where the Trust could build, to inform the Heads of Terms. Once an architect is hired, the Maggie's team will return for a more formal walkaround to finalise the site.

What clinical support is required from the Trust?

- In p.19 of the proposal presentation, Maggie's requires "clinical support" from the Trust partner. This refers to support from the clinical oncology and wider cancer team that a Maggie's Centre is a useful and important service to offer. Maggie's require a clinical voice to reiterate that their offering is different from Macmillan and other charities, and very important for our patients. The Trust has a number of consultants who are keen to engage with this, and our Chief of Service and Clinical Director are extremely supportive.

What, if any, shared services would be required for the operation of the Centre?

- Maggie's would maintain the building and garden areas. There is the potential to share security and cleaning services but that depends on what contracts MTW have in place and whether Maggie's can be added on. However, Maggie's are flexible and willing to pay for and provide these services themselves. The hospital can also contribute or donate these services if they are in the position to do so.
- If space is available, Maggie's can include a car park as part of their costing & building works. If there is no space, Maggie's are happy to share MTW patient parking. This will be worked up re visiting numbers & requirements as Maggie's understands parking space is a premium. If parking is shared, Maggie's would ask that their staff are given access to the MTW staff car park in the same way as MTW staff.

Could you please give us a bit of insight on what it has been like sharing sites with hospitals?

- A working group will be setup once the project is given the go ahead. This would include Maggie's and MTW's Estates, Charity, Cancer teams and anyone else that should be involved.
- In regards to the fundraising, sometimes trust charities, local hospices and other cancer charities worry about Maggie's becoming fundraising competition. The initial capital raised tends to come from a different type of donor to those that would donate to hospitals as Maggie's will engage with people at different levels. Trusts that have previously worked well alongside Maggie's have all approached fundraising differently but ultimately developed a good working relationship.

Next steps: MTW will liaise with University Hospital Southampton (UHS) to better understand their experience, as one of the newest Maggie's Centres in the country. The meeting has been arranged with a contact at UHS and is scheduled for Tuesday 25th May. A verbal update will therefore be provided at the Trust Board meeting on 27th May.


BECOMING PART
OF
MAGGIE'S

MAGGIE'S CENTRES

BACKGROUND : OUR STORY

In 1995, our founder, Maggie Keswick Jencks, wrote this about her experience of cancer:

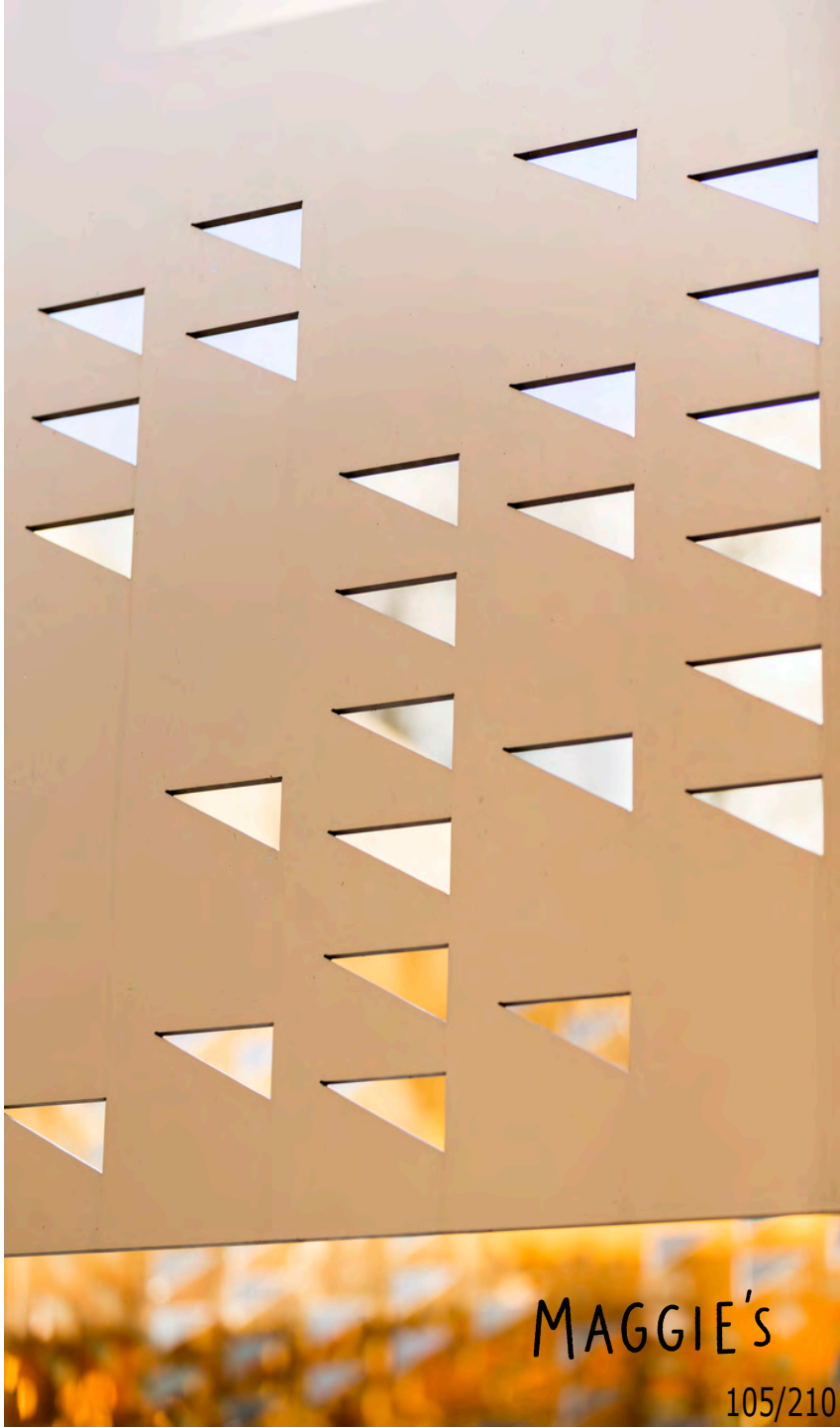
"A diagnosis of cancer hits you like a punch in the stomach…No road. No compass. No map. No training…At one time, I could not sit, or lie, or stand, listen or speak coherently because my shattered mind vibrated so violently through my body I felt I might disintegrate."

Over the course of seven years, Maggie experienced cancer diagnosis, treatment, remission and recurrence. During that time, she took the insight and experience she had gained and transformed it into a pioneering approach to cancer care – creating a new blue print for cancer support.

MAGGIE'S CENTRES

BACKGROUND CONTD.

- Among Maggie Keswick Jencks' beliefs about cancer treatment was the importance of *environment* to a person with cancer.
- She talked about the need for *"thoughtful lighting, a view out to trees, birds and sky,"* and the opportunity "*to relax and talk away from home"*.
- She talked about the need for a welcoming, reassuring space, as well as a place for privacy, where someone can take in information at their own pace.
- We've taken Maggie's blueprint as a model of cancer care and grown it into a network of Centres across the UK and abroad, supporting and empowering hundreds of thousands of people with cancer, as well as their families and friends.



THE ARCHITECTURE

The work of our building and the landscape

- Maggie's Centres are calm, friendly places purposefully and thoughtfully designed to help ordinary people who have cancer find the hope, determination and resources they need to cope with one of the toughest challenges any of us are likely to face.

- Always close to a major NHS cancer hospital, they are informal "domestic" buildings where people can draw on practical, emotional and social support when they need it, without the need for a referral or an appointment.

- The building, the landscape, the design of the interior, the art on the walls all give a different dimension and depth to the help and support people get from Maggie's.

- Environment and great design is vital to the care Maggie's offers, which is why we entrust the creation of our Centres to world-renowned architects and garden designers.

- These are beautiful buildings which helps people feel safe and comfortable.

COMPLEMENTING NHS SERVICES

- Since our inception we have worked alongside the NHS as a partner in pioneering comprehensive cancer support. We have close working relationships with our partner hospitals and approximately 50% of Maggie's visitors are *recommended* by their doctor or nurse.

- Our focus on psychological support and clear information for people with cancer, their families and friends, which complements the NHS's ongoing commitment of improving cancer care.

- In 2020, over two and half million people in the UK are now living with cancer. This means we now have a larger percentage of the population potentially in need of what we offer.

- Our ambition remains to be at the forefront of cancer care and to be there for everyone with cancer in the UK and at all the 60 NHS cancer centre sites.

PROGRAMME OF SUPPORT

- Maggie's welcome people with cancer, their family and friends, at any point in the cancer experience: diagnosis, treatment, post-treatment, recurrence, end of life and bereavement.

- Anyone can drop in to a centre whenever they want. Our programme is free of charge, with no referral or appointment required and people can access our support for as long as they need it.

- Every visitor has access to our cancer professionals and to our core programme of support which encompasses practical information, psychological and emotional support, stress and distress management and help to make choices to live differently.

- We currently have 24 Maggie's centres in the UK and 3 centres overseas in Spain, Hong Kong and Japan. We plan to have 30 centres operational by the end of 2022.

PROGRAMME OF SUPPORT

Professionally trained staff are on hand in each Maggie's centre to provide tailored practical and emotional support.

Each centre has:

- **Centre Head and Cancer Support Specialists:** With a background in cancer nursing and years of experience working in an oncology NHS healthcare setting
- **Clinical Psychologists:** offering individual or family support or group sessions
- **Maggie's Benefits Advisors:** offering specialist guidance on benefits, insurance and money management
- **Exercise specialists:** offering exercise sessions in yoga, tai chi, or Nordic walking
- **Nutritionists:** providing specialist information on eating well with cancer
- **Information:** Visitors have access to information including a library of literature with staff to provide support and guidance
- **Peer support:** Visitors have access to cancer specific groups and peer-to-peer support

PROGRAMME OF SUPPORT

We had 290,000 total visits to our centres in 2019. Our intention is to grow that to 400,000 visits by 2022.

In a recent Maggie's audit:

- **Physically** – **99%** said their visit to Maggie's enabled them to understand more about their cancer diagnosis and treatment
- **Emotionally** – **91%** reported an improved ability to manage stress
- **Professionally** – **80%** said Maggie's helped improve their confidence talking to their employer and helped make their return to work as smooth as possible
- **Financially** – **84%** of visitors said they had an improved understanding of benefits

FUTURE DEVELOPMENT

- **Our ambition remains to be at the forefront of cancer care and to be there for everyone with cancer in the UK, and at all the 60 NHS cancer centre sites.**

- We plan to continue to open new centres across the UK to support people with cancer and their families.

- We plan to work with more International groups to increase our presence over-seas, supporting thousands more people with cancer

- As the numbers of people being diagnosed with cancer continues to rise, we need to ensure all of our centres are able to meet this need.

- When a centre is newly opened our target is to support **10%** of the cancer population in that community. Our ambition is to increase this to above **50%** when centres are fully established.

FUNDING MAGGIE'S

- Our buildings need to be built as economically as possible, without compromising what we are trying to achieve. Each new Centre will vary in size, in proportion to the cancer population it serves.

- Each new centre fundraising campaign is between £5m - £7m, which includes the costs for the building, landscape and two years running costs.

- Each new building project, whether in the UK or overseas is funded through a similar process, which is a four year Capital Fundraising Campaign that is led by a Fundraising Board (volunteer leadership) and supported by a Maggie's Campaign manager.

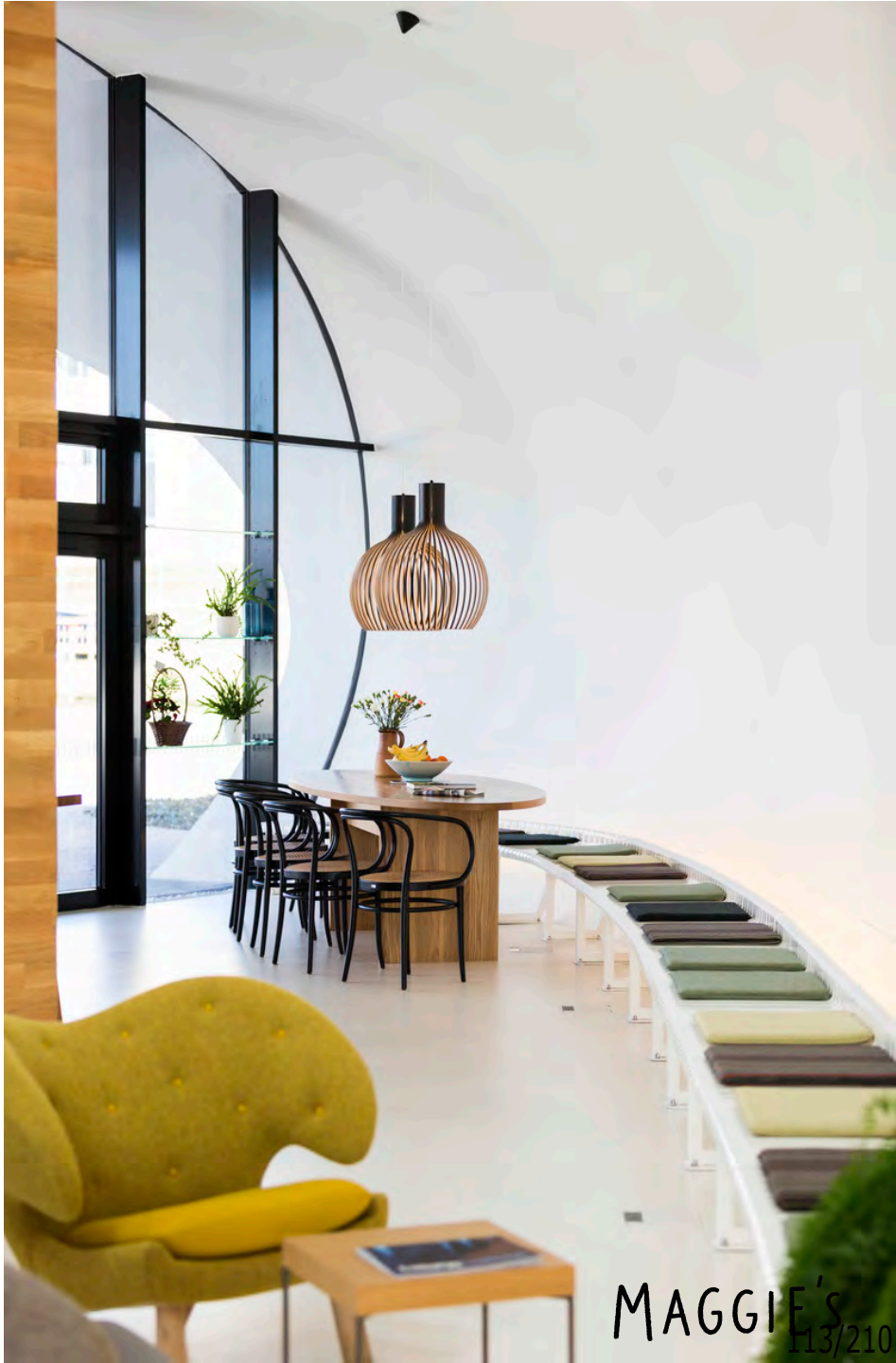
- Construction of each new Centre does not commence until 90% the capital costs have been banked or pledged.
  See Appendix for Fundraising model.

JOIN US: BE A PART OF MAGGIE'S NETWORK

To date Maggie's has grown successfully through our NHS clinical colleagues requesting centres, recognising the value that Maggie's brings to cancer care and support.

To join Maggie's Network certain criteria need to be met by our NHS Trust partners:

- Formal NHS Trust Board approval for a Maggie's centre development
- Land for the Maggie's to be built on the hospital site: 300- 450m^2 for the building plus space for a garden. All at a peppercorn rent.
- A summary of the need, including details of the cancer population and any existing support services
- Clinical support from the hospital



JOIN US:
BE A PART OF MAGGIE'S NETWORK

In 2021, we have 24 centres operational in the UK, 3 overseas.

In addition, we have eight centres currently in development in the UK. They are:

1. Maggie's Merseyside
2. Maggie's at the Royal Free
3. Maggie's Cambridge
4. Maggie's Northampton
5. Maggie's Coventry
6. Maggie's Bristol
7. Maggie's Preston
8. Maggie's Royal Liverpool

There are 2 International centres in development:

9. Maggie's Stavanger, Norway
10. Maggie's Groningen, The Netherlands

WE LOOK FORWARD TO SPEAKING WITH YOU ...

Sarah.beard@maggiescentres.org
Business Development Director
T: 00 44 20 7386 3561
M: 00 44 7866 742174

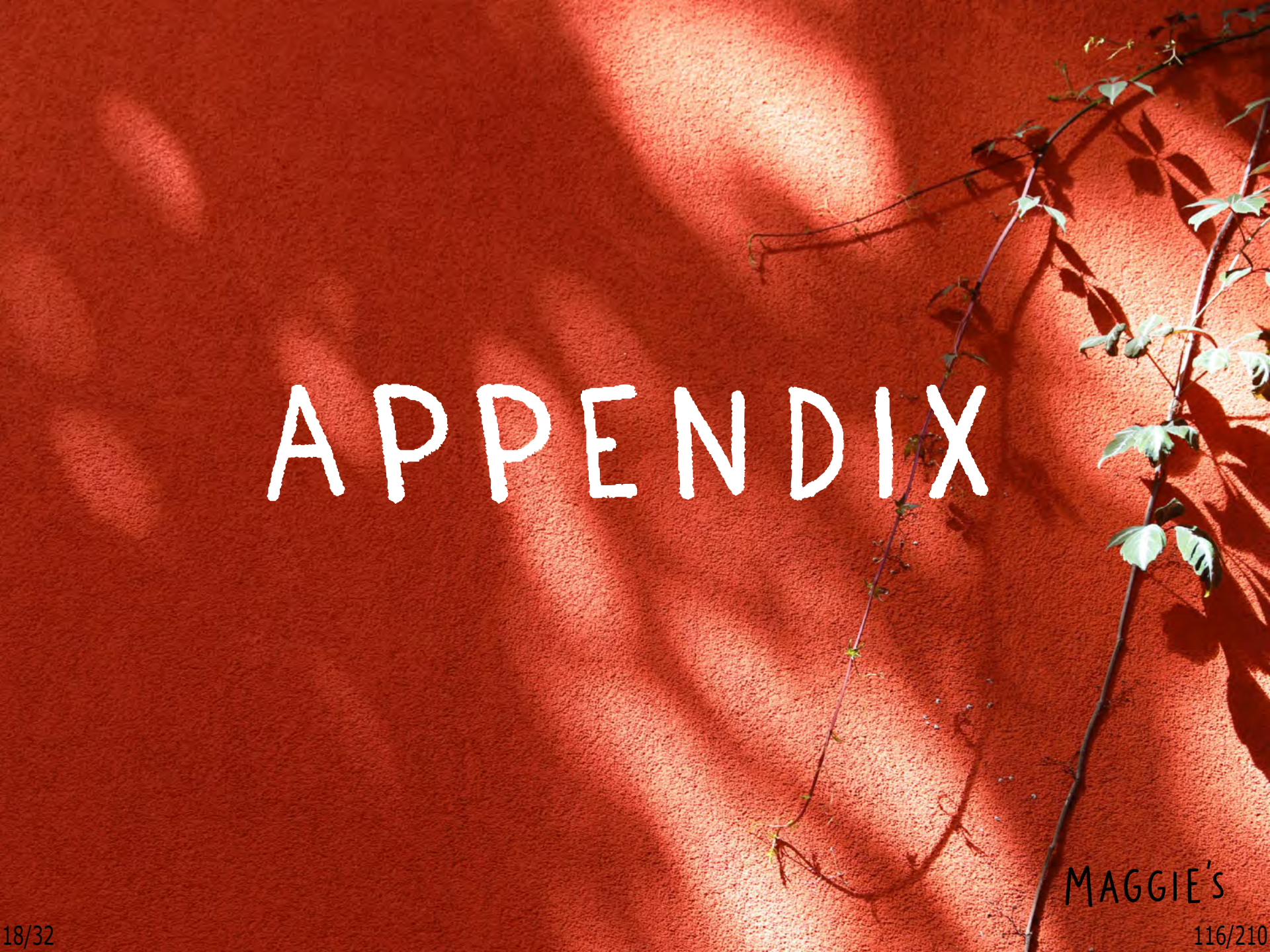
TESTIMONIALS

“Maggie’s is an excellent example of supporting lifestyle change, so that attitudes and behaviours can change positively for the long-term”

Professor Mike Richards CBE, former National Clinical Director for Cancer

“Good medicine necessitates scientific and technical excellence. It also demands engagement with patients as individual human beings with unique values, fears and hopes. Patient care is much more than the treatment of disease; it requires human understanding. Maggie’s contributes hugely to the human side of cancer care and by working in partnership with NHS oncology units ensures that the whole patient is supported.”

Dr Sam Guglani, Consultant Oncologist, Cheltenham General Hospital


APPENDIX
MAGGIE'S

APPENDIX ONE: FUNDING MODEL

- Each new Maggie's centre, whether in the UK or abroad, is funded through a similar model, which includes establishing a fundraising campaign (usually between £4m-£7m) to cover the cost of:
    - **The Capital build:** The building and the landscape, which is usually between £2m-4m.
    - **Fundraising:** This is usually between £350,000 - £650,000, and is based on a 4-year campaign.
    - **A "moving in" fund:** to support the running costs of the Centre for a given period. These costs (approx. 10% of the campaign) also include a building maintenance budget.
- This model above has proved highly successful.
- The development of Maggie's Centre typically follows the timeline, documented in appendix two

Out-line Timescales for New Centre Development

The development of a Maggie's Centres typically follows the timeline below:

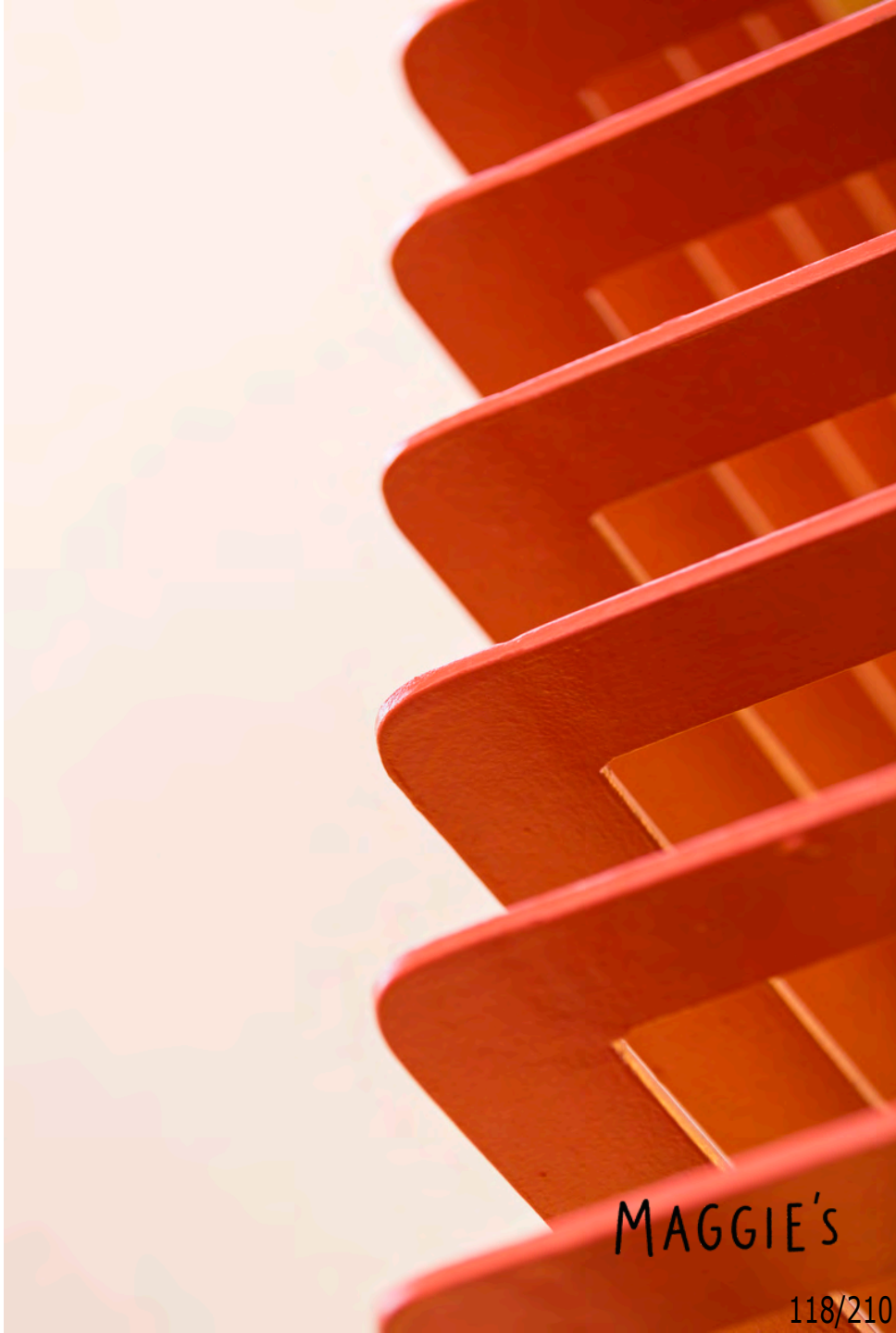
Timeline	Activity
0-12 mths	• Hospital Board Approval for Maggie's Centre • Maggie's Board Approval for project • Site Selection • Agreement of Heads of Terms o Development Agreement • Architect selection process • Formation of Fundraising Campaign and Board
6 – 9 mths	• Appointment of Architect o Preferred site agreed

12 mths	• Launch Fundraising Campaign
	  o Campaign Manager appointed
	  o Private fundraising phase (1 year) then public phase

12-18 mths	• Designs finalised • Hospital Board approval of Design
18-24 mths	• Planning application submitted • Begin public awareness raising locally
18 – 24 mths	• Planning permission granted • Increased fundraising activity

24 – 36 mths	• Maggie's Board approves/reviews funds raised and approves Capital Investment
	  o Tender negotiations and pre-site work
	  o Contractor appointed

36 mths	• Construction Commences (typically 12 month period)
40-48 mths	• Landscaping phase (depending on design and construction period) • Completion of Maggie's Centre Construction
48 mths	• Official opening of centre



2021 - 27 OPERATIONAL CENTRES

1. Maggies Edinburgh – 1996
2. Maggies Glasgow – **2002 & 2011***
3. Maggies Dundee – 2003
4. Maggies Highlands – 2005
5. Maggies Fife – 2006
6. Maggies West London – 2008
7. Maggies Cheltenham – 2010
8. Maggies Nottingham – 2011
9. Maggies Swansea – 2011
10. Maggie's Cambridge **interim -** 2012
11. Maggies Hong Kong – 2013
12. Maggies Newcastle – 2013
13. Maggies Aberdeen – 2013
14. Maggies Oxford – 2014
15. Maggies Lanarkshire – 2014
16. Maggies Clatterbridge **interim** – 2014
17. Maggies Manchester – 2016
18. Maggies Tokyo – 2016
19. Maggie's Royal Free (London) **interim** - 2016
20. Maggies Forth Valley – 2017
21. Maggies Oldham – 2017
22. Maggies Barts (London) – 2017
23 Maggie's Barcelona - 2019
24 Maggie's Cardiff – 2019
25 Maggie's Yorkshire (Leeds) – 2019
26 Maggie's Royal Marsden (Sutton) - 2020
27. Maggie's Southampton - 2021

SCOTLAND - 8
ENGLAND - 13
WALES - 2
OVERSEAS - 3

MAGGIE'S

EUROPE

MIDDLE EAST AND ASIA

Maggie's centres

1. Edinburgh
2. Glasgow
3. Dundee
4. Highlands
5. Fife
6. West London
7. Cheltenham
8. Nottingham
9. Swansea
10. Cambridge (interim)
11. Newcastle
12. Hong Kong
13. Aberdeen
14. Oxford
15. Merseyside
16. Lanarkshire
17. Royal Free (interim)
18. Manchester
19. Tokyo
20. Forth Valley
21. Oldham
22. Barts
23. Cardiff
24. Barcelona
25. The Royal Marsden (Sutton)
26. Leeds
27. Southampton

Operational Maggie's

Construction 2021/2022

EUROPE

MIDDLE EAST AND ASIA

Maggie's centres

1. Edinburgh
2. Glasgow
3. Dundee
4. Highlands
5. Fife
6. West London
7. Cheltenham
8. Nottingham
9. Swansea
10. Cambridge (interim)
11. Newcastle
12. Hong Kong
13. Aberdeen
14. Oxford
15. Merseyside
16. Lanarkshire
17. Royal Free (interim)
18. Manchester
19. Tokyo
20. Forth Valley
21. Oldham
22. Barts
23. Cardiff
24. Barcelona
25. The Royal Marsden (Sutton)
26. Leeds
27. Southampton

Planned centres

17. Royal Free

Operational Maggie's

Construction 2021/2022

Planned Maggie's

EUROPE

MIDDLE EAST AND ASIA

Maggie's centres

1. Edinburgh
2. Glasgow
3. Dundee
4. Highlands
5. Fife
6. West London
7. Cheltenham
8. Nottingham
9. Swansea
10. Cambridge (interim)
11. Newcastle
12. Hong Kong
13. Aberdeen
14. Oxford
15. Merseyside
16. Lanarkshire
17. Royal Free (interim)
18. Manchester
19. Tokyo
20. Forth Valley
21. Oldham
22. Barts
23. Cardiff
24. Barcelona
25. The Royal Marsden (Sutton)
26. Leeds
27. Southampton

Planned centres

17. Royal Free
28. Northampton
29. Coventry
30. Liverpool
31. Stavanger
32. Groningen

- Operational Maggie's
- Construction 2021/2022
- Planned Maggie's
- Potential development 2021/2022

EUROPE

MIDDLE EAST AND ASIA

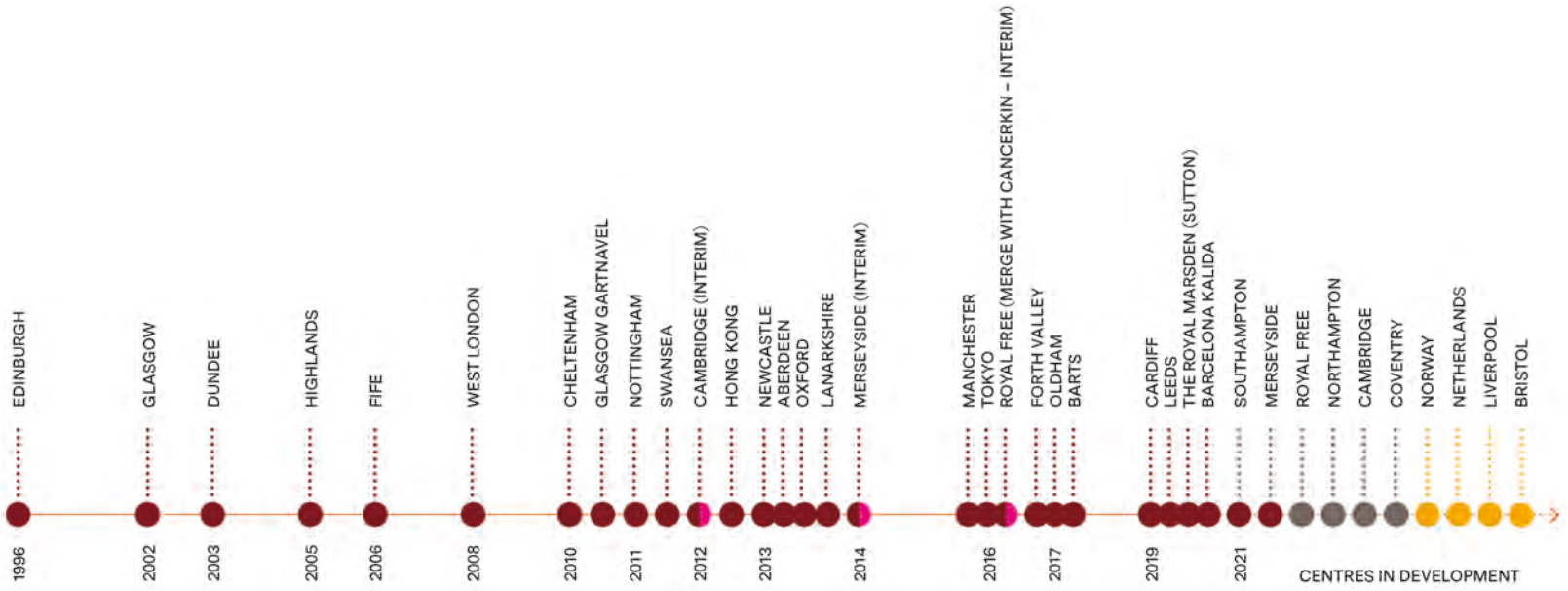
Maggie's centres

1. Edinburgh
2. Glasgow
3. Dundee
4. Highlands
5. Fife
6. West London
7. Cheltenham
8. Nottingham
9. Swansea
10. Cambridge (interim)
11. Newcastle
12. Hong Kong
13. Aberdeen
14. Oxford
15. Merseyside
16. Lanarkshire
17. Royal Free (interim)
18. Manchester
19. Tokyo
20. Forth Valley
21. Oldham
22. Barts
23. Cardiff
24. Barcelona
25. The Royal Marsden (Sutton)
26. Leeds
27. Southampton

Planned centres

17. Royal Free
28. Northampton
29. Coventry
30. Liverpool
31. Stavanger
32. Groningen
33. North Wales

GROWTH IN 25 YEARS



BUSINESS CASE PROPOSAL

Guidance notes on completing this template are available on the Trust Intranet.

Maidstone and Tunbridge Wells NHS Trust

TITLE: **Living with and Beyond Cancer Health and Wellbeing Centre**

Division	Cancer Services	**Author**	D Fitzgerald/C Wadey
Directorate	Oncology	**General Manager**	**Jenny Anderson**
Department/Site	Maidstone	**Finance Manager**	Gemma Paling
ID reference		**Issue date/Version**	

Approved by Division

	Print Name	**Signature**	**Date**
Director of Operations	D Fitzgerald		
Clinical Director/Director	H Taylor		
Executive sponsor	TBC		

Strategic background context and need

There has been an incredible improvement in long term survival for people diagnosed with cancer over the last 10 years. There are many more treatment options available today and patients are living beyond a cancer diagnosis for many years.

However, this has meant that thought needs to be given to how to support those with cancer and those affected by cancer (e.g. family members, friends and carers) as the impact of cancer continues once treatment is over. Many patients face a very busy time with numerous hospital visits when they are first diagnosed for investigations, treatment appointments and outpatient appointments with multiple healthcare professionals.

Patients are given support from many different healthcare professionals and usually also third sector support. However, this is tailored to supporting during an active treatment phase. They are discharged from secondary care back in to primary care following this intense period of appointments and many patients have reported a feeling of being dropped and isolated after treatment has finished.

Macmillan, the cancer support charity, have developed a toolkit known as the “recovery package” that provides practical actions designed to support patients through the transition from active treatment to living with cancer and beyond. Cancer Services have implemented a number of the recommendations in the recovery package, particularly health and wellbeing days that are run to provide advice and guidance on a whole range of issues including appearance/body image, exercise, sexual health, benefits and financial support and also sign posting to other support services such as local support groups.

Cancer Services worked with Macmillian in 2015/2016 to develop a bid to build a Macmillan Centre/Health and Wellbeing Centre on the Maidstone Hospital site. Unfortunately Macmillian then changed their strategic approach and decided that they would no longer fund physical buildings such as this.

Cancer Services have also been approached by Maggies, which is a charity that builds centres that fulfil the Health and Wellbeing Centre function. Maggies Centres are designed to be architecturally interesting and many have won awards. Maggies Centres are designed on the principle of being non-clinical looking, with a central “kitchen” in order to encourage visitors to feel at home and to start discussions in a more organic way.

Maggies Centres also have gardens or outside spaces created for quiet reflection or for gatherings/meetings and include other spaces that can be flexed in order to be used for support groups, information sessions, exercise

classes such as yoga, cooking lessons and many other supportive functions for patients during and after treatment and also for family, friends and carers that have been affected by cancer.

Objectives

1. Provide a supportive environment, holistic treatment and signposting services for patients, family and carers after cancer treatment has been concluded and the patient would normally be discharged from secondary care. This is to meet the recommendations in the Cancer Taskforce report and the NHS Long Term Plan and is in line with Macmillan's Living with and Beyond Cancer guidance.

2. Create a physical space that can act as both a support centre for those with cancer and those affected by cancer for support groups, education, advice and information giving but also to act as a hub for information provision across Kent & Medway in a hub and spoke model.

3. Provide an access point back in to secondary care for patients that have been included on a stratified follow-up pathway (i.e. self-managed and self-referral back in to secondary care).

The preferred option

Unfortunately negotiations and planning with Macmillan have not led to a viable proposal in order to obtain the funding and support for a Health and Wellbeing Centre.

Funding raising for a Health and Wellbeing Centre under the Maidstone and Tunbridge Wells NHS Trust Charity has been considered but there is not a sufficient charitable donation database, staff/fundraising resource or fundraising knowledge currently to successful raise the considerable amount of money required to deliver a project of this size.

Maggies have approached Cancer Services about building a Maggies Centre on the Maidstone Hospital site. Maggies have been approached by a donor who would like to financially support a Maggies Centre for Kent & Medway and would be supportive of this being built at the Maidstone Hospital site. Maggies have indicated that the donation proposed is sizable but have not given the specific amount.

Maggies would undertake all the fundraising required to obtain the funding to build a centre at Maidstone Hospital. They would run and staff the centre in perpetuity with no cost to the Trust. Maggies asks for the land to be donated for the centre to be built on or for a peppercorn rent in order to enter in to a partnership.

The preferred option is for Maidstone and Tunbridge Wells NHS Trust to enter in to a partnership with Maggies in order to fundraise and build a Maggies Centre on the land next to the Academic Centre at Maidstone Hospital. The Trust would agree a Land Lease at peppercorn rent for the land for the Centre to be built on and may choose to demolish the Farm Cottage building to facilitate this.

Main benefits associated with the investment

- Fundraising would be undertaken by a proven charity with the skills, donor database and knowledge to be successful in raising the amount of money a project of this size requires
- Charity commits to run the Centre in perpetuity with no cost to the Trust
- Health and wellbeing centre for Kent & Medway that can provide on-going support to those with and those affected by cancer after traditionally they would cease to be supported by secondary care
- A common access point for patients to be able to self-refer back in to secondary care
- A calming and non-clinical space, away from the main hospital and Oncology Centre, where patients, relatives and carers can visit for support or peace and quiet (and for staff too)
- A non-clinical space that can be utilised for information giving sessions and holistic support and therapies (e.g. yoga, aromatherapy, acupuncture) to patients actively being treated and following active treatment
- A place for patients and relatives to make connections with other people going through similar experiences to them and gain support organically
- To provide a hub centre for cancer information provision across Kent & Medway

- Meet the recommendations of the Cancer Taskforce report and the NHS Long Term Plan for supporting patients, relatives and carers living with and beyond cancer

Main risks associated with the investment

- Damage to future relationship with Macmillan as Maggies is a competing charity (conversations have been had with senior Macmillan representatives to mitigate this risk)
- Unable to raise sufficient charity funds within an appropriate time frame may significantly increase cost of the project or cause it to fail
- Not delivering the project will mean that the Trust and Kent Cancer Centre will be unable to meet the recommendations of the Cancer Taskforce report and NHS Long Term Plan in terms of supporting those with and affected by cancer living with and beyond
- Patients treated at the Kent Cancer Centre will have a poorer experience than elsewhere in England and we will not be able to provide a broader range of complementary and holistic treatments and support without a Health and Wellbeing Centre

Project Timetable

Maggies have indicated that fundraising usually takes around 5 years and then about 2 years to design and complete the build.

Therefore, assuming approval through the appropriate committee's and Trust board in 2019, a Maggies Centre could be open in 2026

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

Summary of financial impact		**Sum(£)**	**Funding source**	**Sum(£)**
CAPITAL COSTS	Estates		Identified in the Trust capital plan	
	IT		Identified in directorate revenue budget	
	Equipment		Other *(specify) Maggies Cancer Charity*	5,000,000
Total Capital cost of project			Additional Info: Maggies will fundraise for the full cost of building the Maggies Centre. MTW will be expected to donate the land or to request a peppercorn rent only.	
REVENUE COSTS	Pay			
	Non-pay			
	Other			
Total Revenue cost per annum				
INCOME	SLA			
	Other			
	Total Income per annum			
	Surplus/Loss			

NOTE: A completed and signed Business Case Proposal Checklist must be submitted with this form, before being submitted to the Executive Team for review and decision.

MAGGIE'S

Maggie's Cancer Caring Centres

Heads of Terms for
Proposed Maggie's Centre at [Hospital]

1. Parties

Landlord - [NHS Trust/Board, full address]

Tenant - The Maggie Keswick Jencks Cancer Caring Centres Trust, a charity registered in Scotland in the Scottish Charity Register (Registered Number: SC024414) being a private company limited by guarantee and registered under the Companies Acts in Scotland with Registered Number SC162451 and having its Registered Office at The Stables, Western General Hospital, Crewe Road South, Edinburgh, EH4 2XU

2. Demise

The premises comprise the building to be built on the land shown on the attached plan at [location] and which extends to approximately [XXXXm2]. The premises are to include the building, landscaping and such other features which Maggie's constructs on the premises. Where feasible, Maggie's will have the ability to construct private car parking spaces on the premises, and will also have the right to use any public parking within the hospital.

3. Rent

[For English/Welsh leases The rent is to be a peppercorn per annum, if demanded.]
[For Scottish leases The rent is to be an open market rent fairly and properly assessed by the Valuation Officer and paid quarterly in advance. The Landlord will provide a Back Letter to the effect that whilst Maggie's, or another organisation carrying on a use permitted under clause 5, is the tenant the Landlord will not seek to collect the rent.]

4. Term

The term is to be 60 years from [insert date].

5. Use

The permitted use is for cancer support and care or such other use as is approved by the Landlord, such approval not to be unreasonably withheld or delayed where the alternative use has healthcare as its primary purpose and is not being carried out for profit. Maggie's will not charge visitors to the Centre for any of the services provided at the Centre. Maggie's may also use the premises for the purposes of fundraising and administration.

6. Repair

Maggie's will maintain the premises in good repair, decorative, and working order.

7. Insurance

Maggie's will maintain buildings and contents insurance (in its name only) for full reinstatement value. In the event of damage or destruction, Maggie's to have the option of re-building or terminating the Lease. Where the Centre is listed or the damage or destruction arises as a result of the negligence of Maggie's, Maggie's will not have the option to terminate the lease. In circumstances where Maggie's choose to terminate the Lease (and have the ability to do so), any insurance monies are to be made available to the Landlord expressly for the purpose of rebuilding the building.

8. Alterations

Material structural alterations will require the prior written consent of the Landlord, such consent not to be unreasonably withheld or delayed.

9. Alienation

Maggie's is not to be permitted to sub-let save to subsidiaries or other group companies. Maggies is to be permitted to assign the whole to another organisation with similar charitable aims only.

10. Termination

Maggie's shall have a right to terminate if the Landlord ceases to have a Cancer Treatment Cancer at the hospital or relocates a substantial part of its cancer services and shall have the option to require the Trust to provide a Centre of equivalent concept, design and size at the new site.

In the event of termination of the lease, for any reason, the Landlord is to reimburse Maggie's its original capital expenditure plus any additional capital expenditure written down on a straight-line basis over the period from the date of the expenditure until the original date of expiry of the lease.

Maggie's will have the right to terminate the lease should it fail to secure the funding for the ongoing operation of the unit for its agreed use after construction. Maggies will not commence construction until sufficient funding has been reserved for this project.

11. Works

Maggie's will be permitted to carry out the construction of the premises to plans and specifications of its own choosing and to its own timetable.

12. Services

The Landlord to grant such rights as are necessary for Maggie's to connect to and use services available within the hospital grounds and where appropriate for service suppliers and undertakers to make direct connections to the proposed Maggie's Centre. The routes for the services shall be subject to the reasonable approval of the Landlord and shall not interfere with the operation of the hospital.

13. Miscellaneous

(a) Each party is to bear its own costs in connection with the negotiation and completion of the Lease.

(b) Maggie's is to be obliged to comply with all reasonable hospital regulations and policies notified to it from time to time.

(c) The Landlord is permitted to exclude Maggie's from the premises on urgent medical grounds. In the event that the period of any exclusion exceeds 8 weeks, Maggie's is to have the option to terminate the Lease.

(d) The Landlord will prove adequate legal title to the premises.

(e) The Landlord will incorporate wayfinding information to the Maggie's Centre on all its existing signage.

(f) This transaction is subject to Maggie's Board approval.

(g) The Parties are targeting completion of this transaction by [insert date]

14. Contract

These Heads of Terms are not intended to, nor shall they form part of any legally binding contract.

Signed: …….....Date: ……...On behalf of the Landlord

Name: ……....Position: ……..

Signed: …….....Date: ……On behalf of Maggie's

Name: ……....Position: ……..

Annexure: Draft Lease Plan

NHS Maidstone and Tunbridge Wells NHS Trust

Quarterly update on progress with the Perinatal Mortality Review Tool (PMRT) — **Chief Nurse**

Please find enclosed the latest quarterly update on progress with the Perinatal Mortality Review Tool (PMRT).

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and discussion

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

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST
Women's and Children's
Perinatal Mortality report
May 2021
Covering Quarter 3 2020/2021

Main author: Harriet Burke, Bereavement Midwife
Rachel Thomas, Deputy Head of Midwifery and Gynaecology

Division: Women's and Children's

Specialty: Maternity

1. Introduction

All perinatal deaths are reported to MBRRACE which is a national organisation that collates information and produces reports on learning from deaths. It is the expectation that all perinatal deaths are reviewed in a multidisciplinary forum using the Perinatal Mortality Review Tool. This tool was introduced in 2018 and from December 2018, all eligible cases are reviewed using this questionnaire.

The tool supports:

- Systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care;
- Active communication with parents to ensure they are told that a review of their care and that of their baby will be carried out and how they can contribute to the process;
- A structured process of review, learning, reporting and actions to improve future care;
- Coming to a clear understanding of why each baby died, accepting that this may not always be possible even when full clinical investigations have been undertaken; this will involve a grading of the care provided;
- Production of a report for parents which includes a meaningful, plain English explanation of why their baby died and whether, with different actions, the death of their baby might have been prevented;
- Other reports from the tool which will enable organisations providing and commissioning care to identify emerging themes across a number of deaths to support learning and changes in the delivery and commissioning of care to improve future care and prevent the future deaths which are avoidable;
- Production of national reports of the themes and trends associated with perinatal deaths to enable national lessons to be learned from the nation-wide system of reviews.
- Parents whose baby has died have the greatest interest of all in the review of their baby's death. Alongside the national annual reports a lay summary of the main technical report will be written specifically for families and the wider public. This will help local NHS services and baby loss charities to help parents engage with the local review process and improvements in care.

The PMRT has been designed to support the review of the following perinatal deaths:

- Late fetal losses where the baby is born between 22+0 and 23+6 weeks of pregnancy showing no signs of life, irrespective of when the death occurred, or if the gestation is not known, where the baby is over 500g;
- All stillbirths where the baby is born from 24+0 weeks gestation showing no signs of life;
- All neonatal deaths where the baby is born alive from 22+0 but dies up to 28 days after birth;
- Post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 days following neonatal care; the baby may be receiving planned palliative care elsewhere

Overview:

In this quarter from October to December 2020 there were 5 cases reviewed with PMRT: 3 third trimester losses, one mid second trimester loss and one neonatal death after birth in the second trimester.

The first case was a mother who was admitted to the antenatal ward with abdominal pain and was diagnosed with a serious rare complication of pregnancy which required urgent delivery. She proceeded to go to theatre and have an emergency CS. The serious complication in this case can be difficult to predict, especially in the absence of contractions. The PMRT meeting found that there were no care issues during pregnancy and in triage assessments, however when the midwife on the antenatal ward was unable to find the fetal heartbeat, it took longer than expected to arrange a doctor to come and perform a scan. The obstetric registrar was busy with another emergency in theatre and learning was identified that the midwives should have escalated to the Gynae registrar.

The second case was a second trimester loss with at gestation not reaching the threshold of viability. The mother had a history of loss in a previous pregnancy around the same gestation. The mother was having cervical length monitoring in pregnancy. She attended triage with bleeding and pain and when scanned, the cervix had shortened. A rescue cervical suture was performed however it was discussed and performed even though the likelihood of it being successful was small. Sadly she presented shortly after and miscarried her baby. PMRT found no care issues.

The third case was a second trimester stillbirth of a mother who presented in triage with reduced fetal movements and a bedside scan diagnosed an intrauterine death. PMRT identified that this mother should have been referred for an obstetric review in antenatal clinic due to her medical history. The referral would normally be made at her booking appointment however the panel agreed this would not have made a difference to the sad outcome. No other care issues were identified.

In the case of the neonatal death, a mother attended maternity triage in the second trimester with brown PV loss. After assessment she was found to be already in established preterm labour and she delivered a short time after. Resuscitation was commenced but ultimately was unsuccessful. There was not a senior neonatologist at delivery as baby was born so quickly however a senior registrar arrived within 2 mins of the crash call being put out. A neonatal consultant was also present within 10 minutes of the birth and made the decision to stop resuscitation attempts which is in line with guidance. PMRT found no issues with the antenatal care for this family. A post mortem examination found that there was an infection in the placenta and membranes which was the like cause of the pre-term labour. This infection is not routinely screened for during pregnancy in line with our

policies and the mother had had no urine samples or swabs to suggest it was present during pregnancy.

Our fifth and final case of 2020 was a third trimester stillbirth. The mother presented with reduced fetal movements and sadly an intrauterine death was confirmed. PMRT identified no care issues in this case.

Month	Trimester	Cause of death	Post mortem	SI declared	PMRT completed
January	Second	Obstetric Emergency	Placenta only	No	Yes
February	Third	Unexplained	Yes	No	Yes
February	Third	Unexplained	Yes	No	Yes
February	Third	Unexplained	Yes	No	Yes
March	Third	Unexplained	Placenta only	No	Yes
August	Third	Unexplained	Yes	No	Yes
September	Third	Diagnosed chromosomal abnormality	No	No	Yes
October	Third	Obstetric Emergency	No	No	Yes
October	Second	Mid trimester loss – unknown cause	No	No	Yes
December	Second	Unexplained	No	No	Yes
December	Third	Unexplained	No	No	Yes
December	Neonatal Death	Extreme prematurity	Yes	No	Yes

Learning from cases

Learning from cases 2019-2020	Action	Action required/Completed	Completed
Apparent capacity issues in obstetric antenatal clinics and lack of clarity amongst midwives over how to escalate this if necessary	Review of process followed to obtain antenatal clinic review appointments Review of agreed process of escalation if difficulty experienced by community midwife in obtaining obstetric review appointment. Involvement of assistant General Manager in this review	1. Nathan Sims/Sarah Mander-McGregor/ Alison Mendes to formulate pathway should there be lack of antenatal clinic appointments	Capacity in antenatal clinic has been escalated to the General Manager who is revising the clinic template to ensure that all clinics have the same number of appointments and there is agreement regarding any over booking. Midwives are aware that they can escalate issues to the ANC ward manager who in turn can discuss with the HOM, DHOM or Care Pathway Coordinator.
Inadequate assessment on Triage	Feedback to individual doctor	Maggie Matthews Consultant Obstetrician	MM has now retired and DM will ensure that this feedback has occurred and will confirm with evidence
Placental histology was performed but was not carried out by a perinatal/paediatric pathologist	Midwives and doctors to be reminded that even if parents do not wish for baby to go for PM, they can have placenta only PM. This can sometimes gain some more information than if examined by a histopathologist.	Reminders to be sent out to all midwives and doctors on 'take 5' weekly updates that until post mortem AND placenta only post mortem has been discussed, formalin solution is not to be applied to the	Completed – Harriet Burke 6/1/21

		placenta and sent to histology.	
When midwife couldn't find fetal heartbeat, there was a delay in arranging a senior doctor to come and perform a scan	Midwives and junior doctors to be reminded that if unable to contact obstetric registrar, to escalate to gynae registrar. If neither are contactable, then the on call consultant.	Reminders to be sent out to all midwives and doctors on 'take 5' weekly updates	Completed – Liz Griffiths 1/11/2020
Missed obstetric referral at booking appointment for a mother who had previous pregnancy complications. This resulted in the risk allocation being incorrect and the type of care planned for this pregnancy i.e.: midwifery led care was incorrect.	Community midwife to be contacted to be advised of incorrect risk allocation in view of previous obstetric history. Reminder to be given of referral criteria.	Liz Griffiths to speak to community team lead to ensure this feedback is given to the community midwife involved.	Completed – Liz Griffiths 6/1/21

Summary

All 5 of these cases were reviewed using the PMRT . All families that have had a PMRT review were asked for their questions and these were all included in the terms of reference for the review. Families are given feedback from the review and it is discussed at the postnatal follow up appointment with the obstetrician. Where possible, the obstetrician is present at the PMRT review so that they are fully informed of the discussion around the case. The full report is sent to the family in the post for them to read and keep.

On December 14th 2020, all Trusts received The Ockenden Report which detailed the independent investigation into maternity services at Telford and Shropshire NHS Trust. This report outlined 7 Immediate and Essential Actions that Trusts must complete and linked them to Maternity Safety Actions and CNST requirements. The first IEA entitled "Enhancing Safety" featured 4 actions relating directly to the PMRT process:

Immediate and Essential Action 1: **Enhanced Safety**		Minimum Evidence Requirements
Q2	External Clinical specialist opinion from outside the Trust must be mandated for intrapartum fetal death, maternal death, neonatal brain injury and neonatal death	• Policy or SOP which in place for involving external clinical specialists in reviews • Audit to demonstrate this takes place
Q4	Are you using the National PMRT to review perinatal deaths to the required standard?	• Local PMRT report and Trust Board Report. SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance • Audit of 100% PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review

Q6	Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme	• Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme
Q8	A plan to implement the Perinatal Clinical Quality Surveillance Model	• Full evidence of full implementation of the perinatal surveillance framework by June 2021.

For each PMRT meeting there was at least one external participant as well as our internal team of obstetricians, midwives and neonatologists. We have a network of individuals from neighbouring Trusts and SECAMB which help us gain an independent perspective. There is work underway with the other members of the LMS to ensure a consistent approach where possible to the PMRT meetings and a commitment to support each other as external reviewers. The CCG have agreed to provide support to administrate a "bureau" of external reviewers to attend PMRT meetings in the LMS. More details of the progress with this and how the Perinatal Clinical Quality Model will work can be given at the next report as these issues are still under discussion.

There is a full report of all stillbirths and neonatal deaths from 2020 being prepared and will be available for the next board meeting.

NHS Maidstone and Tunbridge Wells NHS Trust

Infection prevention and control board assurance framework	Director of Infection Prevention and Control

The infection prevention and control board assurance framework was submitted to the June 2020 meeting. It was noted at the Trust Board meeting in November 2020 that an updated infection prevention and control board assurance framework would be submitted to December 2020 and monthly thereafter. The latest report 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]
Information, assurance and discussion

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

Infection Prevention and Control board assurance framework

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

Section 1:

- Concerns re new variant and high level of staff sickness have led to the Trust recommending FFP3 masks for all staff on Covid wards. Initially for a month but now extended due to delays in second dose vaccination. *This has been stepped down currently (mid April) but may be stepped up again in response to increased incidence/variants of concern*
- No outbreaks in April 21

Section 4:

- Routine visiting re-started from 29 March 21 and extended 17 May. One hour per patient each day
- Neonatal visiting extended to Grandparents
- Partners able to attend all obstetric appointments

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes	• ED triage in place at front door on both sites. Patients assessed with temperature check and observations prior to booking in. Infection risk assessed and documented in ED notes and Symphony. Copy of ED notes in in-patient record for admitted patients. Pathway documented and agreed with CRG and ICC • Temperature checks in place at front door for obstetric patients and accompanying birth partner. Elective C section patients have Covid swab 48 hours prior to admission. Pathway documented and agreed with CRG and ICC • Obstetric patients and their partners have Covid PCR 48-72 hours prior to scan appointments • All patients and visitors have temperature check at front door. Mask provided to patients and visitors who do not have face coverings • Checks in place at oncology entrance		
• there are pathways in place which support minimal or avoid patient	• Patients with confirmed Covid infection cohorted in specified wards. Patients		

bed/ward transfers for duration of admission unless clinically imperative	moved for escalation of care and de-escalation from ICU care only. • Stated aim is to keep confirmed cases in Covid cohort area throughout their inpatient stay. Where step-down is necessary for clinical reasons, PHE guidance is followed. Patients must be 14 days post positive swab, be apyrexial for 48 hours without anti-pyretic medication and have some respiratory improvement. ITU and immunocompromised patients must have negative swabs prior to de-escalation • Suspected patients are isolated on admission pending the results of PCR tests. Medical review must be documented before PCR negative suspected patients are stepped down to green beds		
• That on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance	• Covid contacts are cohorted according to date of exposure • All contacts are nursed in side rooms or bays with the doors shut • All contacts are swabbed twice a week for 14 days • Cohorts with the same isolation date may be merged if necessitated by bed pressure • Level 4 cleaning and UVC decontamination for areas stepped down from Covid to non-Covid		
• Monitoring of IPC practices,	• IPC audits continue to monitor practice		

ensuring resources are in place to enable compliance with IPC practice ○ Staff adherence to hand hygiene? ○ Staff social distancing across the workplace ○ Staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: ▪ a) clinical ▪ b) non-clinical setting	including PPE and hand hygiene. Ward audits and IPC triangulation audits reported through IPCC • PPE stocks closely monitored to ensure supplies available • PPE posters on all wards. • IPC policies available on the intranet • Concerns re new variant and high level of staff sickness have led to the Trust recommending FFP3 masks for all staff on Covid wards. Initially for a month but now extended due to delays in second dose vaccination. This has been stepped down currently but may be stepped up again in response to increased incidence/variants of concern • Maximum occupancy notices on all non-clinical doors rooms and clinical offices		
• Monitoring of compliance with wearing appropriate PPE, consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	• PPE and hand hygiene audits ongoing and reviewed at Infection Prevention and Control Committee • PPE officers on duty every day. Educational, supportive and monitoring role. Advise on PPE use. Induction training for new staff • Sessional mask wearing guidance implemented. Masks provided for non-patient facing staff • PPE officers provide PPE training to new starters • Use of FFP3 masks for all direct care of non-AGP Covid patients has now		

	been stepped down and remains under review • National guidance followed to enable FRSM to be worn for non-covid AGP		
• Implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include organizational systems in place to monitor results and staff test and trace	• Symptomatic staff testing by PCR is in place and available both on and off site • Escalation plan in place with trigger points for increasing asymptomatic testing • Positive lateral flow followed up with PCR • Occupational Health and local managers assess risk of staff contacts of positive cases • All staff now have lateral flow kits except for those within 3 months of Covid infection • Results recorded on on-line platform • Weekly performance report to execs • Plan in place to refresh supplies for those running out of kit • Tests also available for bank and agency staff		
• Additional targeted testing of all NHS staff, if your Trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team	• All staff on outbreak wards have lateral flow checked and additional swabs as necessary for PCR • Outbreaks closely monitored by IPC team • Additional targeted testing has not been necessary to date		
• Training in IPC standard infection	• All staff receive infection control training at induction which includes a		

control and transmission-base precautions are provided to all staff • IPC measures in relation to Covid-19 should be included in all staff induction and mandatory training	section on Covid-19 • National e-learning package level 1 and 2 in place since November 20. Face to face training prior to this. • All clinical staff have annual infection prevention and control training (level 2) which includes Covid-19 • Non-clinical staff have bi-annual training (level1) which includes Covid-19 • Additional ad hoc training on ward during IPC visits • Junior doctors have induction training including Covid delivered by DIPC		
• All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to PPE that protects them for the appropriate setting and context as per the PHE national guidance	• National guidance on PPE implemented within Trust. FIT testing for FFP3 masks in place with resources identified and PPE project team managing resources on day to day basis. • Dedicated FIT testing team in place on both sites. • New staff FIT tested as part of induction as required • Regular discussion at executive level. • Procurement lead sits in ICC • Active management of stocks by procurement leads. Electronic monitoring system in place • Active monitoring of PPE burn rate and stocks • Reusable masks and air powered respirators available for those who fail		

	FIT testing • All patient facing staff trained in use of PPE and supported by PPE officers • Use of powered air respirators monitored through site offices with documented log and cleaning • Regular updates provided to staff through ICC and daily bulletin • PPE guidance available on Covid page of Trust intranet • Posters and signage with PPE information in donning and doffing areas. • Repeat FIT testing available for those affected by national withdrawal of one type of FFP3 mask • Business case under development to make FIT testing team substantive as part of IPC team		
• There are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace	• Extensive communication with staff on face masks, hand hygiene and space through staff Pulse publication, posters, social media etc. • All staff wear face masks • Hand hygiene audits reported to IPCC – no concerns • Posters widely displayed throughout the Trust • Screensavers for Hands Space Face		
• national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely	• DIPC and deputy DIPC responsible for checking for updates to national guidance and advising executive team. • Updates shared with staff in daily		

way	Covid Bulletin and Covid intranet page • Patient and Staff Safety work stream moved to BAU • IPC team support ward staff in implementing changes • IPC team work arrangements flexed to provide 24/7 cover during escalation • IPC leadership on key work streams • Emerging risk of *Burkholderia aenigmatica* infection associated with the use of multi-use bottles of ultrasound gel on ITU. Information shared with clinicians and sterile single patient use gel implemented (risk stepped down but recommendations on u/s gel stand)		
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• DIPC is member of exec team and updates as required • Covid update is standing item on Board agenda		
• risks are reflected in risk registers and the Board Assurance Framework where appropriate	• ICC risk register reflects IPC risks associated with Covid-19 • DIPC attends Trust Board meetings		
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• All pre-existing IPC risk assessment processes and policies remain in place and in date for non-Covid-19 infections • Trust compliant with Hygiene Code prior to pandemic. • IPC team reinforce practice at ward level • IPC PPE requirements for non-Covid infections are superseded by Covid		

	requirements. Additional risks recognised eg for C. difficile and Covid co-infection • IPC team advising on a case-by-case basis. Variation to some policies required. Documented on ICNet.		
• that Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sit rep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner	• Signed off by Head of ICC under delegated authority from CEO • Daily analysis shared with senior staff		
• This Board Assurance Framework is reviewed and evidence of assessments are made available and discussed at Trust Board	• IPC Board Assurance Framework is updated by the DIPC and reviewed monthly at Trust Board. Evidence base is available as required		
• ensure Trust board has oversight of ongoing outbreaks and action plans	• Ongoing outbreaks discussed at daily exec strategic command meetings • Twice weekly outbreak meetings for Trust chaired by deputy DIPC – stood down to weekly in January 21 – stood down end February 21– no active outbreaks • DIPC updates to execs and Board at every meeting • IPCC reports to Quality Committee • Daily sitrep of open outbreaks from IPCT • No outbreaks in April 21		

• There are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas	• Execs and senior managers visit clinical and non-clinical areas regularly		

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	• Covid cohort areas on both sites including respiratory HDU and ICU escalation areas. • ICU training programme for non-ICU trained staff required to work on ICU. • Consultant anaesthetist rota to provide 24/7 on site ICU cover. • ICU-trained nurse/patient ratio decreased during escalation with additional staff to assist. • Covid wards fully staffed. Consultant of the week rota for senior medical cover • IPC team and PPE officer support to Covid wards • Respiratory HDU staffed by respiratory trained nurses and consultants • NIV patients cared for by trained staff • All suspected/ confirmed cases are admitted to side rooms on designated wards pending PCR results. • ITU on both sites have beds identified for Covid		

• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas. • decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance • Assurance processes are in place for monitoring and sign off for terminal cleans as part of outbreak management • increased frequency, at least twice	• Cleaning standards in place for cleaning during the pandemic. • Facilities staff trained in donning and doffing PPE and FIT tested where appropriate. • Decontamination and terminal cleaning completed according to national guidelines. • HPV and UVC decontamination available when required • All surfaces cleaned with Diff X including walls • In-house cleaning teams in place • Cleaning audits reported to IPCC and divisions • Lapses in cleaning standards reported as Datix incidents and investigated with shared learning • Deep clean programme for wards as they are de-escalated is being planned • Existing UVC light decontamination technology to be employed • Additional robotic UVC resource (Thor) procured • Cleaning robot for public areas • Nurse in charge checks cleans and signs off • IPC team advise on cleaning levels for outbreak management • Increased frequency of cleaning complies with national guidance		

daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	• Regular cleaning audits undertaken and results monitored. • Audits reported to IPCC		
• Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (ICPT) should be consulted on this to ensure that this is effective against enveloped viruses	• Diff X confirmed as suitable cleaning agent for enveloped viruses by IPCT		
• Manufacturer's guidance and recommended product contact time' must be followed for all cleaning/disinfectant solutions/products	• Manufacturer's guidance is followed in all areas • Instructions are displayed where needed • Environmental cleaning policy reflects manufacturers requirements		
As per national guidance: • 'frequently touched' surfaces, eg door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body	• In place since June 20 • Ward staff clean high-touch surfaces including keyboards and telephones • Disinfectant wipes available for cleaning workstations in non-clinical areas		

fluids			
• Electronic equipment, eg mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily	• Staff advised to clean equipment as in guidance. • Pre-existing guidance for clinical areas		
• Rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	• Regular twice daily cleaning in place		
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	• All linen from Covid cohort wards treated as infectious linen • Laundry is compliant with HTM 01-04 • Laundry report goes to IPCC and Health and Safety committee		
• single use items are used where possible and according to Single Use Policy	• Single use items used widely across the Trust. • Policy in place and available to staff on the Trust intranet		
• reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	• The provider of surgical reusable instrument decontamination for MTW: IHSS Ltd: is run in accordance with audited quality management systems. • The service is accredited to EN ISO 13485:2012 and MDD 93/42/EEC-Annex V. • In respect of Covid-19 all processes have been assessed to meet the current guidance. Additional precautions and measures have been		

	put in place in line with local, PHE and national policy.		
• ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	• Non-clinical areas are part of the cleaning audit schedule. Action plans developed where areas fail audit		
• ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air	• Tunbridge Wells Hospital was constructed fourteen years ago and is designed with ventilation supply and extract systems in clinical, rest, dining and administration areas. The ventilation in this building is compliant with the NHS Health Technical Memoranda HTM 03-01. HTM 03-01 specifies a high standard of supply and extract ventilation design with single pass air supply and no recirculation of internal for infection control purposes. • Maidstone Hospital was constructed in 1986. The building is a “Nucleus Design“ hospital constructed on design concept of natural ventilation rather than mechanical ventilation by the use of opening windows. Operating Theatres and pharmaceutical production areas all installed with HTM 03-01 ventilation systems. • Windows in ward bays and side rooms to be opened for 15 minutes 3 times per day to improve ventilation		
• Monitor adherence to	• A Covid-active disinfectant (DiffX) has		

environmental decontamination with actions in place to mitigate any identified risk • Monitor adherence to the decontamination of shared equipment with actions in place to mitigate any identified risk	been used throughout the pandemic response. • Cleaning audits carried out by domestic, nursing and estates MDT according to schedule. Reported to and monitored by IPCC • Wards also received audit results • Additional checks in outbreak areas • Commode cleaning audited with triangulation audits in addition. Reported to IPCC • Other cleaning of nursing equipment monitored daily by matrons as part of daily ward checks and included on MDT cleaning audits		

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained	• Antimicrobial stewardship continues as for pre-Covid. • Antimicrobial stewardship group has continued to meet throughout. ASG reports to Drugs, Therapeutics and Medicines Management Committee • Antimicrobial report to IPCC • Training for new doctors has continued • Ward pharmacists review prescribing	• Routine ward based audits suspended for April and May 20	• C. difficile PII audits continuing • Reports to IPCC reinstated for June 20

	• Guidance for antibiotic prescribing in Covid patients issued by ASG • Prescribing of antibiotics is low compared with peer K&M organisations • Audits and reporting restarted and maintained in second wave • Information on national increase of Aspergillus infection in Covid patients in the ITU setting has been shared with ITU clinicians		
• mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Mandatory reporting of antimicrobial usage has continued. • IPCC and DTMMC report to Quality committee		
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting	• Routine visiting re-started from 29 March 21 and extended 17 May. One hour per patient each day • Additional visitors permitted only on compassionate grounds and to assist patients with specific needs. ITU has separate arrangements • Birth partner allowed. Both parents can visit in neonatal unit. Covid testing in place to facilitate this. • neonatal visiting extended to Grandparents		

	• Outpatients have accompanying person only when required for care needs • All visitors have temperature checks at the front door • Mask provided to patients and visitors who do not have face coverings • Support in place for relatives to deliver patient property • Viewings of deceased patients have re-started in the Trust mortuary including for patients diagnosed with Covid-19 • Introduction of partners to antenatal scans following risk assessment, vaccination of staff, provision of FFP3 masks for sonographers and pre-scan testing for pregnant woman and partner • Partners able to attend all obstetric appointments		
• areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	• Signage is in place to identify Covid areas and advise on PPE requirements on entry • Restricted access by swipe card only is in place • Advice is given at points of entry relating to PPE, visiting expectations and managing hygiene • Masks are available at the exit of all Covid areas allowing change of mask on leaving the area		
• information and guidance on COVID-19 is available on all Trust	• Information for staff is available on the Trust intranet Covid page	• Easy read version not yet available	• Information currently under review prior to

websites with easy read versions	• Coronavirus information for the public can be found at https://www.mtw.nhs.uk/2020/12/latest-information-on-the-coronavirus/		submission to the Accessible Information Standard group for conversion into easy read.
• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	• For inter-departmental transfer, handover of information by telephone or accompanying nurse • PHE guidance on discharge of patients is implemented. Local guidance based on national guidance is published on trust intranet Covid page and has been shared through ICC bulletin. • Integrated discharge team manages discharge of patients to residential care facilities. • Designated care home beds now available • All patients being discharged to residential care have Covid test 48 hours before expected date of discharge with result available. • Any patients self-isolating following confirmed Covid contact receive a letter explaining their need to self-isolate. Medically fit patients may complete their self-isolation at home • Staff use appropriate PPE for all patient transfers • All patients have EDN on discharge		
• there is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice	• Posters prominently displayed in public areas • Hand, Face and Space logo on trust Covid internet pages • Posters in wards to encourage patients		

	to wear face masks		
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • Screening and triaging of all patients as per IPC and NICE guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases	• Contacts of positive cases tested twice a week for 14 days whilst inpatients • All non-elective admitted patients (suspected and non-suspected) are tested for Covid-19 in ED, SAU, EGAU, Woodlands unit or delivery suite. Suspected medical patients are admitted directly to side rooms on Covid cohort ward awaiting PCR results. Non-suspected patients remain in AAU/AMU until rapid results available. Surgical, T&O, gynae, paediatric and obstetric patients admitted directly to single room on specialty ward pending results. Pathways in place and agreed through CRG and ICC. • All suspected patients who do not require admission are tested prior to discharge from ED. Positive cases are followed up by ED with results to provide anticoagulation therapy. Pathway approved by ICC • Patients screened day 1, 3 and 5-7 • Patients on non-covid pathway have Covid point of care test in A&E.		

• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection as per national guidance	• ED triage in place at front door on both sites. Patients assessed with temperature check and observations prior to booking in. • Triage nurse performs infection risk assessment and patient directed through red or green pathway for further assessment and separation. Pathway documented and agreed with CRG and ICC • Red, amber and green pathways are accommodated separately in different zones of ED • Isolation room available for immunocompromised and shielding patients in ED • Temperature check and triage in place at front door for obstetric patients and accompanying birth partner. Elective C section patients have Covid swab 48 hours prior to admission. Pathway documented and agreed with CRG and ICC • All elective patients have Covid swab 24-48 hours prior to admission including patients for outpatient procedures • All patients and visitors entering through main entrances have temperature check and are given masks • Paediatric patients triaged in paediatric assessment area which is zoned for Covid risk • All pathways documented and agreed		

• staff are aware of agreed template for triage questions to ask	with CRG and ICC and published on Covid page of Trust Intranet • Standard triage template supported y electronic system (Symphony) and printed version		
• triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	• Triage carried out by senior nursing staff. • Immediate allocation of patient to pathway • Obstetric triage in place with senior midwife. Labour ward has designated red and green beds		
• face coverings are used by all outpatients and visitors	• All patients asked to wear a face mask on entering ED. • All outpatients and visitors wear masks except for those carrying exemption certificates • Masks provided at front entrance if required • Information on Trust website to support		
• facemasks are available for all patients and they are always advised to use them • provide clear advice to patients on use of facemasks to encourage the use of surgical facemasks by all inpatients (particularly when moving around the ward) if this can be tolerated and does not	• Face masks available for all patients and patients advised to use them rather than own face coverings • Inpatients encouraged to use masks as much as tolerated and always when leaving the bedside • Posters in ward bays and patient information available		

compromise their clinical care • ideally segregation should be with separate spaces, but there is potential to use screens eg to protect reception staff	• Reception staff are protected with screens in all areas • ED reception has physical separation of staff by Perspex screens • Perspex screens on outpatient reception areas, outpatient pharmacy and main entrance reception • Cubicles in ED majors are separated by solid walls • Social distancing in place in waiting areas • Vaccination centre has been organized with social distancing and separate spaces		
• To achieve 2 metre social and physical distancing in all patient care areas	• 2m minimum bed spacing in all wards and ED • Outpatients waiting areas are socially distanced		
• for patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative	• Patients who develop symptoms after admission are tested promptly and moved to side room on Covid ward. The rationale for testing is documented in the patient's notes • Contact tracing carried out if patient tests positive. Business Intelligence programme in place to track contacts • Patients exposed to confirmed case are isolated and given information and duty of candour letter. Medically fit patients who are discharged to their own home continue to self-isolate at home.		

	• Patients from residential care are swabbed prior to discharge and care facility informed of the result. IDT manage discharge to residential care. • All patients who test negative on admission are re-tested at 5-7 days in line with national guidance. Additional day 3 swab implemented in November • All laboratory results submitted to PHE for national track and trace		
• Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly	• Suspected patients who test negative have medical review prior to step down to non-Covid ward. Those who continue to be suspected cases have repeat testing and remain in side room on Covid ward • Any patients with new symptoms after admission are tested and isolated until the result is known		
• There is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document	• All patients who test negative on admission are re-tested at day 3 then 5-7 days in line with national guidance. • National guidance followed in all cases. Local guidance developed from national guidance and published through daily staff Bulletin and Covid pages on intranet. • Negative patients swabbed within 48 hours of expected discharge date for discharge to residential care facility and result available before transfer • Post-covid patients (14+days since diagnosis) are not re-swabbed prior to		

• patients attending for routine appointments who display symptoms of COVID-19 are managed appropriately	discharge unless immunocompromised. • Covid positive patients within 14 days of diagnosis requiring discharge to care facility are only discharged to designated centres • Revised guidance issued removing the need for negative swabs in de-escalated patients and restricting the requirement for negative swabs prior to discharge • All outpatients have temperature checking at the front door. • Patients with fever are reviewed by clinician to determine whether to continue with appointment or to go home to self-isolate and rebook • Patients for elective admission who are unwell on the day of admission despite a negative pre-admission Covid swab have a medical review to determine if their planned treatment can proceed.		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			

• Separation of patient pathways and staff flow to minimize contact between pathways. For example this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage and restricted access to communal areas	• Separate entrances for staff and patients • Stay left signs in corridors • Visitors and patients not permitted to use staff catering facilities		
• all staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	• Local induction for new staff. PPE officers provide training. • Dedicated FIT testing team. All results recorded and database maintained • Nurse in Charge of a shift ensures bank and agency staff aware of PPE expectations • Online training for medical care of Covid patients • ICU training in place for non-ICU trained staff • PPE officers provide face to face training on wards. • IPC team provide training to staff • Mandatory IPC e-learning package includes Covid-19. National package in use		
• all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	• Donning and Doffing videos available on Trust intranet site. • PPE officers provide workplace training. • PPE helpers available in ICU • Donning and doffing stations provided		

	on Covid wards • FIT testing available for all staff who require it and when available masks change. • Signage and posters displayed in donning and doffing areas		
• a record of staff training is maintained	• Fit testing records maintained • Records maintained for cleaning of reusable masks • Records maintained of formal IPC training • On line learning and development system records mandatory training		
• adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk	• PPE audits ongoing and reported to IPCC • Combined hand hygiene and PPE audit in place • Action plans for non-compliance • Local decision to use FFP3 masks for all direct patient care of Covid positive patients since late December 2020. Decision kept under review and stepped down to national guidance 14 April 21 in view of low numbers of patients and high uptake of vaccine amongst staff • Provision made for staff with risk factors etc to continue to use FFP3. • Some clinical areas with long standing variations to the guidance to allow staff to wear FFP3 masks such as obstetric ultrasound, and these variations will		

	continue.		
Hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimize Covid-19 transmission such as:			
• hand hygiene facilities including instructional posters	• Hand wash basins widely available. • Instructions on all splash backs • Sanitising gel widely available including entrances to all clinical areas		
• good respiratory hygiene measures	• All staff, outpatients and visitors wear masks • Inpatients encouraged to use masks as much as tolerated and always when leaving the bedside		
• maintaining physical distancing of 2m wherever possible unless wearing PPE as part of direct care	• Social distancing encouraged • Signage on doors stating maximum occupancy • Additional breakout areas available • Covid secure offices identified		
• Staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace	• Staff advised of social distancing rules and to avoid car sharing • Reminders on intranet and in daily Pulse to follow public health advice at all times		
• frequent decontamination of equipment and environment in both clinical and non-clinical areas	• Disinfectant wipes available in both clinical and non-clinical areas • I am clean stickers in use		

	• Domestic and nursing cleaning in place on wards • High touch areas frequently disinfected		
• clear visually displayed advice on the use of face coverings and face masks by patients/individuals, visitors and by staff in non-patient facing areas	• PPE posters widely displayed • Non-clinical areas assessed for Covid-secure status • Advice widely publicised through staff Pulse magazine and Trust internet and intranet pages		
• staff regularly undertake hand hygiene and observe standard infection control precautions	• Ward based audits in place. • Triangulation audits completed monthly by IPCT. • Directorates report to IPCC		
• The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	• All hand wash basins are co-located with paper towel dispensers		
• Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff toilets	• All hand wash sinks have hand washing and drying guidance on back boards in both clinical and public areas		
• staff understand the requirements for uniform laundering where this is not provided for on site	• Scrubs are worn on all Covid wards and several other wards and clinical areas. • Scrubs are laundered by the Trust laundry and staff are advised not to		

• all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	take them off-site • Staff launder their own uniforms. Guidance has been published through the daily bulletin and Covid intranet page. • Uniform bags gifted to the Trust provided for staff to carry uniform home and launder with uniform. • All staff advised to travel to and from work in their own clothes and change on site • Staff changing and shower facilities provided on both sites • Staff sickness line available to report symptoms • Information on symptoms of Covid shared widely including posters, staff bulletin and intranet site • Staff testing available in drive through facility and on-site testing pods. On-line appointment system in place. Also available for family members and partner organisations • All staff members testing positive for Covid-19 have their result delivered by occupational health. • Occupational Health support and maintain contact with self-isolating staff • Staff testing positive self-isolate for a minimum of 14 days if symptomatic and 10 days if asymptomatic throughout. • Lateral flow testing available for all clinical staff. • Positive lateral flow tests confirmed by		

• A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organization onset cases (staff and patients/individuals) • Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger and outbreak investigation and are reported • Robust policies and procedures are in place for the identification of and the management of outbreaks of infection	PCR • Post-vaccine infection followed up with additional swab and blood for antibody testing. Enhanced surveillance forms completed on-line • Community rates of infection are continuously monitored with information disseminated to senior managers • Discussed at strategic command meetings • Daily sitrep analysis available to managers • Outbreaks declared according to national guidance • All outbreaks are investigated and Serious Incidents declared. • Concise investigation and consistent Terms of reference developed –under review • Twice weekly outbreak meetings • IIMARCH forms completed for all outbreaks • Outbreaks reported via national online platform • Outbreak policy in place • Active management by infection control team • Lab results available in real time via emailed list • Outbreaks declared as Serious Incidents		

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • Restricted access between pathways if possible (depending on the size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff	• Pathways clearly identified and approval process in place • Surgical green pathway implemented and reviewed according to prevalence of infection • Visitors are not permitted in Covid positive areas except in compassionate circumstances		
• Areas/wards are clearly signposted, using physical barriers as appropriate so patients/individuals and staff understand the different risk areas	• Signage in place • Wards accessible by swipe access • Restricted access to Covid areas		
• patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	• All suspected and confirmed Covid patients are placed in designated cohort wards. Suspected cases are placed in side-rooms until test results are available	• A designated self-contained area or wing is not available for the treatment and care of Covid patients. No separate entrance is available	• Access is through closed doors with swipe card card access. • Not used as staff/visitor throughfare
• areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national	• Cohort bays have privacy curtains between the beds to minimise opportunities for close contact. • Separated from non-segregated areas by closed doors • Signage displayed warning of the		

guidance • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	segregated area to control entry • Cohort areas differentiate the level of care (general, respiratory HDU, Covid ICU) • Paediatric confirmed patients isolated in single rooms with en-suite facilities • Windows in all ward areas opened for 15 minutes three times per day to improve ventilation • Pre-existing IPC policies continue to apply. • Some variance required to meet the requirements of Covid levels of PPE and co-infected patients • Active management of side room provision by ICP team		
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals • patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	• Testing undertaken by registered BMS staff with documented competencies. • Method validated prior to diagnostic testing • In house testing turnaround time of less than 24 hours • Tests sent to Pillar 2 labs when demand outstrips capacity • Extended laboratory working hours to		

	deliver service • All non-elective patients are tested on admission • All positive patient results are phoned to ward by IPCN and provided to site team and ICC. • All results reported to PHE via Co-surv • All elective patients are tested 24-48 hours prior to admission • Online booking for staff and elective patient testing. • Weekly testing for all patient-facing staff by end of June 2020 • All staff positive results are delivered by Occupational health staff • Staff results sent by text message directly from on-line system • Antibody testing available to all patients and staff on request • Near patient testing available with 8 machines at Maidstone and 4 at TWH • 24/7 service for near patient testing across the Trust		
• Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	• Turnaround times closely monitored • Results usually available within 24 hours		
• regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	• All positive inpatients reported directly to IPC team and site practitioners via email • All staff positives reported to Occupational Health via email		

	• All positives reported to consultant microbiologists • Results directly authorized and available in real time		
• screening for other potential infections takes place	• MRSA, MSSA, GRE, and CPE screening continues as in pre-covid policies • All routine diagnostic microbiology continues including C difficile.		
• That all emergency patients are tested for COVID-19 on admission	• All patients on the green (non covid) pathway have point of care (SAMBA) testing on admission • All patients on the red pathway have point of care (LIAT) tests when available and/or PCR		
• That those inpatients who go on to develop symptoms of COIVD-19 after admission are re-tested at the point symptoms arise	• Any inpatient who develops symptoms of Covid has a laboratory PCR test and clinical review		
• That those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission	• All patients who test negative on admission are re-tested in line with national guidance on day 3 and day 5-7 • Testing guidance is published in the daily Pulse and available on the intranet		
• That sites with high nosocomial rates should consider testing	• Trust nosocomial rate is in line with national experience. • Daily swabbing has not been		

COVID negative patients daily • That those being discharged to a care home are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organization prior to discharge • That those being discharged to a care facility within their 14-day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation • That all elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission	implemented • Contacts of Covid patients are swabbed twice weekly for 14 days • All patients who have been negative throughout their inpatient stay are tested 48 hours prior to discharge to a care home • Results are shared with the receiving care facility • Post-Covid patients are not tested further for 90 days unless they develop new symptoms • All patients within 14 days of initial diagnosis of Covid who require discharge to a care facility are discharged to a designated care setting. • All elective patients are tested 3 days prior to admission and asked to self-isolate until admission • Some patients are required to self-isolate for a longer period due to their underlying illness • Plan under development to return to national guidance for all patients following decrease in community prevalence		
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure that:			
• staff are supported in adhering to all IPC policies, including those for other alert organisms	• IPC team supports wards. All wards visited daily. Full range of policies and procedures in place. • Advice available from IPC team and consultant microbiologists. On call rotas in place. • All IPC policies reviewed and in date		
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	• DIPC and deputy DIPC responsible for checking for updates to national guidance and advising executive team. • Updates shared with staff in daily Covid Bulletin and Covid intranet page • IPC team support ward staff in implementing changes		
• all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	• All clinical waste related to possible, suspected or confirmed Covid-19 cases is disposed of in the Category B (orange) clinical waste stream. • New guidance for disposal of lateral flow tests and vaccination centres – current practice already in line with guidance • All linen from patients on amber and red pathways treated as infectious linen • PPE central stocks held on both main		

• PPE stock is appropriately stored and accessible to staff who require it	sites • Active management of stock levels by procurement to ensure safe levels of stock • Regular (twice daily) deliveries of PPE to clinical areas. • Central email address for PPE orders. • Reusable masks distributed to named staff as required following FIT testing		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	• Staff risk assessment in place. Managers advised to ensure all staff risk assessed. Risk assessment developed with BAME network and Ethics committee • Redeployment opportunities and working from home enabled for high risk staff • Staff welfare programme in place including wobble rooms, free food, breakout areas, psychological support. • Staff sickness phone line in use.		
• that risk assessments are undertaken and documented for any staff members in an at risk shielding group, including Black, Asian and minority ethnic (BAME) and pregnant staff	• 93% of BAME staff have risk assessment completed • 80% of 'at risk' staff have had a risk assessment completed • Weekly return submitted		• HRBPs/divisions have plan in place to complete outstanding risk assessments

• staff required to wear FFP3 reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained • staff who carry out fit test training are trained and competent to do so • all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used • a record of the fit test and result is given to and kept by the trainee and centrally within the organisation • for those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods • for members of staff who fail to be adequately fit tested a discussion should be had, regarding re	• FIT testing in place including training on fit, maintenance and cleaning. • Powered air respirators available for staff who fail all fit testing • Individual use reusable respirator masks available • FIT testing register held in ICC • Dedicated FIT testing team in place and fully trained • All staff required to wear a FFP respirator are fit tested • Fit testing on new models available as required • A database of FIT testing outcomes is maintained. • Staff provided with information identifying the type of mask to be worn • As above • Re-usable masks and hoods are available for staff who fail FIT testing with disposable masks • Records are kept and stored electronically • If all respirator options are unsuitable staff work from home wherever possible		

deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	• Manager works with HR to identify re-deployment opportunities • New opportunities to work with vaccination teams available		
• a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health	• Discussions are documented and records stored electronically		
• following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record	• An electronic system is in place to record and store details for risk assessments and any necessary mitigation to support individual members of staff. Any redeployment decision is retained as part of this record. This process adopts and follows the nationally agreed algorithm		
• boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	• database of all staff maintained and includes record of all FIT testing • Weekly assurance template submitted by divisions against rotas • All staff not tested provided with FIT testing prior to shift • All areas have access to powered air respirators • ICC and site team receive assurance template for weekend shift		
• Consistency in staff allocation is	• Patient and Staff Safety workstream		

maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between panned and elective care pathways and urgent and emergency care pathways, as per national guidance	(part of Reset and Recovery programme) has defined the principles to be used when developing elective pathways • Green pathways for elective care developed. • Weekly executive and divisional meeting to discuss progress and interdependencies • Staff screened for Covid-19 • Ward areas maintained as secure with minimal footfall • Theatre SOP in place designating green and red pathways to avoid cross over		
• All staff adhere to national guidance on social distancing wherever possible, particularly if not wearing a facemask and in non-clinical areas	• Staff social distancing in corridors and queues. • Work to ensure that office spaces are socially distanced with risk assessments completed. • CCG review identified good practice in social distancing interventions • Staff working from home wherever possible • Consideration to 7 day working and shifts to reduce the number of staff in non-clinical areas. • All ward staff to wear masks at all times on wards from 1 June • Continual mask wearing guidance implemented for patient facing staff from 10 June. Non-patient facing staff from 22 June • Computers on wheels provided in some areas to support social		

	distancing • Managers asked to review all office space to ensure social distancing in COO letter 12 June. • Managers also requested to review staff working patterns and breaks to reduce the number of non-clinical staff working on site at any time • Additional breakout areas created on both sites including outdoor space		
• health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone	• All non-clinical areas assessed for Covid security. • Maximum occupancy identified on signage • Disinfectant wipes available to staff in non-clinical areas to clean workstations • Homeworking support package including training and IT kit in place for staff who now work at home		
• staff are aware of the need to wear facemask when moving through COVID-19 secure areas.	• Advice given to staff to don masks whenever moving around Covid secure areas • Continued communication via team brief, Pulse and Directors communications to re-iterate “hands – face – space” campaign		
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to	• Staff welfare programme in place including wobble rooms, free food, breakout areas, psychological support/ first aiders.		

access testing	• Staff sickness phone line in use and covered daily, 7 days from 1st December 2020, providing advice and information on sickness, swabbing and other COVID sickness questions. • Newly established "staffing hub" designed to proactively review staffing absence and ensure that ward shifts are effectively covered, supporting safe staffing. • Roll out of lateral flow underway • ICC monitors sickness • Occupational health support staff who are self-isolating and shielding. • Managers support staff working from home. Home working toolkit published • All staff able to access testing via on-line booking system • Symptomatic staff can access testing • Weekly asymptomatic testing to be rolled out to all patient facing staff by end of June • Review of cases of staff Covid infection to identify any key themes and learning • Trust-wide Pulse survey in April and May. Results reviewed at executive and divisional level. Learning identified • Staff vaccination centre established and vaccine available to all Trust staff and offered to some partner agencies		
• staff that test positive have adequate information and support	• Occupational health support Covid-positive staff and advise on return to work and re-testing • Psychological support available		

to aid their recovery and return to work.	• Occupational Health maintain a list of staff who test positive more than 10 days post-vaccination. Support provided and additional swab and blood tests arranged. Enhanced surveillance completed on-line		

NHS Provider licence: Self-certification for 2020/21 **Trust Secretary**

The Health and Social Care Act 2012 introduced a licence for providers of NHS services. The NHS Provider Licence was subsequently introduced in February 2013 as the main tool with which providers of NHS services would be regulated. Foundation Trusts were licensed from April 2013, with other providers being licensed from April 2014. It was later confirmed that the Licence would *not* apply to NHS Trusts, but in April 2017, NHS Improvement (NHSI) confirmed that NHS Trusts must undertake a self-certification against the NHS Provider Licence, on the basis that, despite their exemption from needing to hold the Licence, directions from the Secretary of State required NHSI to ensure that NHS Trusts comply with conditions equivalent to the Licence, as it deemed appropriate. As NHSI's Single Oversight Framework based its oversight on the Licence, NHS Trusts are legally subject to the equivalent of certain Provider Licence conditions, and must self-certify under these licence provisions.

NHS Trusts were required to undertake self-certification for the first time in May 2017 (covering 2016/17), and are now required to self-certify for 2020/21. Specifically, NHS Trusts are asked to self-certify that they have:

- Effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution (licence condition G6(3));
- Complied with governance arrangements (licence condition FT4(8))

It is up to providers how they undertake their self-certification, but any process should ensure that the provider's Board understands clearly whether or not the provider can confirm compliance. NHS England/Improvement (NHSE/I) provide templates which Trusts can (but are not obliged to) use.

NHS providers must self-certify against condition G6 by 31/05/21 and against condition FT4(8) by 30/06/21. Providers must then publish their G6 self-certification by 30/06/21 (the publication is itself a licence condition). NHS Trusts are not required to submit their self-certification declarations to NHSE/I unless specifically requested to do so. NHSE/I usually retains the option of contacting a select number of NHS Trusts to ask for evidence that they have self-certified, either by providing the completed or relevant board minutes and papers recording sign-off.

The proposed self-certification, which uses the template provided by NHSE/I, is enclosed. The Trust Board is asked to review, and approve, the content. Ordinarily, the Board would receive the Annual Report, which contains the Annual Governance Statement (AGS), at the same meeting it considered the self-certification (under a separate agenda item), and the Annual Report and AGS would usually provide sufficient information and supporting evidence to enable the Board to self-certify that the Trust has been compliant with all relevant licence conditions. However, as the timetable for the Annual Accounts was delayed due to the COVID-19 pandemic, the Board will not see the draft Annual Report for 2020/21 until its meeting on 24/06/21. Ideally, the self-certification process would be deferred to that meeting, but as the self-certification timescale has not been changed, a draft version of the AGS has been included in this report, to support the proposal that the Trust Board self-certify that the Trust has been compliant with all relevant licence conditions. This same approach was taken for the self-certification for 2019/20, which the Trust Board approved in May 2020 (i.e. before it then approved the Annual Report for 2019/20 on 18/06/20).

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Review and approval of the proposed self-certification for 2020/21

[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

Worksheet "FT4 declaration" | **Financial Year to which self-certification relates** | 2020/21

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	Refer to the content of the draft 2020/21 Annual Governance Statement for full details (see Appendix 1)
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	Refer to the content of the draft 2020/21 Annual Governance Statement for full details (see Appendix 1)
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	Refer to the content of the draft 2020/21 Annual Governance Statement for full details (see Appendix 1)
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	Refer to the content of the draft 2020/21 Annual Governance Statement for full details (see Appendix 1)
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	Refer to the content of the draft 2020/21 Annual Governance Statement for full details (see Appendix 1)
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	Refer to the content of the draft 2020/21 Annual Governance Statement for full details (see Appendix 1)

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Name** Miles Scott

Signature _____ **Name** David Highton

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A: N/A

OK

Worksheet "G6 & CoS7" | **Financial Year to which self-certification relates** | 2020/21

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	N/A

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account i particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	N/A

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available t it for the period of 12 months referred to in this certificate.	N/A

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

N/A

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Miles Scott	**Name**	David Highton
Capacity	Chief Executive	**Capacity**	Chair of the Trust Board
Date	27th May 2021	**Date**	27th May 2021

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

N/A

Annual Governance Statement (AGS) for 2020/21

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Maidstone and Tunbridge Wells NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that Maidstone and Tunbridge Wells NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Maidstone and Tunbridge Wells NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Maidstone and Tunbridge Wells NHS Trust for the year ended 31st March 2021 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

The ways in which leadership is given to the risk management process

Risks are identified, analysed and controlled in accordance with the Trust's Risk Management Policy and Procedure. The overall Executive Lead for risk management is the Chief Nurse, who is supported in this role by a range of staff, including the Trust Secretary and Risk and Compliance Manager. A number of specific risk-related roles are also held by Trust Board Members, as follows:

- The Chief Nurse is the Senior Information Risk Owner (SIRO)
- The Medical Director is the Caldicott Guardian and the Responsible Officer (for Medical Revalidation)
- The Chief Executive is the Board Level Director (with fire safety responsibility)[1] and the Security Management Director[2]
- The Chief Operating Officer is the Accountable Emergency Officer for Emergency Preparedness, Resilience & Response (EPRR)[3]
- One of the Non-Executive Directors has been appointed as the Non-Executive Lead for Safeguarding and Resuscitation[4], and they have also been allocated the EPRR portfolio[5]
- The Chair of the Quality Committee is the Non-Executive Director with specific role/responsibilities for leading falls prevention[6], and also the Non-Executive lead on mortality and learning from deaths[7]

The Trust has a Risk Register and Board Assurance Framework (BAF) and in place, the operation of which are informed by accepted best practice[8]. The BAF is the document through which the Trust Board is apprised of the principal risks to the Trust meeting its key objectives, and to the controls in place to manage those risks. The objectives within the BAF are devolved for oversight

[1] Required by "Firecode – fire safety in the NHS. Health Technical Memorandum 05-01: Managing healthcare fire safety"
[2] Required by the "Secretary of State Directions to NHS Bodies on Security Management Measures 2004 (amended 2006)"
[3] Required by The Health and Social Care Act 2012
[4] Health Services Circular 2000/028 states that "Chief executives should ensure that"…"a…NED…of the Trust is given designated responsibility on behalf of the Trust Board to ensure that a resuscitation policy is agreed, implemented, and regularly reviewed within the clinical governance framework"
[5] The Core Standards for Emergency Preparedness, Resilience and Response (EPRR) assess whether "The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation"
[6] The Falls and fragility fractures audit programme (FFFAP) pilot national audit of inpatient falls (2015) asks "Does your organisation have a Non-executive Director (or other Board member) who has specific roles/responsibilities for leading falls prevention (can be as part of a wider remit for patient safety)?"
[7] The CQC's "Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England" report states that "We also recommend that provider Boards strongly consider nominating a non-executive director to lead on mortality and learning from deaths"
[8] HM Treasury : Assurance frameworks

by one or more Trust Board sub-committees, and reports on the objectives are submitted to such sub-committees. The full BAF is then considered by the Audit and Governance Committee and then by the Trust Board, with the report presented by the Chair of the Audit and Governance Committee (supported by the Trust Secretary and relevant members of the Executive Team).

As is the case every year, the BAF and Risk Register are subject to review by the Trust's Internal Audit function (which is provided by TIAA Ltd). The review for 2020/21, gave an overall assessment of "Reasonable Assurance".

The ways in which staff are trained or equipped to manage risk in a way appropriate to their authority and duties (including the guidance provided to them and the ways in which the Trust seeks to learn from good practice)

The Trust has in place a range of systems to prevent, deter, manage and mitigate risks and measure the associated outcomes. In addition to the Trust's Risk Management Policy and Procedure, a comprehensive range of risk management policies and guidance is made available to staff. This includes the policies and procedures for risk assessment, incident reporting, managing complaints, investigation of incidents, health and safety, and 'being open' to staff and patients (to support the statutory Duty of Candour). Additional advice on good practice can be obtained from a range of professional and specialist staff. The remit of the Trust's Clinical Governance department includes patient safety/clinical risk management; clinical governance; clinical audit; complaints; the Patient Advice and Liaison Service (PALS); legal services; and research and development. The systems to oversee staff health and safety are managed via the Estates and Facilities department, but there is close liaison between the relevant staff. In addition, Directorates and sub-specialities have clinical governance and risk leads. There is a forum for clinical governance and risk management within each Directorate and within the majority of clinical sub-specialties.

Trust staff are involved in risk management processes in a variety of ways, including raising any concerns they may have (anonymously, if they so wish) via a range of methods, including via the Freedom to Speak Up Guardian or their Deputy (who was appointed during 2020/21); being aware of their responsibility to report and act upon any incidents that occur; being involved in risk assessments; and attending regular training updates.

The Trust's mandatory induction and ongoing training programme for all staff reflects the need for staff to have a sound basis in managing risks relating to Information Governance, Infection Prevention and Control, fire safety, Safeguarding, Health and Safety and Moving and Handling. Non-mandatory training is also available to staff on a wide range of issues relating to risk management, both general (e.g. risk assessment) and in response to specific risks (e.g. falls prevention), whilst in-house support and advice on risk management is also available (which includes advice relating to patient safety, health and safety, Emergency Planning & Response and information governance. Certain types of risk are also addressed via the engagement of external expertise. For example, the risk of fraud is managed and deterred via the appointment of a Local Counter Fraud Specialist (LCFS) and the Trust engages a Dangerous Goods Safety Advisor (DGSA) to advise on the safe management of healthcare waste.

The Trust's advisers on risk seek to learn from best practice from a variety of means, including continuing professional development and via networking with counterparts from other organisations.

The risk and control framework

The key elements of the Risk Management policy (including the way in which risk (or change in risk) is identified, evaluated, and controlled; and how risk appetites are determined)

Risks are identified, analysed and controlled in accordance with the Trust's Risk Management Policy and Procedure. Mitigations are aimed to be identified in advance (where appropriate), so that these can be applied should the identified risk materialise. Most risks are identified at local level and initially managed by department managers. Identified risks are added to the Risk

Register and are then either managed locally or escalated through the Trust's management and/or committee structure. The Trust's competent persons (individuals with specialist skills, knowledge and qualifications that are assessed by external bodies who are able to advise managers and employees on all aspects of health, safety and risk) identify hazards within their area of expertise, and undertake Trust-wide risk assessments for hazards that affect multiple areas. Risks are identified, analysed and controlled in accordance with the Trust's Risk Assessment Policy and Procedure and guidance documents, which includes grading risks for their potential impact and likelihood of harm using a standard Risk Categorisation Matrix. The risk score determines the priority, response and level of management required to manage the risk. Risk appetite is the level of risk the Trust will accept for a particular type of risk. When a risk is assessed the uncontrolled risk score is determined, along with a target risk score, which indicates the risk rating that would be considered as satisfactory. This target risk score should be set as high as can be tolerated, and constitutes the risk appetite for that risk.

The key elements of the quality governance arrangements (including how the quality of performance information is assessed and how assurance is obtained routinely on compliance with Care Quality Commission (CQC) registration requirements)

The Trust's Quality Governance arrangements are overseen via the Quality Committee, which receives a report from each Divisional clinical governance committee whenever it meets in its 'main' form[9]. The Quality Committee then aims to seek and obtain assurance on the effectiveness of the Trust's structures, systems and processes to enable delivery of the Trust's objectives relating to quality of care (as well as oversee quality within the clinical divisions).

Clinical audit is supported by a central team, within the Clinical Governance department, and is primarily overseen by the Clinical Audit Overview Committee. The investigation of, and learning from, incidents are predominantly managed within Directorates and discussed at Divisional, Directorate and specialist clinical governance meetings. Serious Incidents (SIs) are discussed and monitored at a corporate level via the Learning and Improvement (SI) Panel, and an SI report is submitted to each 'main' Quality Committee.

Complaints are managed by the central complaints team in partnership with the relevant Directorates and Divisions. The rate of new complaints and percentage of complaints responded to within target are monitored monthly at the Trust Board, while detailed reports on Complaints and Patient Advice and Liaison Service (PALS) contacts are received by the 'main' Quality Committee and also the Patient Experience Committee.

Compliance with CQC registration requirements is ultimately assessed via inspections by the CQC, and the Trust was subject to such inspections in the latter part of 2017 (which resulted in an overall assessment of "Requires Improvement"). However, regular engagement events have taken place with the CQC during 2020/21. Although such engagement events do not affect the Trust's formal assessment rating, the CQC have provided positive feedback on the areas that have been covered by these events.

The Trust's preparations and planning for CQC inspections are fully integrated and embedded as part of the Trust's 'business as usual' quality improvement agenda, and overseen by a Quality Improvement Committee, which is accountable to the Executive Team Meeting (ETM) via the Chief Nurse. The ETM and 'main' Quality Committee receive regular reports on progress with the Trust's ambition to achieve an "Outstanding" rating by the CQC.

How risks to data security are being managed and controlled

Risks to data security are managed and controlled via a range of methods, and the Trust undertakes an assessment against the National Data Guardian's ten data security standards. That assessment is primarily done via the Data Security and Protection Toolkit, and the Trust made a "Standards Met" Toolkit submission for the 2019/20 year on 29th September 2020 (the submission

[9] The Quality Committee meets monthly, with each alternate month being a 'main' meeting (which involves a broad membership and discussion of a wide range of subjects) or a 'deep dive' (which involves a smaller membership and discussion of a small number of targeted subjects)

deadline for the Toolkit was extended because of the COVID-19 pandemic). The Trust is required to make its submission for the 2020/21 Toolkit by the end of June 2021 (as the deadline was again extended because of the pandemic).

Brief description of the organisation's major risks (including how they are/will be managed and mitigated and how outcomes are/will be assessed)

The objectives for 2020/21, which were approved by the Trust Board on 23rd July 2020[10], are as follows:

1. Finance and Contracts: To deliver the Trust's financial plan, which is set within the context of its financial strategy, and underpinned by a robust, sustainable recurrent surplus.
2. Operational Performance: To improve the management of our patient journeys through the utilisation of evidence-based practice to ensure good quality care and achievement of the constitutional access standards within agreed resources.
3. Quality and CQC: To deliver high quality care to our patients and carers and be recognised as an outstanding organisation.
4. Electronic Patient Record (EPR): Delivery of Allscripts' EPR solution "Sunrise"; aligning and supporting the wider strategic objective of digitally transforming MTW to improve patient outcomes through providing safer and more efficient care.
5. Education/Kent and Medway Medical School (KMMS): To enable fulfilment of MTW's role in the delivery of an integrated reputable, high quality educational programme and student experience for KMMS students in line with the KMMS curriculum; provision of necessary student accommodation and teaching infrastructure at Maidstone Hospital (MH) and Tunbridge Wells Hospital (TWH) in time for the first intake of KMMS students on 01/09/22.
6. Strategy - Estates: To define an estates and facilities strategy and plan for MTW informed by both the clinical strategy and Reset and recovery workstreams.
7. Strategy – Clinical: To define the future state (short medium and long term) configuration options for a range of clinical services with timelines and plans for implementation.
8. Integrated Care Partnership (ICP)/External: To oversee and enable the ICP Development in West Kent and ensure appropriate stakeholder engagement and participation in MTW's work (e.g. in clinical strategy development).
9. Organisational Development and Workforce: Make MTW a great place to work - For MTW to be an excellent organisation that puts staff engagement, well-being and experience at the fore front to nurture a place where people want to come to work, stay, be proud and enable staff to be exceptional by recruiting, retaining and developing exceptional people to deliver outstanding care for our communities.

The main risks to the achievement of these key objectives (i.e. the issues that could prevent the objectives being achieved) are described within the BAF, and the Trust Board received formal update reports on the performance of each objective, and the management of risks to non-achievement in November 2020 and March 2021. In-year reports BAF reports on specific objectives were also considered by several Trust Board sub-committees. A year-end BAF report regarding the achievement of the objectives was then received by the Trust Board in April 2021.

In addition, a number of risks were rated as 'red' in 2020/21. Red-rated risks are reviewed and validated at the ETM (see below) each quarter. The underlying risks have been discussed at the Trust Board and its sub-committees throughout 2020/21, and include the cost pressures associated with the use of temporary staff; risk associated with failing to learn from incidents; the inability to fulfil the national standard of 35% of women being cared for by Continuity of Carer teams within the Maternity service; the risk of harm from delays in psychiatric assessment and implementing the required actions following assessment; the risk of insufficient capacity in certain specialties (glaucoma, ENT, Head and Neck, Critical Care); staffing absences in certain specialties; the ability to undertake timely mortality reviews; statutory legionella management control; the number of policies that had exceeded their review date; and the effect of COVID-19

[10] The Trust Board originally approved key objectives for 2020/21 on 30th April 2020, subject to some changes being made to the format of the objectives' structure, and enhancing the precision of one of the proposed objectives. However, the objectives approved at that point did not take into account the objectives within the COVID-19 'reset and recovery' programme. The Trust Board duly approved some revised objectives at its meeting on 23rd July 2020.

(coronavirus) outbreak on the Trust's ability to carry out its functions. Each associated risk assessment describes the efforts being made and/or planned to manage and mitigate the risk, and the Trust's Risk and Compliance Manager oversees the regular reviews of the assessments with the relevant risk leads.

Are the Trust's services well-led (under NHS Improvement's well-led framework)?

The CQC inspection in 2017 that was referred to above rated the Trust as "Good" for the Well-led domain. It is likely that the Trust will be assessed again by the CQC during 2021/22.

The principal risks to compliance with the NHS provider licence, condition 4, and actions identified to mitigate these risks

In May 2020, the Trust Board completed the required self-certification (for 2019/20) that the Trust could meet the obligations set out in the NHS Provider Licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution); and that it complied with governance requirements (condition FT4(8)). The Trust Board confirmed full compliance, on the basis of the content of the Trust's Annual Report, and Annual Governance Statement for 2019/20. The Trust Board will be asked to undertake the required self-certification for 2020/21 at its meeting in May 2021, and it will again be proposed that full compliance be confirmed.

The key ways in which risk management is embedded in the activity of the organisation

As noted earlier in this Statement, risks are identified, analysed and controlled in accordance with the Trust's Risk Management Policy and Procedure, and a range of supporting systems and processes are in place to embed risk management activity. For example:

- The Trust's mandatory induction and ongoing training programme for all staff reflects the need for staff to have a sound basis in managing risks relating to Information Governance, Infection Prevention and Control, fire safety, Safeguarding, Health and Safety and Moving and Handling.
- Incident reporting is openly encouraged across the Trust, and lessons learned from incident investigations are disseminated and promoted (including via the "Governance Gazette" newsletter produced by the Clinical Governance department).
- Risk is regularly discussed at a wide range of forums, including the Trust Board and its sub-committees (which sets the tone for discussions at Divisional-, Directorate- and departmental-levels forums)
- Risk management is incorporated into the Trust's planning and Cost Improvement Programme (CIP) arrangements, via the Quality Impact Assessment (QIA) process.

The key ways in which the Trust ensures that short, medium and long-term workforce strategies and staffing systems are in place (which assure the Trust Board that staffing processes are safe, sustainable and effective)

The Trust complies with the "Developing Workforce Safeguards"[11] recommendations via the following methods:

- A bi-annual review of safe staffing levels is led by the Chief Nurse, using a combination of historical data, professional judgement and reference to quality outcomes. The reviews follow the National Quality Board's 2016 guidance[12] cover the necessary three components (i.e. evidence-based tools, professional judgement and outcomes).
- The Trust has a workforce plan that is submitted to NHS England/Improvement (NHSE/I) along with the annual financial and activity plans. The Trust Board discusses all of these plans before submission
- The ETM received regular updates during 2020/21 on progress against the Trust's recruitment plan

[11] "Developing workforce safeguards - Supporting providers to deliver high quality care through safe and effective staffing" (NHS Improvement, October 2018)
[12] "Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time" (National Quality Board, July 2016)

- Service changes including those related to skill mix and the introduction of new roles are subject to a QIA process led by the Medical Director and Chief Nurse
- The Trust Board reviews workforce metrics on a monthly basis as part of its Integrated Performance Report (IPR), to ensure that workforce challenges and risks are understood as part of the wider context of service delivery.
- Where there are critical service risks in relation to staffing and the safe delivery of care these, along with their associated mitigations are escalated to the Trust Board and external regulators as required.
- The Trust's People and Organisational Development Committee (a sub-committee of the Trust Board, which is chaired by a Non-Executive Director) meets every two months. The Committee's purpose (as stated it its Terms of Reference) is to provide assurance to the Board in the areas of people development, planning, performance and employee engagement. The Committee also works to assure the Trust Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that supports success.

Care Quality Commission (CQC) registration

The Trust is fully compliant with the registration requirements of the CQC.

Register of interests

The Trust has an established "Gifts, hospitality, sponsorship and interests policy and procedure". However, it has not yet implemented NHS England "Managing Conflicts of Interest in the NHS" guidance and has not therefore published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff within the past twelve months, as required by the "Managing Conflicts of Interest in the NHS" guidance. The Trust's Audit and Governance Committee (which receives reports of declarations made under the "Gifts, hospitality, sponsorship and interests policy and procedure") has however been kept informed of the Trust's plans regarding the guidance, which the Trust intends to implement in full in 2021/22.

NHS Pension scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Obligations under equality, diversity and human rights legislation

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

Obligations under the Climate Change Act and the Adaptation Reporting requirements

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. This is primarily driven by the implementation of the Trust's Sustainable Development Management Plan (SDMP), which is approved by the Trust Board each year (this was approved in May 2020, and is scheduled to be approved next in May 2021).

Review of economy, efficiency and effectiveness of the use of resources

A range of processes are applied to ensure that the Trust's resources are used economically, efficiently and effectively. The monitoring of this is primarily overseen by the Trust Board, Finance

and Performance Committee and Audit and Governance Committee, although the People and Organisational Development Committee, Quality Committee and Remuneration and Appointments Committee have all participated in this oversight during 2020/21. The Trust's annual Internal Audit plan for 2020/21 included a range of reviews relating to this area, including "Critical Financial Assurance – Financial Accounting and Non Pay Expenditure", and "Critical Financial Assurance – Payroll", which achieved overall assessment of "Reasonable Assurance".

Information governance

The Trust had four serious incidents involving personal data that met the criteria for reporting to the Information Commissioner's Office (ICO), as described within NHS Digital's Data Security and Protection Toolkit, during 2020/21. Three of the incidents related to unauthorised disclosure, while the other related to the non-secure disposal of paperwork. All four were subject to an internal investigation and remedial action was taken. The ICO confirmed it was satisfied that appropriate measures were taken for three of the incidents, while for the fourth, which was notified to the ICO in March 2021, the Trust is currently awaiting further contact from the ICO.

Data quality and governance

The controls in place to ensure the accuracy of data (including the quality and accuracy of elective waiting time data)

The following processes are in place to assure the quality and accuracy of elective waiting time data (and to manage the risks to such quality and accuracy):

- The Trust has a "Patient access to elective care policy" (which was revised and ratified in September 2020), which covers the management of waiting lists at all stages of a referral to treatment pathway. The Policy also states the responsibilities of key staff, including those relating to data quality.
- The Trust also has an "Information Lifecycle Management Policy and Procedure", which describes the Trust's general approach to data quality
- There is a validation process involving operational, management and information leads, to assure the quality of local and national waiting times reporting/data.
- The Trust has a Data Quality Steering Group, chaired by the Deputy Chief Executive/Chief Finance Officer, and the Group has, during 2020/21, overseen the creation of a Data Quality Strategy and workplan. This is linked to NHS Digital's Provider Data Quality Assurance Framework, against which a baseline assessment was undertaken, and the workplan has been developed to improving the Trust's position against that assessment. A Task and Finish group, chaired by the Associate Director of Business Intelligence, has been established to deliver the workplan.

The quality of performance information is primarily assessed via the Internal Audit programme, and in particular via the review of "Data Quality of Key Performance Indicators", which forms part of the Internal Audit plan each year. The "Data Quality of Key Performance Indicators" that was undertaken as part of the 2019/20 Internal Audit plan (and which was issued in September 2020 because of the delays arising from the COVID-19 pandemic) covered the Stroke Best Practice Tariff and 18 Weeks Referral to Treatment (RTT) incomplete pathway indicators, and gave an overall assessment of "Reasonable Assurance".

In addition, the Trust's contract with the Clinical Commissioning Group (CCG) includes a requirement to have a Data Quality Improvement Plan (DQIP). The governance processes defined in the contract mean that any data quality issues relating to our RTT or cancer waiting times can be raised and resolved via that route. The Trust's commissioners receive copies of the Trust's performance reports, as well as information provided to them via NHSE/I, to support the performance management of the Trust's services (with the aim of ensuring the achievement of key targets such as the RTT and cancer waiting time standards). Any associated data quality issues are raised as part of this dialogue and are managed via the technical groups established under the contract and documented in the DQIP.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, the Audit and Governance Committee and the Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit Opinion for 2020/21 states that "My overall opinion is that Reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.". The last sentence of the Opinion reflects the fact that some reviews undertaken by Internal Audit during 2020/21 resulted in a "limited assurance" conclusion. As is the case with all reviews with such a conclusion, the details have been, or will be, considered at the Audit and Governance Committee and actions to address the weaknesses identified in controls are monitored as part of the routine reports that Internal Audit submit to that Committee.

The Audit and Governance Committee approves the Internal Audit plan for the year and receives details of the findings from each of the Internal Audit reviews that are undertaken. Summary reports of relevant Internal Audit reviews are also submitted to the Trust Management Executive (TME), Finance and Performance Committee, People and Organisational Development Committee, and 'main' Quality Committee during the year. Although a number of the Internal Audit reviews completed in 2020/21 resulted in an overall 'Reasonable assurance' assessment, four led to an assessment of 'Limited assurance'. These related to the processes for the management of post, the effective use of the Electronic Staff Record (ESR), the Oncology ICT Healthcheck, and the Roche Managed Service Contract, and actions to address the issues identified in these reviews will be taken during 2021/22.

The role of the Trust Board in maintaining and reviewing the effectiveness of the system of internal control

The Trust Board meets every month (with the exception of August) in public (a 'Part 1' meeting). All Trust Board meetings in 2020/21 were held 'virtually', as a result of the COVID-19 pandemic, and from June 2020, the requirement to meet in public was met via the Trust Board's meetings being broadcast live on the internet, via the Trust's YouTube channel. The agenda and reports for all 'Part 1' Trust Board meetings are available via the Trust's website.

The agenda for Trust Board meetings is mainly focused around the key aspects of operational performance; quality; planning and strategy; assurance and policy; and reports from sub-committees. A separate ('Part 2') meeting is held on the same day as the meeting held in public, to consider confidential matters, in accordance with the Public Bodies (Admission to Meetings) Act 1960. A 12-month rolling forward programme of agenda items is actively managed to ensure the Board receives the information, and considers the matters it requires to perform its duties efficiently and effectively.

A key part of the information the Board receives at each meeting in public is an IPR, which contains up-to-date details of performance across a range of indicators.

The role of the Trust Board's sub-committees and other key forums in maintaining and reviewing the effectiveness of the system of internal control

The Trust Board operates with the following sub-committees (which are listed alphabetically):

- The Audit and Governance Committee. This supports the Trust Board by critically reviewing the governance and assurance processes on which the Board places reliance. This therefore incorporates reviewing Governance, Risk Management and Internal Control (including the BAF); oversight of the Internal and External Audit, and Counter Fraud functions. The Committee also undertakes detailed review of the Trust's Annual Report and Accounts, is the Trust's Auditor Panel (in accordance with Schedule 4, Paragraph 1, of the Local Audit and Accountability Act 2014). The Committee is chaired by a Non-Executive Director, and meets five times each year (including a specific meeting to review the Annual Report and Accounts prior to the Trust Board being asked to approve these). All other Non-Executives Directors (apart from the Chair of the Trust Board) are members.
- The Charitable Funds Committee. This aims to ensure that the Maidstone and Tunbridge Wells NHS Trust Charitable Fund is managed efficiently and effectively in accordance with the directions of the Charity Commission, relevant NHS legislation and the wishes of donors, which includes reviewing, and agreeing the Charitable Fund Annual Report and financial accounts, for approval by the Trust Board. The Committee is chaired by a Non-Executive Director, and meets three times per year.
- The Finance and Performance Committee. This aims to provide the Trust Board with: assurance on the effectiveness of financial management, treasury management, investment and capital expenditure and financial governance; an objective assessment of the financial position and standing of the Trust; and advice and recommendations on all key issues of financial management and financial performance. In addition, the Committee receives assurance on informatics (including Information Technology) strategies and plans, and on plans and proposals for major development and investment in Information Technology. The Committee is chaired by a Non-Executive Director, and meets monthly.
- The Patient Experience Committee. This considers the effectiveness of the Trust's progress in utilising the learning from patient and service users experience of Trust services in order to improve, and identify the level of inclusion achieved for patients and service users by Trust operations. The Committee is chaired by a Non-Executive Director, and meets quarterly. In addition to Trust staff, its membership includes representatives from the Trust's catchment area, Healthwatch Kent, and from Leagues of Friends of Maidstone and Tunbridge Wells Hospitals.
- The People and Organisational Development Committee. This provides assurance to the Board in the areas of people development, planning, performance and employee engagement; and works to assure the Trust Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that supports success. The Committee is chaired by a Non-Executive Director and meets monthly.
- The Quality Committee. This aims to seek and obtain assurance on the effectiveness of the Trust's structures, systems and processes to enable delivery of the Trust's objectives relating to quality of care. The Committee is chaired by a Non-Executive Director and meets monthly. On alternate months, the Committee meets in the form of a 'deep dive', with a reduced membership, to enable a small number of subjects to be scrutinised in greater detail.
- The Remuneration and Appointments Committee. This reviews, on behalf of the Trust Board, the appointment of members of the Executive Team, to ensure such appointments have been undertaken in accordance with Trust Policies. It also reviews the remuneration, allowances and terms of service of such staff; reviews (with the Chief Executive) the performance of members of the Executive Team; oversees appropriate contractual arrangements for such staff (including the proper calculation and scrutiny of termination payments, taking account of such national guidance, as appropriate); and considers and approves, on behalf of the Trust Board, proposals on issues which represent significant change. The Committee is chaired by the Chair of the Trust Board, and meets on an ad-hoc basis (although it met several times during 2020/21).

Although not a Trust Board sub-committee, the ETM enables key clinical and managerial issues to be discussed, debated, developed, scrutinised, monitored and agreed and/or approved. The ETM meets every week, is chaired by the Chief Executive and its membership comprises all members of the Executive Team, the five Divisional Chiefs of Service, the Deputy Medical Director and the Director of Estates and Facilities. The ETM is authorised to make decisions on any matter that is

not reserved for the Trust Board or its sub-committees, and the key issues considered are reported to the Trust Board as part of the monthly report from the Chief Executive.

The TME, which meets quarterly, supports the delivery of robust risk management policies and processes and the identification and addressing of all key risk issues. The meeting is chaired by the Chief Executive and its membership comprises circa 50 senior clinical and managerial leaders from across the Trust.

In addition to the above committees, there are a range of other forums, structures and processes in place to oversee and manage any issues relevant to particular aspects of risk and governance. In this respect, the Trust has, for example, an Infection Prevention and Control Committee; a Health and Safety Committee; a Drugs, Therapeutics and Medicines Management Committee; an Information Governance Committee; and a Joint Safeguarding Committee.

The impact of the COVID-19 pandemic during 2020/21

The impact of the COVID-19 pandemic began to be felt materially by the Trust during March 2020, but was more significantly felt within 2020/21, particularly during the 'second wave', which was experienced during the winter of 2020/21. However, despite the unprecedented scale of the impact, the Trust's structure of governance allowed a prompt response to the significant change in circumstances. The Incident Command Centre that was established in March 2020, with the Chief Operating Officer as the Strategic Commander, led and coordinated the Trust's response to the pandemic, including acting as the single point of contact for the escalation of issues; acting as the single point of contact for external agencies; being responsible for identifying and mitigating Trust-wide risks; and having decision-making authority over all substantial issues, queries, operational changes and expenditure requests relating to the COVID-19 response.

Significant internal control issues

The following significant internal control issues[13] have been identified in 2020/21:

1. Two "Never Events" were declared at the Trust in 2020/21. One related to a misplaced naso-gastric (NG) tube and one involved a retained swab following a delivery. The incidents were subject to scrutiny through the SI investigation process, and the Quality Committee, to aim to ensure that lessons were learnt to prevent recurrence.
2. In November 2020, HM Coroner issued the Trust with a Regulation 28 ("Report to Prevent Future Deaths") report, following the Inquest into the death (in August 2019) of one of the Trust's patients, who sustained a severe head injury following a fall from a trolley in the Clinical Decision Unit. The Trust wrote to HM Coroner in January 2021 to explain the actions that had been taken, and would be taken in the future, to learn from the incident, and prevent it from recurring.

Conclusion

The Trust has maintained a sound system of internal control during 2020/21, and has identified only two significant internal control issues during the year. These are described above, in the body of the Annual Governance Statement.

Miles Scott, Chief Executive, 24th June 2021

[13] The Trust considered the following criteria when identifying if any significant internal control issues had occurred during 2020/21: Might the issue prejudice achievement of priorities? Could the issue undermine the integrity or reputation of the NHS? What view does the Audit and Governance Committee take on this point? What advice has internal or external audit given? Could delivery of the standards expected of the Accountable Officer be at risk? Has the issue made it harder to resist fraud or other misuse of resources? Did the issue divert resources from another significant aspect of the business? Could the issue have a material impact on the accounts? Might national or data security or integrity be put at risk?

NHS Maidstone and Tunbridge Wells NHS Trust

Extraordinary Charitable Funds Committee, 07/05/21	**Committee Chair (Non-Executive Director)**

An Extraordinary Charitable Funds Committee (CFC) was held on 7th May 2021 virtually, via webconference.

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

- The Committee reviewed the **Heads of Terms for the proposed partnership with Maggie's Centres** wherein an extensive discussion was held regarding the considerations that should be made for the development of a Maggie's Centre at the Trust and the following agreements were reached:
  - That the Divisional Director of Operations for Cancer Services should investigate and confirm, following discussions with Maggie's, the proposed location for the development of a Maggie's Centre at the Trust
  - That the Assistant General Manager for Outpatients should liaise with representatives from Maggie's to investigate what "clinical support" was required from the Trust and what, if any, shared services would be required for the operation of a Maggie's Centre at the Trust
  - That the Assistant General Manager for Outpatients should liaise with representatives from Trusts that have recently developed Maggie's Centres to investigate the impact on their fundraising initiatives and to gain feedback on the working relationship with Maggie's
  - That the Trust Secretary should arrange for the 'Part 1' Trust Board in May 2021 to review, and if appropriate, support in principle, the development of a Maggie's Centre at the Trust
  - That the Trust Secretary should schedule the approval of the Heads of Terms for the proposed development of a Maggie's Centre at the Trust at a future 'Part 1' Trust Board meeting, as appropriate
- Under **Any Other Business** the Committee commended contribution of the Fundraising Manager during their tenure at the Trust.

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

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

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

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

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

Summary report from Quality Committee, 12/05/20 (incl. approval of revised Terms of Reference)	**Committee Chair (Non-Executive Director)**

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

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

- As part of International Nurses Day 2021 the Committee commended the continued contribution of the nursing staff across the Trust.
- The Committee agreed **revised Terms of Reference**, as part of the routine annual review. These are enclosed in Appendix 1, with the proposed changes shown as 'tracked', and the Trust Board is asked to approve the changes.
- The issues raised from the **reports from the clinical Divisions** included the continued staffing pressures within the clinical Divisions; the increase in referrals to the Cancer Services Division; the increased activity within Maternity Services and the associated suspension of out of areas bookings to enable a continued focus on the delivery of safe care; an update on the Trust's Sepsis action plan; and the focus on recruitment within the Clinical Divisions.
- The Divisional Director of Operations for Cancer Services, Matron for Outpatients and General Manager for outpatients attended to provide a comprehensive **update on the plans to improve outpatient services** wherein it was agreed that the Divisional Director of Operations for Cancer Services should ensure that the Patients' voice group considered the reasonable adjustments that would be required to ensure accessibility of appointments for neuro-diverse patients
- The Deputy Chief Operating Officer gave an **update on harm reviews for patients who have waited a long time**, wherein a discussion was held regarding the importance of a ensuring a Standard Operating Procedure (SOP) across the Kent and Medway Integrated Care System.
- The Medical Director reported on the **output from the COVID-19 Ethics Committee and Clinical Reference Group**.
- The Deputy Chief Nurse gave an **update on the work to achieve an 'Outstanding' CQC rating** wherein the importance of framing the improvement work in the appropriate context of the Trust was emphasised.
- The Chief of Service, Medicine & Emergency Care gave the latest **update on mortality**, which included the impact the new Medical Examiner role was having on mortality reviews and an in-depth analysis of weekend vs weekday mortality data.
- The latest **Serious Incidents (SIs)** were reported by the Director of Infection Prevention and Control and the continued work of the Patient Safety Team was commended.
- The Committee reviewed the **draft Quality Accounts for 2020/21** wherein the Committee recommended that the draft Quality Accounts for 2020/21 be submitted to the 'Part 1' Trust Board in June 2021, subject to the required formatting amendments.
- The report from the last **Quality Committee 'deep dive' meeting** was noted.
- Reports were received from the **Committee's sub-committees** (the Complaints, Legal, Incidents, PALS, Audit and Mortality (CLIPAM) group; the Infection Prevention and Control Committee; The Joint Safeguarding Committee; the Drugs, and Therapeutics and Medicines Management Committee; and the Health and Safety Committee) and it was agreed under the Joint Safeguarding Committee report that the Assistant Trust Secretary should ensure that the "Summary report from the Patient Experience Committee, 10/06/21" to the 'main' Quality Committee meeting in July 2021 included the "Update on the provision of care for patients with learning disabilities" report and associated minute as appendices. It was also agreed under the Health and Safety Committee report that the Divisional Director of Nursing and Quality, Medicine and Emergency Care should ensure that future summary reports from the Health and Safety Committee include an update from the Water Steering Group
- The **summary report from the Patient Experience Committee** meeting held on 04/03/21 was noted.

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

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

- The Committee's Terms of Reference were reviewed and the proposed changes were agreed. The revised Terms of Reference are enclosed in Appendix 1, for the Trust Board's approval

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

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

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

Appendix 1

QUALITY COMMITTEE - TERMS OF REFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

1. Purpose

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

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

2. Membership

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

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

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

3. Quorum

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

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

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

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

4. Attendance

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

The following are invited to attend each 'main' meeting

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

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

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

5. Frequency of Meetings

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

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

6. Duties

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

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

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

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

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

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

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

7. Parent committees and reporting procedure

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

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

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

8. Sub-committees and reporting procedure

The Committee has the following sub-committees.

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

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

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

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

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

10. Patient Experience Committee

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

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

11. Administration

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

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

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

12. Emergency powers and urgent decisions

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

13. Review of Terms of Reference

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

Review history

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

Audit and Governance Committee, 13/05/21 (incl. approval of revised Terms of Reference) | **Committee Chair (Non-Executive Director)**

The Audit and Governance Committee met on 13th May 2021.

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

- The **actions from previous meetings** were noted.
- The Committee agreed some **proposed amendments to the Terms of Reference**. These are enclosed in Appendix 1, with the proposed changes shown as 'tracked', and the Trust Board is asked to approve the changes.
- The Associate Director for Facilities Management and the Quality & Technical Manager for Facilities attended for the **limited assurance internal audit review: Review of Processes for the Management of Post** and provided the Committee with assurance that the appropriate actions had been implemented.
- The Divisional Director of Operations for Cancer Services and Director of IT attended for the **Limited assurance internal audit review: Assurance Review of Oncology ICT Healthcheck** and outlined the mitigation which had been implemented, the action plan which had been developed and the proposed approach for the future.
- The Committee undertook the **year-end review of the Board Assurance Framework for 2020/21** wherein it was noted that the Board Assurance Framework would be replaced by the Trust's Strategy Deployment work in the 2021/22 financial year.
- The Committee reviewed the **Trust's Risk Register** and it was agreed that the Trust Secretary should submit a "Review of the Trust's red-rated risks" report, which included an executive summary which provided assurance regarding the management of individual risks, to the Committee's meeting in August 2021.
- The Committee received the **Internal Audit Annual Report for 2020/21 (incl. the draft Head of Internal Audit Opinion)** wherein the Trust received a rating of **"Reasonable Assurance"** for the draft Head of Internal Audit Opinion.
- An **update on progress with actions from previous Internal Audit reviews** (incl. response to the Internal Audit survey findings) was reported which included details of Outstanding Audit Recommendations. The list of recent Internal Audit reviews is shown below (in section 2).
- The latest **Counter Fraud update** was received and the **response to the External Audit survey findings** was noted.
- The **Informing the audit risk assessment for Maidstone and Tunbridge Wells NHS Trust 2020/21 – The Trust's response** report was noted with no areas of concern raised by External Audit.
- The **Draft Annual Report for 2020/21 (incl. the Governance Statement)** was reviewed wherein the following agreements were made:
  - That the Assistant Trust Secretary should ensure that a Microsoft Word version of the "Draft Annual Report for 2020/21 (incl. the Governance Statement)" was provided to Committee members upon request.
  - That the Assistant Trust Secretary should amend the "Directors' interests" section of the Draft Annual Report 2020/21 and the Trust's Register of Interests to include that the Committee's Chair's son worked for Grant Thornton UK LLP.
  - That the Assistant Trust Secretary should liaise with the Head of Staff Engagement & Equality to consider, and confirm, whether the "Z Not Stated" response for Trust Board members should be included within the "Fair and inclusive recruitment" section of the "Annual Report for 2020/21".
  - That the Trust Secretary should review and amend the "Conclusion" section of the "Annual Governance Statement 2020/21" section of the "Annual Report 2020/21" to ensure that it provided a definitive year-end position.
- The **Draft Annual Accounts for 2020/21** (incl. latest losses & compensations data) was reviewed by the Committee.
- The Committee approved the **"Audit and Governance Committee Annual Report for**

2020/21" which will be submitted to the 'Part 1' Trust Board meeting in June 2021 as part of the assurances required, by the Trust Board, for approval of the Trust's Annual Report and Accounts for 2020/21.

- The **latest single tender / quote waivers data** was reviewed.
- The **details of gifts, hospitality and sponsorship** were noted and it was agreed that the Trust Secretary should submit the 'People' functions plan for the implementation of the "My-ESR" self-service portal to the Committee's meeting in August 2021
- Under the **Forward Programme** the Committee was informed of the intention to reschedule the June 2021 meeting from the 24th June 2021 to the 23rd June 2021.
- The Committee undertook an **evaluation of the meeting**.

2. The Committee received details of the following completed Internal Audit reviews:

- "Assurance Framework and Risk Management" (which received a "Reasonable Assurance" conclusion)
- "Patient Involvement and Experience" (which received a "Reasonable Assurance" conclusion)
- "Critical Financial Assurance – Payroll" (which received a "Reasonable Assurance" conclusion)
- "Clinical Governance Arrangements" (which received a "Reasonable Assurance" conclusion)
- "Data Quality of Key Performance Indicators (RTT and Stroke Best Practice for 2019/20)" (which received a "Reasonable Assurance" conclusion)

3. The Committee was also notified of the following "Urgent" priority outstanding actions from Internal Audit reviews: N/A

4. The Committee agreed that (in addition to any actions noted above): N/A

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

- The Committee's Terms of Reference were reviewed and the proposed changes were agreed. The revised Terms of Reference are enclosed in Appendix 1, for the Trust Board's approval

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Appendix 1 – Revised Terms of Reference

Audit and Governance Committee

Terms of Reference

NHS Maidstone and Tunbridge Wells NHS Trust

1. Constitution / Purpose

1.1 The Audit and Governance Committee has been established by the Trust Board as a non-executive sub-committee of the Trust Board. The Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

1.2 The Committee supports the Trust Board by critically reviewing the governance and assurance processes on which the Trust Board places reliance. This therefore incorporates reviewing Governance, Risk Management and Internal Control (including the Board Assurance Framework (BAF)); & oversight of the Internal and External Audit, and Counter Fraud functions. The Committee has primary responsibility for ensuring compliance with the Trust's established governance structures.

1.3 The Committee also undertakes detailed review of the Trust's Annual Report and Accounts.

1.4 The Trust Board has also appointed the Audit and Governance Committee as the Trust's Auditor Panel, in accordance with Schedule 4, Paragraph 1 of the Local Audit and Accountability Act 2014. The Auditor Panel will advise the Trust Board on the selection, appointment and removal of External Auditors, and on the maintenance of independent relationships with such Auditors.

2. Authority

2.1 The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2.2 The Committee is authorised to undertake all relevant actions to fulfil its role as the Trust's Auditor Panel.

3. Membership

3.1 The Committee shall be appointed by the Trust Board from amongst the Non-Executive Directors of the Trust (other than the Chair of the Trust Board), and shall consist of not less than three members. A Non-Executive Director Chair of the Committee will be appointed by the Chair of the Trust Board, together with a Vice-Chair. If a Non-Executive Director member is unable to attend a meeting they will be responsible for finding a replacement to ensure quoracy for the meeting. The Chair and Vice-Chair of the Committee will also act as Chair and Vice-Chair (respectively) of the Auditor Panel.

3.2 Other individuals may be co-opted to become formal members of the Committee, to address issues of specific concern, at the discretion of the Committee Chair.

3.3 When undertaking the role of the Auditor Panel, the membership shall comprise the entire membership of the Audit and Governance Committee, with no additional appointees. This means that all members of the Auditor Panel are independent, Non-Executive Directors.

3.4 Conflicts of interests relevant to agenda items must be declared and recorded at the start of each meeting (including meetings of the Auditor Panel). If a conflict of interest arises, the Committee Chair may require the affected member to withdraw at the relevant discussion or voting point.

4. Quorum

4.1 The Committee shall be quorate when two Non-Executive members are present (including either the Committee Chair or Vice Chair).

4.2 However, when the Committee is undertaking the role of the Trust's "Auditor Panel", the Committee shall be quorate when three Non-Executive members are present (including either the Committee Chair or Vice Chair)[1].

5. Attendance

5.1. The following will routinely attend meetings of the Committee (but will not be members):

- Associate Non-Executive Directors
- Deputy Chief Executive / Chief Finance Officer
- Deputy Director of Finance (Financial Governance)
- Head of Internal Audit and/or other appropriate representatives
- External Audit Engagement Lead and/or other appropriate representatives
- Local Counter Fraud Specialist
- Trust Secretary

5.2 Members (listed above) are expected to be present at all meetings of the Committee. Those listed in section 5.1 are expected to be in attendance at all meetings of the Committee.

5.3 The Chief Executive, other members of the Executive Team, or any other member of staff will be invited to attend if the Committee is discussing areas of risk or assurance that are the responsibility of that individual and it is felt that their attendance is necessary to fully understand or address the issues

5.4 The Chief Executive may be invited to attend to discuss the process for assurance that supports the Annual Governance Statement; and the agreement of the Internal Audit annual plan. The decision as to whether to invite the Chief Executive for these items rests with the Committee Chair.

5.5 The Committee will, if requested by the External and Internal Auditors, meet privately with those Auditors at the start of each meeting. A private session with the External and Internal Auditors will however be held once a year, ahead of the first Audit and Governance Committee meeting that reviews the draft Annual Report and Accounts, regardless of whether the Auditors have any issues to raise. Individual Committee members can however approach the External or Internal Auditors in private, should such members consider this necessary.

5.6 The Trust Secretary will provide appropriate support to the Chair and Committee members, and will be responsible for the administration of the Committee (see section 10).

5.7 The Chair may also invite others to attend when the Committee is meeting as the Auditor Panel. These invitees are not members of the Auditor Panel

6. Frequency of meetings

6.1 Meetings shall be held not less than four times a year. The Chair of the Committee will have the discretion to agree additional meetings in order to fulfil the 'Committee's purpose and/or meet its duties.

6.2 The External Auditor or Head of Internal Audit may request an additional meeting if they consider that one is necessary. Any member of the Trust Board may also put a request in writing to the Chair of the Committee for an additional meeting, stating the reasons for the request. The decision whether or not to arrange such a meeting will be at the sole discretion of the Chair of the Committee.

[1] Independent members of the Auditor Panel must be in the majority and there must be at least two independent members present or 50% of the auditor panel's total membership, whichever is the highest

6.3 As a general rule, the Auditor Panel will meet on the same day as the Audit and Governance Committee. However, Auditor Panel business shall be identified via a separate agenda, and Audit and Governance Committee members shall deal with these matters as Auditor Panel members, not as Audit and Governance Committee members. The Auditor Panel's Chair shall formally state (and this shall be formally recorded) when the Auditor Panel is meeting in that capacity.

7. Duties

7.1 The duties of the Committee can be categorised as follows:

Governance, risk management and internal control

7.2 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

7.3 In particular, the Committee will review the adequacy of:

7.3.1 All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, External Audit opinion or other appropriate independent assurances, prior to endorsement and/or approval by the Trust Board

7.3.2 The underlying assurance process that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

7.3.3 The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.

7.3.4 The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority (or successor bodies).

7.4 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from members of the Executive Team and managers, as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

7.5 This will be evidenced through the Committee's use of an effective BAF to guide its work and that of the audit and assurance functions that report to it.

7.6 As part of its integrated approach, the Committee will have effective relationships with other key committees, so that it understands processes and linkages. However, these other committees must not usurp the Audit and Governance Committee's role.

Internal Audit

7.7 The Committee shall ensure that there is an effective Internal Audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and Trust Board.

This will be achieved by:

7.6.1 Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal

7.6.2 Review and approval of the Internal Audit Charter (or equivalent), operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the BAF

7.6.3 Consideration of the major findings of Internal Audit work (and management's response), and ensure co-ordination between the Internal and External auditors to optimise audit resources

7.6.4 Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation

7.6.5 Carrying out an annual review of the effectiveness of Internal Audit

External Audit

7.8 The Committee shall review the work and findings of the Trust's External Auditor and consider the implications & management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the External Auditor
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy
- Discussion with the External Auditors of their evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- Review all External Audit reports, including the report to those charged with governance, agreement of the Annual Audit Letter (before submission to the Trust Board) and any work carried outside the annual audit plan, together with the appropriateness of management responses
- Ensuring that there is in place a clear framework for the engagement of external auditors to supply non audit service

Other assurance functions

7.9 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, as it sees fit, and consider the implications to the governance of the organisation, in so far as they affect the Trust's agreed objectives. These will include, but will not be limited to, any reviews by Department of Health and Social Care's Arm's Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

Counter Fraud

7.10 The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud that meet NHS Counter Fraud Authority's (NHSCFA) standards and shall review the outcomes of Counter Fraud work. The Committee will ensure that any suspicions of fraud, bribery and corruption are referred to the NHSCFA.

Management

7.11 The Committee shall request and review reports and positive assurances from members of the Executive Team and managers on the overall arrangements for governance, risk management and internal control.

7.12 They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

Annual Report and Financial Reporting

7.13 The Committee shall monitor the integrity of the financial statements of the Trust and the formal announcements relating to the Trust's financial performance (in so far as they may affect the Trust's Annual Report and Accounts).

7.14 The Committee should ensure that the systems for financial reporting to the Trust Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Trust Board. This duty will usually be met via the commissioning of, and reviewing the outcome of, the Core Financial Assurance reviews within the annual internal audit programme.

7.15 The Committee shall review the Annual Report and Financial Statements before submission to the Trust Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- Changes in, and compliance with, accounting policies and practices
- Unadjusted mis-statements in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit
- The letter of Management Representation
- Explanations for significant variances
- Qualitative aspects of financial reporting

Freedom to Speak Up

7.16 The Committee shall support the People and Organisational Development Committee and Trust Board in reviewing the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently. The usual method of meeting this duty would be to commission an Internal Audit review of the arrangements, as the Committee sees fit.

Auditor Panel

7.17 As the Auditor Panel, the Committee shall advise the Trust Board on the selection and appointment of the Trust's External Auditor. This includes:

- Agreeing and overseeing a robust process for selecting the External Auditors in accordance with the Trust's normal procurement rules
- Making a recommendation to the Trust Board as to who should be appointed (ensuring that any conflicts of interest are dealt with effectively)
- Advising the Trust Board on the maintenance of an independent relationship with the appointed External Auditor
- Advising (if asked) the Trust Board on whether or not any proposal from the External Auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable
- Advising on (and approving) the contents of the Trust's policy on the purchase of non-audit services from the appointed External Auditor
- Advising the Trust Board on any decision about the removal or resignation of the External Auditor

8. Parent committee and reporting procedure

8.1 The Committee is a sub-committee of the Trust Board.

8.2 The minutes of Committee meetings shall be formally recorded by the Trust Secretary. The Chair of the Committee shall also provide a brief written report to the Trust Board, summarising the issues covered at the meeting and drawing to the attention of the Trust Board any issues that require disclosure to the full Board, or require executive action.

8.3 The Committee will report to the Trust Board annually (via a written Annual Report) on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the BAF, the completeness and embeddedness of risk management in the organisation, and the integration of governance arrangements. The Annual Report should also describe how the Committee has fulfilled its Terms of Reference, and give details of any significant issues that the Committee considered in relation to the financial statements, and how these were addressed. The work of the Committee as the Trust's Auditor Panel should also be included.

8.4 The Committee shall undertake an annual self-assessment to ensure the objectives of the Terms of Reference are being met.

8.5 The Chair must report to the Trust Board on how the Auditor Panel has discharged its responsibilities.

8.6 The Chair must draw to the attention of the Trust Board any issues that require disclosure to the Board in relation to Auditor Panel duties.

9. Sub-committees and reporting procedure

9.1 The Committee has no sub-committees.

10. Administrative arrangements

10.1 The Committee shall be supported administratively by the Trust Secretary, whose duties in this respect will include:

- Maintenance of a forward programme of work, setting out the dates of planned meetings and key agenda items
- Agreement of agenda for next meeting with Chair, allowing adequate notice for reports to be prepared which adequately support the relevant agenda item.
- Collation and distribution of agenda and reports one week before the date of the meeting
- Ensuring the minutes are taken and that a record is kept of matters arising and issues to be carried forward
- Advising the Committee on all pertinent areas

11. Emergency powers and urgent decisions

11.1 The powers and authority which the Trust Board has delegated to the Audit and Governance Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least one other Non-Executive Director member. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Audit and Governance Committee, for formal ratification.

12. Review of Terms of Reference and Monitoring Compliance

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

History
Terms of Reference agreed by Audit and Governance Committee: April 2013
Terms of Reference approved by the Board: May 2013
Terms of Reference agreed by the Audit and Governance Committee, November 2014
Terms of Reference approved by the Trust Board, December 2014
Terms of Reference agreed by the Audit and Governance Committee, November 2015
Terms of Reference approved by the Trust Board, November 2015
Terms of Reference agreed by the Audit and Governance Committee, February 2016 (N.B. the Board had already authorised the Audit and Governance Committee to agree changes in relation to the Committee's role as Auditor Panel)
Terms of Reference agreed by the Audit and Governance Committee, November 2016
Terms of Reference approved by the Trust Board, November 2016
Terms of Reference agreed by the Audit and Governance Committee, November 2017
Terms of Reference approved by the Trust Board, November 2017
Terms of Reference agreed by the Audit and Governance Committee, December 2018
Terms of Reference approved by the Trust Board, December 2018
Terms of Reference agreed by the Audit and Governance Committee, November 2019
Terms of Reference approved by the Trust Board, November 2019
Terms of Reference agreed by the Audit and Governance Committee, November 2020
Terms of Reference approved by the Trust Board, November 2020
Amended Terms of Reference agreed by the Audit and Governance Committee, May 2021 (to reflect the Committee's primary responsibility for ensuring compliance with the Trust's established governance structures).
Amended Terms of Reference approved by the Trust Board, May 2021

NHS
Maidstone and Tunbridge Wells NHS Trust

Summary report from the People and Organisational Development Committee, 21/05/21	Committee Chair (Non-Exec. Director)

The People and Organisational Development Committee met (virtually, via webconference) on 21st May 2021 (the first 'deep dive' meeting).

The key matters considered at the meeting were as follows:

- The Vice Chair introduced the meeting by informing the Committee of the approach which would be adopted for future 'deep dive' meetings
- The Organisational Development Consultant and Transformation Programme Manager attended for a **review of the Culture and Leadership Programme as part of the Exceptional People, Outstanding Care (EPOC) programme (incl. development of the People & Organisational Development Strategy for the Trust)** wherein an in-depth discussion was held regarding the importance of alignment with the Trust's Strategy Deployment work and various organisational development workstreams, as well as the need to prioritise psychological safety within the Trust and adopt a consistent approach throughout the Trust. The Committee also emphasised the importance of preventing 'burnout' of managers and staff and outlined the narrative that should be developed in relation to the benefits of working at the Trust. It was agreed that the Organisational Development Consultant should ensure that the next iteration of the "Culture and Leadership Programme" report to the Trust Board incorporated the discussion held at the May 2021 People and Organisational Development Committee 'Deep Dive' meeting.
- The Committee reviewed the **underlying causes for staff turnover at the Trust and the associated response** wherein the Committee noted the importance of the alignment between job descriptions and the Agenda for Change framework however it was acknowledged that there was increased market sector competition and that there needed to be investment in line managers to improve the quality of conversations and interviewing. It was agreed that the Chief People Officer should ensure that relevant Human Resources Business Partner or the author of the report, is invited to future 'Deep Dive' items; and that the Organisational Development Consultant should review, and confirm, whether the staff turnover figure at the Trust included internal staff transfers.
- The Chief People Officer presented the **proposals for the operating model and strategy for the People function** wherein the following agreements were reached:
  - That the Assistant Trust Secretary should liaise with the Chief People Officer, Chair and Vice Chair of the Committee to consider, and confirm, the future scheduling of the "review the operating model and strategy for the People function" item
  - That the Chief People Officer should consider, and confirm, the timeframe for the implementation of a 'customer survey' to gain feedback on staff experience of the Trust's 'People' Function, taking into consideration capacity limitations within the 'People' Function
  - That the Chief People Officer should ensure that the approach outlined for the development of Human Resources Business Partners was expanded to encompass Business Partners from other Corporate functions at the Trust, to enable the development of an aligned Business Partnership model
- Under the **evaluation of the meeting** feedback was provided from Committee members on the process which had been adopted and it was agreed that the Assistant Trust Secretary should ensure that future 'Deep Dive' meetings are scheduled via Microsoft Teams, due to the increased visibility of the "Raise Hand" functionality.

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

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

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

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

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the Finance and Performance Committee, 25/05/21	Committee Chair (Non-Exec. Director)

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

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

- The **"Focus on…"** item was on the implementation of the Electronic Patient Record (EPR), and the Programme Director for EPR (Sunrise) and Digital Transformation attended to report on the latest position ahead of the scheduled 'go live' on 16/06/21.
- The Director of IT attended to give an **update on IT strategy and related matters**. The Committee acknowledged the significant recent IT developments but gave some comments regarding the implementation of the eNotes document storage solution.
- The Deputy Chief Operating Officer reported on the **month 1 non-finance related performance**, which included that the trajectory target for elective activity had been met.
- The **financial performance for month 1** was reviewed, which noted that the Trust had delivered against its financial plan for the month.
- A lengthy discussion was held on the **capital plan for 2021/22**, after which the Committee recommended the approval of the overall capital plan to the Trust Board; and approved the approach to the management of the capital programme in 2021/22 (the plan will be submitted to the Trust Board, for approval, in June 2021).
- The Director of Strategy, Planning and Partnerships attended to give an **update on the Kent and Medway Medical School accommodation project**, which confirmed that the Full Business Case (FBC) would be submitted to the Committee, for review, and the Trust Board, for approval, in June 2021.
- An **update on 2021/22 planning** was also given, which involved a discussion of the various assumptions had had been applied.
- The programme of **reviews of previously approved Business Cases** covered the implementation of the Business Cases for a post-COVID assessment service; and East Kent oncology, and the Director of Strategy, Planning and Partnerships gave his perspective on the reasons for the significant delay to the implementation of the latter, which had been scheduled to be completed by the autumn of 2020/21
- The Deputy Director Strategy Programme and Financial Planning, Strategy and Population Health Directorate for NHS Kent and Medway CCG, Director of Pathology Transformation at the Kent and Medway Pathology Network, and LIMS Project Manager for the Kent and Medway Pathology Network all attended to present the **FBC for the Laboratory Information Management System (LIMS)**, The Committee duly recommended the FBC for approval by the Trust Board, which will be scheduled at the Trust Board's meeting in June 2021.
- The Committee was notified of the **use of the Trust Seal** since the Committee's last meeting.

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

- The Director of IT should liaise with the Head of Clinical Information Systems and Healthcare Records Services and provide the Executive Team Meeting (ETM) and Committee with a detailed update on the implementation of the eNotes document storage solution (including the allocated resources); and also ensure that the comments made at the meeting regarding 'back scanning' were considered in the future scanning strategy for eNotes.
- The Trust Secretary should amend the Committee's forward programme to incorporate future "Detailed review of the Trust's cash flow position" items within the monthly financial performance report; and also schedule all future Committee meetings between 11am to 2pm.

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

- N/A

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

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