Maidstone and Tunbridge Wells NHS Trust

# Trust Board Meeting ('Part 1')

**30 April 2020, 09:45 to 12:00**
**Virtual meeting, via webconference**

## Agenda

- **N.B. Following national guidance on social distancing, Trust Board meetings will not be held in public at present. Members of the public with queries should contact the Trust Secretary's office (please refer to the Trust website for contact details).**

### 04-5
### To receive apologies for absence

David Highton

### 04-6
### To declare interests relevant to agenda items

David Highton

### 04-7
### To approve the minutes of the 'Part 1' Trust Board meetings of 26th March 2020 and 16th April 2020

David Highton

Board minutes 26.03.20 (Part 1).pdf (8 pages)

Extraordinary Board minutes 16.04.20 (Part 1).pdf (1 pages)

### 04-8
### To note progress with previous actions

David Highton

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

### 04-9
### Safety moment

Claire O'Brien and Peter Maskell

Safety Moment for Trust Board April 2020 v1 (2).pdf (5 pages)

### 04-10
### Report from the Chair of the Trust Board

David Highton

Chair's Report.pdf (1 pages)

### 04-11
### Report from the Chief Executive

Miles Scott

Chief Executive's report April 2020 final.pdf (2 pages)

### 04-12
### Update on the Trust’s response to COVID-19

This will be a verbal report

Miles Scott

**04-13**
**Integrated Performance Report for March 2020**

Miles Scott

IPR month 12.pdf (46 pages)

**04-13.1**
**Safe (incl. planned and actual ward staffing for March 2020)**

Claire O'Brien

**04-13.2**
**Safe (infection control)**

Sara Mumford

**04-13.3**
**Effective**

Sean Briggs

**04-13.4**
**Caring**

Claire O'Brien

**04-13.5**
**Responsive**

Sean Briggs

**04-13.6**
**Well-Led (finance)**

Steve Orpin

**04-13.7**
**Well-Led (workforce)**

Simon Hart

## Board Assurance Framework (BAF)

**04-14**
**Year-end review of the Board Assurance Framework, 2019/20**

Kevin Rowan

Year-end review of BAF for 2019-20.pdf (5 pages)

## Planning and strategy

**04-15**
**Update on the 2020/21 Operating Plan**

Steve Orpin and Amanjit Jhund

Update on the 202021 Operating Plan.pdf (11 pages)

**04-16**
**Update on the establishment of the Hyper Acute Stroke Unit (HASU) at Maidstone Hospital**

Sean Briggs

Update on the establishment of the Hyper Acute Stroke Unit (HASU) at Maidstone Hospital.pdf (6 pages)

**04-17**
**Agreement of key objectives for 2020/21**

Amanjit Jhund

Agreement of key objectives for 202021.pdf (3 pages)

Agreement of key objectives 202021 V2.pdf (3 pages)

## Assurance and policy

**04-18**
**Review of the Workforce Race Equality Scheme (WRES) (including the Trust's Model Employer aspirational targets)**

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

Rantimi Ayodele

WRES.pdf (25 pages)

**04-19**

## Quarterly report from the Freedom to Speak Up Guardian

Maureen Choong

FTSU Board Report April 2020.pdf (5 pages)

**04-20**

## The outcome of the Estates and Facilities review undertaken by The Grichan Partnership

This will be a verbal report

Miles Scott

**04-21**

## Ratification of the Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ('Policy for Policies')

Kevin Rowan

Policy for policies (full report).pdf (74 pages)

# Reports from Trust Board sub-committees

**04-22**

## Audit and Governance Committee, 19/03/20

David Morgan

Summary of Audit and Governance Cttee 19.03.20.pdf (2 pages)

**04-23**

## Charitable Funds Committee, 24/03/20 (to include approval of revised Terms of Reference)

David Morgan

Summary of Charitable Funds Cttee, 24.03.20 (incl. revised ToR).pdf (4 pages)

**04-24**

## Workforce Committee, 26/03/20 (to include approval of revised Terms of Reference)

Emma Pettitt-Mitchell

Summary of Workforce Cttee, 26.03.20 (incl. revised ToR) - draft.pdf (5 pages)

**04-25**

## Quality Committee, 02/04/20

Sarah Dunnett

Summary of Quality C'ttee, 02.04.20.pdf (1 pages)

**04-26**

## Finance and Performance Committee, 28/04/20

Neil Griffiths

Summary of Finance and Performance C'ttee 28.04.20.pdf (1 pages)

**04-27**

## To consider any other business

David Highton

***Date of next meeting: 21st May 2020, 9.45am***

# MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 26TH MARCH 2020, 9.45 A.M, VIA WEBCONFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

**FOR APPROVAL**

| | | | |
|---|---|---|---|
| Present: | David Highton | Chair of the Trust Board | (DH) |
| | 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 | 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) |
| | Simon Hart | Director of Workforce | (SH) |
| | Amanjit Jhund | Director of Strategy, Planning & Partnerships | (AJ) |
| | Sara Mumford | Director of Infection Prevention and Control | (SM) |
| | Jo Webber | Associate Non-Executive Director | (JW) |
| | Kevin Rowan | Trust Secretary | (KR) |
| | Kathryn Brown | Transformation Programme Manager (for items 03-8 and 03-9) | (KB) |
| | Rita Lawrence | Associate Director of Organisational Development (for items 03-8 and 03-9) | (RL) |
| Observing: | Aoife Cavanagh | Deputy Director of Quality Governance | (AC) |
| | Wendy Glazier | Associate Director, Quality Governance | (WG) |

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

DH acknowledged that the meeting was not being held in public, but noted that the agenda and reports had still been made available on the Trust's website, and the minutes of meeting would also be made publically available, as per the Trust's usual process. DH added that national guidance on the issue was expected but the approach had been replicated at many other Trusts.

## 03-1 To receive apologies for absence

Apologies were received from Sean Briggs (SB), Chief Operating Officer, as DH stated that he had agreed to MS' request to excuse SB from the meeting, to enable him to focus on the Trust's COVID-19 response.

## 03-2 To declare interests relevant to agenda items

DH declared that he remained the interim Chair of the Kent and Medway Sustainability and Transformation Partnership (STP) until the end of March 2020.

## 03-3 To approve the minutes of the 'Part 1' meeting on 27th February 2020

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

## 03-4 To note progress with previous actions

The circulated report was noted. The following actions were discussed in detail:

- **01-9.6 ("Arrange for the revised Integrated Performance Report to be reviewed, in response to the comments made at the Trust Board meeting on 30/01/20 and to determine whether it was operating as effectively as intended").** DH noted that the report of the review would be submitted to the Trust Board meeting in May 2020.

- **01-9.7 ("Ensure that the review of the revised Integrated Performance Report that was requested at the Trust Board meeting on 30/01/20 consider the appropriateness of the current workforce-related Key Performance Indicators in the "Well-Led" domain"").** DH noted that the report of the review would be submitted to the Trust Board meeting in May 2020.
- **01-14b ("Ensure that all Trust Board Members received the report submitted for the "Update on IT strategy and related matters" item at the Finance and Performance Committee meeting on 25/02/20").** KR reported that the "Update on IT strategy and related matters" item had again been deferred from the Finance and Performance Committee and was currently scheduled to be considered at the Committee's meeting in April 2020. KR therefore queried whether the Trust Board still felt the action was important enough to remain open and following a discussion it was confirmed that the action should be closed.
- **02-5 ("Liaise to consider the future of the "Safety moment" item at the Trust Board (including the frequency of the item), taking into account the Trust's potential future improvement programme relationship with Western Sussex Hospitals NHS Foundation Trust").** It was noted that the work was continuing, but was not yet complete.
- **02-8 ("Liaise to explore how the ratings within the Board Assurance Framework could be synchronised with the forecast ratings within the Integrated Performance Report"). Noted work was continuing.** DH acknowledged that the Board Assurance Framework for 2020/21 would be different and discussions would be needed outside the Trust Board meeting.

**03-5 Safety moment**

COB referred to the relevant attachment and highlighted the key points therein. DH asked whether the "Safety moment" would continue over the next few months. SDu suggested that "Safety moments" continue, given the need to ensure that non-COVID-19 patients were safe. DH acknowledged the point but clarified that his query related to whether the current format of "Safety moments" would continue, with specific action scheduled each week during the month. COB noted that the "Safety moment" for April 2020 had already been planned, but noted that this would now be reconsidered. It was therefore confirmed that the decision regarding the future of "Safety moments" should rest with members of the Executive Team.

SDu then referred to the "The Good" example of a completed Mental Capacity Assessment and noted that the form referred to a patient called "Gabriella Jenson" who was given the title "Mr". COB acknowledged the error.

**03-6 Report from the Chair of the Trust Board**

DH referred to the relevant attachment and invited questions or comments. None were received.

**03-7 Report from the Chief Executive**

MS referred to the relevant attachment and invited questions or comments. None were received.

**03-8 Update on the Trust's response to COVID-19 (Incl. an update on the 2020/21 Operating Plan)**

MS reported the latest position in relation to COVID-19 patients (including the number of deaths); capacity planning (including the planning being undertaken with local private healthcare providers); the plans for a potential 'super surge' of cases; Personal Protective Equipment (PPE) provision for staff; social distancing (including the arrangements with the retail outlets at Maidstone Hospital (MH) and Tunbridge Wells Hospital (TWH)); hospital visiting arrangements; the impact of COVID-19 on reducing capacity in outpatients; the current and planned arrangements for staff to work from home; and the impact on the Trust's 'business as usual' activity. On the latter point, MS noted that the Executive Team Meeting on 24/03/20 had agreed to defer the implementation of the Electronic Patient Record (EPR), on the basis that proceeding with the scheduled 'go live' date would require significant User Assessment Testing over the coming weeks, which would not be feasible, given the COVID-19 situation.

MS also gave details of the plans regarding non-COVID-19 patients, which included the transfer of stroke rehabilitation patients to another facility.

MS then invited PM to speak. PM commended and thanked the staff for their response to the current situation, which was very challenging. PM then gave further details of the approach being taken to PPE, including FFP3 masks. PM elaborated on the issues affecting staff, and the Trust's response. PM also noted that iPads had been provided to enable patients to communicate with their relatives, given the restrictions on visiting.

PM continued that the peak of the surge in COVID-19 cases was expected on or around 11/04/20, and gave details of the plans to cope, as well as the partnership working that was taking place with other local provider organisations and GPs. PM emphasised that prioritisation and communication with staff were the key factors. PM also reported that the COVID-19 Incident Command Centre seemed to be working well; clinical pathways had been written, and agreed by the Clinical Reference Group for all clinical areas in the 'green' and 'amber' phase, but further work was required for the 'red' and 'black' phases; and national guidance on triaging was expected, which would be implemented after being agreed locally.

PM then asked SM to comment further on PPE. SM stated that the situation was challenging as there were different views on what PPE should be used, but the Trust was adhering to the Public Health England (PHE) guidance, rather than the guidance issued by the Royal Colleges. SM added that extra precautions were also being given within the areas in which COVID-19 patients had been cohorted. SM also gave details of the protection being given to portering staff.

SM then gave details of the staff testing that was being undertaken, noting that laboratory capacity was being increased, but until that was completed, it would not be possible to test all of the staff that needed testing. MS asked SM to comment on how the Trust's testing related to NHS workers at organisations without laboratories. SM reported that it was intended to extend the Trust's testing to include first responders, but the Trust was not yet ready to enact that step.

MS then asked COB to speak. COB reported that confidence of the staff in the use of PPE was one of the largest challenges, while overseas nurses were finding the situation very difficult, so work was taking place to allay their fears. COB also stated that shift patterns were being reviewed, as staff were under pressure and were working long days.

COB then stated that the Friends and Family Test (FFT) and Commissioning for Quality and Innovation (CQUIN) targets had been stood down, to enable staff to focus on COVID-19. COB added that staff had been asked to ensure that emerging issues were added to their risk registers, so these could be discussed at the Quality Committee; while third year nursing students had volunteered to help and the Trust was finalising the necessary arrangements.

CO continued that emergency legislation would be passed to enable nurses who had not yet passed their Objective Structured Clinical Examination (OSCE) to work, and the Trust was supporting such staff. COB added that the Trust was also exploring other issues, including supporting families of patients who had died.

DH then invited SO to speak. SO reported that the rules were being updated regularly, at a national level, on how the finance system would work, but a preliminary payment of revenue and capital had already been made to the Trust. SO added that the Trust's procurement team had worked hard to secure equipment, and was working with other Trusts to help each other obtain the PPE and other equipment each Trust required.

SO added that the number of Virtual Private Network (VPN) tokens had been increased markedly to support home working, but the current supply of laptops had been exhausted, so the Trust would deliver desktop PCs to staff. SO also reported that the Trust's firewalls had been adjusted, but the Trust had seen an increase in the number of cyberattacks, which was one of the reasons staff were not being allowed to use their own IT devices.

SH then reported that there had been a marked increase in staff joining the Trust Bank, so national guidance was being followed. SH continued that psychological support was being provided, particularly for staff in the 'at risk' groups, such as those who were pregnant; while the Trust was working with the nurseries at MH and TWH to provide additional nursery spaces for staff.

AJ then reported that work was taking place to model the number of COVID-19 cases, though the national modelling data was being used as the 'gold standard'. AJ continued that there was a paucity of data points, so data from overseas was being used, and modelling showed that the local peak in cases was expected to occur between 16/04/20 and 22/04/20, noting that the national peak was expected to occur between 11/04/20 and 14/04/20, although the Trust was planning for the national peak dates.

DH asked whether the outsourcing of activity to private healthcare providers created a tension with releasing the Trust's own orthopaedics and anaesthetic staff. PM explained that a 'red' rota for anaesthetic staff would be introduced on 27/03/20 and gave further details.

DH also noted that he had joined the latest meeting of the COVID-19 Ethics Committee and asked PM where that forum reported to, in terms of Trust Board oversight. PM replied that the outcome of the COVID-19 Ethics Committee was reported to the Executive Team Meeting, and suggested that DH provide Trust Board oversight. DH noted that that it had been suggested at the meeting that had been held with Non-Executive Directors before the 'Part 1' Trust Board meeting that the COVID-19 Ethics Committee should report its output to the Quality Committee. MC expressed her support for that suggestion and PM agreed to implement that arrangement.

**Action: Arrange for the output from the COVID-19 Ethics Committee to be reported to the Quality Committee (Trust Secretary / Medical Director, March 2020 onwards)**

SDu asked about the arrangements for non-COVID-19 patients who required critical care. PM stated that the Trust's ICU capacity had been divided into COVID-19 and non-COVID-19 patients and elaborated on the specific arrangements, including the arrangements that were intended for the anticipated aforementioned 'super surge'.

SDu then referred to the "Daily staff briefing" issued by the COVID-19 Incident Command Centre and PM's YouTube videos, and opined that she did not believe these provided the information staff required, particularly for those needing PPE. SDu added that staff may not have the time to view a 30-minute video. PM acknowledged the points and MS agreed to arrange for the effectiveness of the "Daily staff briefing" to be tested with frontline staff.

**Action: Arrange for the effectiveness of the "Daily staff briefing" issued by the COVID-19 Incident Command Centre to be tested with frontline staff (Chief Executive, March 2020)**

RF then referred to the Trust's wider communications, echoed SDu's views on internal communications, and asked whether sufficient resources were being allocated to external communications. MS explained the external communications arrangements, including the daily stakeholder briefing that was issued, and noted that all media requests had been responded to in timely manner. MS added that the arrangements were however likely to be managed on a Kent and Medway wide basis in the future. RF asked whether sufficient proactive work was taking place. MS explained the wider context in which the Trust's external communications operated but confirmed he was content to consider any suggestions. DH stated that he would expect the Trust's local population to be assured on the work being done at the Trust, to give public confidence. MS acknowledged the point and stated that he would reflect on the comments made. JW added that it would helpful to express gratitude to the public for staying away from the Trust's sites. MS agreed.

**03-9 Outcome of the diagnostic phase of the Exceptional People Outstanding Care programme**

SO introduced the item and noted that it had originally been intended to include members of the change team in the presentation, but that had to be adjusted due to the COVID-19 situation. SO added that it was however more important than ever to focus on the Trust's culture and leadership.

KB then gave a presentation which covered "Our Culture as at January 2020"; "Diagnostics"; "Data Analysis Methodology"; "Board Interviews"; "Behaviour Survey"; "Culture and Outcomes Dashboard"; "Workforce Leadership Analysis"; "Culture Conversations"; and "Patient Experience". RL then continued with the presentation, which covered "How to improve our culture"; "Actions and next steps"; and "Current and future priorities". SO then presented details of the "Phase 2 – Design", which emphasised the need to test the findings from Phase 1.

RF emphasised the need for the Trust to not stop investment in its leaders. RF also suggested that another “Quick Win” would be to carry out a ‘pulse’ survey of the staff involved with the COVID-19 situation, to understand how they were thinking and feeling as the crisis continued. RF also stated that he was unsure how the programme aligned with other work. The suggestions and points were acknowledged.

JW asked for further details of the “Patient Experience” aspects. KB obliged the request and gave details of the findings and the intended approach. SO added that the work had identified lots of recommendations from staff about improvements that had not been put forward via other means.

EPM confirmed that the work would feature at each meeting of the Workforce Committee and RL would be invited to attend the Committee’s meetings. EPM asked what the response had been from members of the Executive Team. SO noted that the detailed findings had not yet been considered at the Executive Team Meeting, but from his perspective, he had not been surprised by the findings.

SDu welcomed the presentation of the detailed findings and noted the vast amount of work that was being done to support staff during the COVID-19 period. SDu also emphasised the need to reinforce the positive work that was being done for staff, and the significant changes that had been made within a few days. SDu added that COVID-19 was likely to be present for a long time, perhaps 12 months or more, until a vaccine was developed, and it was therefore important to be positive. SO agreed but noted the need to do more, given the experiences of frontline staff.

SDu then asked about the support being given to staff who had been asked to return to the Trust having previously left. SH explained the approach being taken to such staff and acknowledged the need to honestly communicate on any issues where the Trust could have done better.

MS summarised by stating that there was a significant amount of information to digest, which the members of the Executive Team had not yet been able to discuss, so proposed that RL and KB proceed with the work, but appealed for further clarity on what the key messages were, what issues required a response, and what actions needed to be taken, accepting that the action plan would evolve. MS also noted that he would not expect a planning blight because of the COVID-19 period. SDu referred to the workshop that had been held with Western Sussex Hospitals NHS Foundation Trust and appealed for the work to only focus on a small number of priorities. DH acknowledged the point, but cautioned against aiming solely for a small number of “Quick Wins”, as these would inevitably need to involve ‘top down’ actions. DH therefore emphasised the need to engage with staff in designing the Trust’s response.

**Integrated Performance Report**

**03-10 Integrated Performance Report for February 2020**

DH referred to the relevant attachment and asked each member of the Executive Team to highlight any points of note.

**03-10.1 Safe (incl. update on progress with the Perinatal Mortality Review Tool; and planned and actual ward staffing for February 2020)**

COB referred to relevant attachment and highlighted the key points therein, which included the Never Event that had occurred in February 2020, and the fact that the falls target for 2019/20 would not be achieved.

**03-10.2 Safe (infection control)**

The circulated report was noted.

**03-10.3 Effective**

The circulated report was noted.

**03-10.4 Caring**

COB gave details of complaints response performance, including the current position for March 2020. COB added that the Trust was considering extending the timescale for complaints responses during the COVID-19 period, but no decision had yet been made. COB added that consideration was also being given as to how to involve staff who were working at home in the complaints response process.

COB also reported that the performance on the FFT had been poor in recent months but, as had been noted under item 03-8, the FFT process had been stopped because of COVID-19.

**03-10.5 Responsive**

In SB's absence, MS referred to the relevant attachment and highlighted the key points therein, which included the latest performance on the Emergency Department 4-hour waiting time target and elective care.

**03-10.6 Well-Led (finance)**

SO referred to the relevant attachment and highlighted the key points therein, which included that SO was confident that the Trust would achieve its planned year end position, once COVID-19-related costs had been excluded.

SO then gave details of some of the COVID-19-related finance arrangements that had been introduced, noting that these had been discussed in detail by the Finance and Performance Committee on 24/03/20. SO noted that a block contract would be in place and the timetable for the submission of the 2019/20 Annual Accounts had been changed. SO added that the latter point would require changes to the scheduling of the Trust Board's approval of the Accounts, which was currently scheduled for May 2020. SO added that KR would arrange the revised scheduling.

**03-10.7 Well-Led (workforce)**

SH referred to the relevant attachment and highlighted the key points therein, which included the final rate achieved for the staff flu vaccination campaign, which had been very good.

EPM then asked whether the Integrated Performance Report would continue to report the same information as the Trust entered a new financial year. MS replied that the default position was to continue to report the same information, but work was taking place to review whether the reporting of some indicators could be temporarily suspended. DH pointed out that budgetary control would need to continue. SO agreed and suggest that he submit some proposals to the Finance and Performance Committee on how such control could be monitored.

**03-11 Review of Nurse staffing Ward and non-Ward areas (major review)**

COB referred to the relevant attachment and highlighted the key points therein, which included the methodology for the review, and the 21% 'head room' allowance that was in place to cover leave. COB also noted that the recommendations from the review were subject to due process and governance, and actions were not enforced 'top down'.

COB continued that the acuity model within the HealthRoster IT system was not embedded and although this would be addressed in due course, now was not the time for such action.

DH noted that the current arrangements for cohorting COVID-19 patients would mean that the staffing arrangements would be different for the future period. COB agreed and confirmed that there would be no national guidance on safe staffing during COVID-19, so it would be up to Trusts to determine safe staffing levels and work on that issue was underway at the Trust.

MC noted that there had been some discussion at a national level about changing the ICU staffing ratio during the COVID-19 period from one staff member per patient to one staff member per six patients and asked COB how that potential change had been received. COB explained the work that was taking place to upskill non critical care staff to work in critical care and noted that although such discussions had started, they had not yet concluded. PM added that the General Medical

Council and Nursing and Midwifery Council had issued some supportive words regarding the situation and it was clear that a different way of working would have to be found.

**Board Assurance Framework (BAF)**

**03-12 Review of the Board Assurance Framework 2019/20**

DM referred to the relevant attachment and highlighted the key points therein, which included that the BAF had been discussed at length at a number of forums, including the Audit and Governance Committee, on 19/03/20. DH also noted that there was confidence that 8 of the 12 objectives would be achieved, which would be a reasonable performance. KR added that there was a time lag and although some performance data was now available for March 2020, such data had not been able to be reflected in the BAF.

**Quality items**

**03-13 Quarterly mortality data**

PM referred to the relevant attachment and highlighted the key points therein, which included the work undertaken by the Mortality Surveillance Group regarding mortality related to renal failure.

PM also commented on the likely approach to be taken in relation to reviewing the deaths of patients with COVID-19. SM suggested the option of training clinical staff from specialities whose clinical activity had been reduced to undertake mortality reviews. PM noted that the suggestion would need to be discussed with the Chief of Service for Medicine & Emergency Care, who chaired the Mortality Surveillance Group.

**Assurance and policy**

**03-14 To approve a proposal to temporarily extend the delegated expenditure limits for members of the Executive Team**

DH referred to the relevant attachment and highlighted the key points therein. DH pointed out that the Finance and Performance Committee meeting on 24/03/20 had been notified of the proposal, and gave its support.

The proposal was approved as submitted.

**03-15 Update from the Senior Information Risk Owner (SIRO) (incl. approval of the Data Security and Protection Toolkit submission for 2019/20, and Trust Board annual refresher training on Information Governance)**

COB referred to the relevant attachment and highlighted the key points therein, which included that the deadline for submission of the Data Security and Protection Toolkit had now been extended to 30/09/20 because of the COVID-19 period. DH asked whether the Trust still intended to make a submission by the original deadline (of 31/03/20). COB stated that she understood the Trust would likely make a submission now, but may consider making a submission later in the year.

The proposed submission for the Trust's 2019/20 Data Security and Protection Toolkit was approved as submitted.

**03-16 Six - monthly update on Estates and Facilities**

SO referred to the relevant attachment and highlighted the key points therein, which included the Estates and Facilities review undertaken by The Grichan Partnership. MS proposed that the outcome of the review be submitted to the Trust Board meeting in April 2020. This was agreed.

**Action: Schedule the outcome of the Estates and Facilities review undertaken by The Grichan Partnership for consideration at the Trust Board in April 2020 (Trust Secretary, March 2020 onwards)**

DH then asked for an update on the construction of the additional car parking capacity. MS reported that the additional capacity was expected to be ready in approximately two to three

weeks, but that was dependent on any government decision to halt construction activity, as had been the case in Scotland. DH noted that hospital construction had been allowed continue in Scotland. The point was acknowledged.

DH asked whether the delayed implementation of International Financial Reporting Standard (IFRS) 16 (leases) had enabled the Trust to obtain a better deal for the construction. SO replied that the Trust was bound by the deal it had already signed, but the delay to IFRS 16 would have a beneficial impact on the Trust's income and expenditure position, at least in the first quarter of 2020/21, of about £800k.

**Annual Report and Accounts**

**03-17 Confirmation of the outcome of the Trust's 'going concern' assessment**

SO referred to the relevant attachment and highlighted the key points therein. KR pointed out that the specific text of the statement that would be included in the Trust's 2019/20 Annual Accounts and Annual Report would need to change from that within the report, as, for example, the dates of the planning submissions for 2020/21 had now been changed due to the COVID-19 period. The point was acknowledged.

The proposed statement was approved, subject to the amendments that would be required following the changes to the 2020/21 planning process and other COVID-19 related changes.

**Reports from Trust Board sub-committees**

**03-18 Patient Experience Committee, 04/03/20**

MC referred to the relevant attachment and highlighted the main points therein. Questions were invited. None were received.

**03-19 Quality Committee, 11/03/20**

SDu referred to the relevant attachment and highlighted the main points therein, which included the concern raised regarding the patient transport contract that was managed by West Kent Clinical Commissioning Group. SDu added that the update that had been requested on the issue should however be given at a future point, as it was not a priority at the present time.

**03-20 Audit and Governance Committee, 19/03/20**

The circulated report was noted.

**03-21 Finance and Performance Committee, 24/03/20**

NG referred to the relevant attachment and highlighted the main points therein. Questions were invited. None were received.

**03-22 Charitable Funds Committee, 24/03/20**

DH noted that a written report would be submitted to the Trust Board's meeting in April 2020, but DM reported that it had been agreed to establish a Charity Management Committee, to coordinate fundraising across the Trust.

**03-23 To consider any other business**

There was no other business.

# MINUTES OF THE EXTRAORDINARY TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 16TH APRIL 2020, 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 | Chief Finance Officer | (SO) |
| | Emma Pettitt-Mitchell | Non-Executive Director | (EPM) |
| | Miles Scott | Chief Executive | (MS) |
| In attendance: | Richard Finn | Associate Non-Executive Director | (RF) |
| | Simon Hart | Director of Workforce | (SH) |
| | Amanjit Jhund | Director of Strategy, Planning & Partnerships | (AJ) |
| | Sara Mumford | Director of Infection Prevention and Control | (SM) |
| | Jo Webber | Associate Non-Executive Director | (JW) |
| | Lynn Gray | Deputy Chief Operating Officer | (LG) |
| | Kevin Rowan | Trust Secretary | (KR) |

**04-1 To receive apologies for absence**

No apologies were received.

**04-2 To declare interests relevant to agenda items**

NG declared that he was the UK Managing Director of TeleTracking Technologies International, the company that provided the preferred option in the Business Case for realtime patient flow Command Centre capabilities to support a response to COVID-19 that would be considered at the 'Part 2' Trust Board meeting scheduled for later that day.

DH noted that he was no longer the interim Chair of the Kent and Medway Sustainability and Transformation Partnership.

**04-3 To approve the motion to delegate the authority to the 'Part 2' Trust Board meeting scheduled on 16th April 2020 to approve a Business Case for realtime patient flow Command Centre capabilities to support a response to COVID-19; and to provisionally approve COVID-19 guidance to support clinical decision-making.**

The motion was approved and the requested authority was therefore delegated.

**04-4 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] |
|---|---|---|---|---|
| 01-9.6 | Arrange for the revised Integrated Performance Report to be reviewed, in response to the comments made at the Trust Board meeting on 30/01/20 and to determine whether it was operating as effectively as intended | Chief Finance Officer | March 2020 | It was instead confirmed at the Trust Board meeting on 27/02/20 that it was intended to introduce the new style report for the data for the first month of 2020/21, which would mean the report submitted to the Trust Board meeting in May 2020. |
| 01-9.7 | Ensure that the review of the revised Integrated Performance Report that was requested at the Trust Board meeting on 30/01/20 consider the appropriateness of the current workforce-related Key Performance Indicators in the "Well-Led" domain | Chief Finance Officer / Director of Workforce | March 2020 | It was instead confirmed at the Trust Board meeting on 27/02/20 that it was intended to introduce the new style report for the data for the first month of 2020/21, which would mean the report submitted to the Trust Board meeting in May 2020. |
| 01-15 | Ensure that the recommendations from the Case Reviews published by the National Guardian's Office were included in future quarterly reports from the Freedom to Speak Up Guardian (along with the details of any action/s required by the Trust in response) | Freedom to Speak Up Guardian | April 2020 | The intention is to incorporate the requested information into the quarterly report from the Freedom to Speak Up Guardian that is scheduled for discussion at the Trust Board meeting on 30th April 2020. |
| 02-8 | Liaise to explore how the ratings within the Board Assurance Framework could be synchronised with the forecast ratings within the Integrated Performance Report | Trust Secretary / Chief Finance Officer | February 2020 onwards | Liaison has occurred and consideration is being given as to how the Board Assurance Framework (BAF) needs to / should be amended for 2020/21, in recognition that the format and operation of the BAF will be influenced by the Trust's proposed relationship with Western Sussex NHS Foundation Trust (which is anticipated to commence later in 2020). In the |

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

| Ref. | Action | Person responsible | Original timescale | Progress[1] |
|---|---|---|---|---|
| | | | | meantime, the Chief Finance Officer will discuss the methodology involved in developing the forecast ratings within the Integrated Performance Report with the Associate Director of Business Intelligence. |

**Actions due and 'closed'**

| Ref. | Action | Person responsible | Date completed | Action taken to 'close' |
|---|---|---|---|---|
| 02-5 | Liaise to consider the future of the "Safety moment" item at the Trust Board (including the frequency of the item), taking into account the Trust's potential future improvement programme relationship with Western Sussex Hospitals NHS Foundation Trust | Chief Nurse / Medical Director / Director of Infection Prevention and Control | April 2020 | Liaison has occurred, and the value of the "Safety moment" report has been reconsidered. It has been agreed that the "Safety moment" report submitted to the meeting of the Trust Board on 30th April 2020 will be the last "Safety moment" report in this format that will be submitted to the Trust Board (and therefore to all Trust Board sub-committees). It has instead been agreed that key safety issues will be incorporated into the Trust's learning events, once the Trust is in a position to launch the events. However in the meantime, the "Governance Gazette" will be used to share key messages". |
| 02-8.3 | Arrange for an "Update on the establishment of the Hyper Acute Stroke Unit at Maidstone Hospital" report to be submitted to the Trust Board in April 2020 | Medical Director / Chief Operating Officer | April 2020 | An update has been submitted to the April 2020 Trust Board meeting. |
| 03-8a | Arrange for the output from the COVID-19 Ethics Committee to be reported to the Quality Committee | Trust Secretary / Medical Director | April 2020 | The output from the COVID-19 Ethics Committee has been scheduled to be submitted to the next meeting of the Quality Committee (6th May 2020), and will be submitted to subsequent meetings as a standing item. |
| 03-8b | Arrange for the effectiveness of the "Daily staff briefing" issued by the COVID-19 Incident Command Centre to be tested with frontline staff | Chief Executive | April 2020 | The effectiveness was tested via a staff 'pulse' survey that took place in April (the findings from which are scheduled to be considered at the Workforce Committee meeting on the afternoon of 30th April 2020). |
| 03-16 | Schedule the outcome of the Estates and Facilities | Trust Secretary | March 2020 | A verbal update has been scheduled for the Trust Board |

| Ref. | Action | Person responsible | Date completed | Action taken to 'close' |
|---|---|---|---|---|
| | review undertaken by The Grichan Partnership for consideration at the Trust Board in April 2020 | | | meeting in April 2020, with a more substantial update scheduled for the Trust Board meeting in April 2020. |

**Actions not yet due (and still 'open')**

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

**Safety Moment** **Chief Nurse / Medical Director**

The Safety Moment for April has been focussed on safeguarding children.

The enclosed report contains a summary of the key messages that have been shared each week.

Trust Board members should note that this will be the last "Safety moment" report in this format that will be submitted to the Trust Board (and therefore to all Trust Board sub-committees). In response to the feedback from recent Trust Board meeting, the value of the "Safety moment" report has been reconsidered and it has been agreed to incorporate key safety issues into the Trust's learning events, once the Trust is in a position to launch the events. However in the meantime, the "Governance Gazette" will be used to share key messages.

**Which Committees have reviewed the information prior to Board submission?**
- Finance and Performance Committee, 28/04/20

**Reason for receipt at 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

**Week One 03/04/2020**

**Domestic Abuse in Pregnancy and Safeguarding Children**

Domestic abuse is defined as 'any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to psychological, physical, sexual, financial and or emotional abuse.
Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.'
Domestic abuse can start, or escalate during pregnancy. On average victims will experience 50 episodes of abuse before they ask for help, and will attempt to leave 2-3 times before they are successful. Victims may tell you that their children don't witness the abuse, or that domestic abuse cannot harm an unborn baby. Research highlights that domestic abuse puts children / unborn babies at risk of both physical and emotional harm.
Children who have been living in an abusive home can experience anxiety, depression, sleep disturbance; they may have low self-worth, or exhibit behavioural problems such as aggression, regressive behaviour, temper tantrums or enuresis; they may truant or be disruptive at school. Children may exhibit physical pain; unborn babies are at risk of these problems as they grow and develop. Children who have been victims of domestic abuse may grow up to become abusers themselves, or to be victims of domestic abuse because to them these are normal behaviours. Therefore, it is imperative that clinicians keep domestic abuse at the forefront of our minds. Victims report that they wanted a professional to ask: 'how are things at home?' and to keep asking at every opportunity.

**Week Two 10/04/2020**

**Safeguarding Children in the Emergency Department (ED)**

Within an Emergency Department (ED) professionals play a vital role in identifying the signs of child abuse and neglect and acting on these concerns. The team will work together to gather details that enables a safeguarding risk assessment to be carried out on **every** child and young person attending.
From the reception team to the discharging practitioner information gathering is fundamental. Using a combination of observation, knowledge, and clinical skills enables a holistic approach to make a complete assessment.
On registering in ED, all demographics must be recorded, along with information as to who has brought the child to the department and their relationship to that child. Understanding who has parental responsibility is important, as it enables the ED team to gain consent for treatment or a procedure; if a request for support is required to be sent to children's services (previously known as a referral to social services) consent MUST be sought from the adult/carer with parental responsibility. It is the responsibility of the ED team to document what the parent/child relationship looks like.
When an adult attends ED it is vital that information is documented about children who live with them - this should always be done for any adult attending with a Mental Health crisis, substance misuse concerns of as a victim of Domestic Abuse. This is about staff thinking 'family' and not just focussing on the patient in ED.
**Safeguarding Assessment** - Every child and young person must have a safeguarding risk assessment completed. The questions are designed to act as an aide memoir for the ED practitioners. They are based on research that provide us with some known safeguarding concerns. For example all families will be routinely asked if they are "*known or open to social services?"* We know from research that a history of Children's Social Services involvement (current or historical) means that they may be at an increased risk of significant harm again (**Working Together 2018**)
**Child Protection Information System (CP-IS) -** If the child is open to children's services CP-IS will share the details of the named Social Worker; this information enables the ED practitioners to inform the Social Worker that the child has presented to ED (whether there is a safeguarding

concern or not). It is mandatory to inform a Social Worker of a child's presentation to ED for any reason. This duty also extends to all children who are designated as **Looked After Children** (Child in Care). This vulnerable group have already been assessed to be at significant risk of abuse or may have suffered abuse already. Again information sharing is key.
The pathways followed within the ED and actions taken are supported with ongoing training and ad hoc supervision as required by The Royal College of Paediatrics and Child Health (RCPCH). Together we work to safeguard all children and young people.

**Week Three 17/04/2020**

**Learning from Child Safeguarding Practice Reviews**
**(Formerly known as Serious Case Review's)**

**What is a Child Safeguarding Practice Review (CSPR)?**

A CSPR is a multi-agency review into the circumstances of a child death or where a child sustains serious harm and abuse or Neglect are suspected; about 50/year are published. The purpose of a CSPR is to:

- Establish whether there are lessons to be learnt from the case about the way professionals and organisations work together to safeguard children.

- Identify clearly what the lessons are, how they will be acted on, and what is expected to change as a result; its aim is to improve inter-agency working to better safeguard children.

A review is not a criminal enquiry and is not about blame; it is an open and transparent process about learning from practice to improve inter-agency working

**What is the process of a CSPR?**

Once there is agreement that a CSPR will be commissioned a panel will meet to look closely at the work of all the professionals and agencies who were involved with the child. Each organisation will produce an independent report containing the full details of when and what services they provided to the child and family. An Independent Reviewer will consider all the reports and will write an overview report on all the information known.

When the Review has been completed, organisations will agree what actions they may need to take to change the way they support children, young people and their families and these will be monitored by the LSCP.

**Family Involvement**

Families are encouraged to be part pf the process. If there is an on-going police investigation there will be a delay in family involvement.

**Who will see the report?**

The final report will be published on the LSCP website. In situations where this is not possible, an anonymised version may be made available on the NSPCC website. The report findings are shared with the family before publication.

Seven CSPR's have been published in Kent since 2017. They can be found via the following link – https://www.kscmp.org.uk/about-kscb/kscb/kent-scrs
The main themes identified are

- Poor information sharing – share what you know with relevant professionals
- Neglect – know what Neglect looks like and understand its impact on a child
- Fathers and their role in a family – who are the adults living in a child's home; is there a new male at home?
- Young parents – may have vulnerabilities in their own right

- Professionals who do not display ‘professional curiosity’ – ask questions; do not accept explanations at face value; do not collude with parents

Remember – safeguarding is everyone’s responsibility. This is enshrined in law. If you have a concern talk to the Safeguarding Children team for advice and support.

**Week Four 24/04/2020**

**Neglect and Non-Accidental Injury (NAI)**

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs which is likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy; where there is domestic abuse towards a carer, the needs of the child may be neglected.

Once a child is born, neglect may involve a parent failing to:

- Provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- Protect a child from physical and emotional harm or danger;
- Ensure adequate supervision (including the use of inadequate care-givers);
- Ensure access to appropriate medical care or treatment

It may also include neglect of, or unresponsiveness to, a child's basic emotional, social and educational needs.

There are **four types** of **neglect** –

- Physical neglect – a child not being provided with the basic necessities of life (food, clothing etc.)
- Medical neglect – health needs (physical or mental) not being met
- Educational neglect – lack of educational opportunities or stimulation
- Emotional neglect – lack of nurture, or ignoring, humiliating, intimidating or isolating a child

Neglect is very difficult to evidence – one sign doesn’t necessarily mean that a child is being neglected. Professionals need to recognise that there are a number of factors that can indicate neglect. These can include –

- Listless/apathetic child with no medical cause – under stimulation
- Abnormal growth patterns – faltering growth or high BMI
- Dental decay and/or untreated head lice
- Unmet health needs – what is the impact on the child of not being brought to a health appointment?
- Poor school attendance
- Children left with inappropriate or no care givers
- Families where there is a lack of routine/boundaries
- Poor engagement with services
- Child’s behaviour or presentation

Child neglect is the most common form of child maltreatment – over 12000 referrals to the NSPCC in 2019, with 18706 child cruelty offences recorded.

**Non-Accidental Injury (NAI)**
A NAI is any injury that is deliberately inflicted on a child; this may include hitting, kicking, burning, biting or choking. An NAI should be considered where there is a traumatic head injury, or no explanation (or multiple explanations) for the injury, a delay in seeking treatment or an unusual injury (e.g., a spiral fracture in a non-mobile child). Bruising in a non-mobile child should always be considered non-accidental until otherwise proven.

For any suspected NAI a body-map should be completed and the child should be admitted with consideration for a skeletal survey, head CT and bloods. The child must be reviewed by a Consultant Paediatrician.

**The most common sites for an NAI are:**

- Eyes
- Ears
- Cheeks
- Mouth
- Shoulders
- Chest
- Upper and inner arms
- Stomach/abdomen

Remember – safeguarding is everyone's responsibility. This is enshrined in law. If you have a concern talk to the Safeguarding Children team for advice and support.

**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 |
|---|---|---|---|---|---|
| 30/03/2020 | Dr | Phillip | Davidson | Respiratory | TBC |
| 30/03/2020 | Prof | Terry Foo Tat | Lim How | Respiratory | TBC |
| 02/04/2020 | Dr | Hermione | Race | Paediatrics | TBC |
| 02/04/2020 | Dr | Azhari | Elsoni-Ali | Paediatrics | TBC - July |

N. B. At the Trust Board meeting on 30/04/20, it was agreed to include retrospective clarification, on the report, that Dr Azhari was appointed as a locum consultant, for a six-month period.

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

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

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

**Report from the Chief Executive** **Chief Executive**

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

1. MTW featured in a special one-hour documentary, which aired on Channel 4 this month. Filmed by Bafta-winning, Oscar-nominated film-maker Wa'ad al-Kateab, the programme sensitively highlighted how coronavirus is affecting our local communities and our frontline teams.

2. The programme demonstrated the hard work, professionalism, dedication and compassion shown by our staff and the very highest levels of care we are providing to our most vulnerable patients when they need our help the most. I am extremely proud of all our staff and everything they've achieved in such a short space of time. Particular thanks to some of our teams working tirelessly behind the scenes, including our Infection Control and Prevention and Occupational Health teams who have been working round the clock to support staff on the frontline.

3. We continue to work with our partners across the region and nationally to respond to the Covid-19 (coronavirus) pandemic. Our services have coped well with the unprecedented challenges placed on us due to the preparations we've put in place and hard work of our staff as well as the social distancing measures local people are following. Thank you to our staff and our local communities for protecting the NHS.

   The initiatives we have implemented over the past month include:

   - We have adapted seven clinical areas at both hospital sites to provide specialist respiratory support for patients with suspected coronavirus or those who have tested positive. Suspected cases and confirmed positive patients are cared for in separate designated areas with separate clinical teams caring for them.
   - We have increased our critical care capacity to 92 beds (up from 15 across both sites). Thankfully we are not currently using the full capacity we've put in place to care for patients with coronavirus.
   - Around 80% of our outpatient appointments have been converted to telephone consultations with increasing numbers being conducted via video conference software.
   - Over 170 people have now been recruited to our staff Bank team to support clinical, administration and facilities roles. A number of retired nurses, doctors, midwives, laboratory assistants and therapists have also returned to the frontline.
   - We continue to work with the independent sector to ensure patients requiring cancer and emergency surgery have their procedures. We now have arrangements in place with Spire, Nuffield, Horder Centre, KIMS and QVH.
   - MTW has worked with other NHS trusts in the county and the University of Kent to significantly expand the region's capacity for testing staff with the potential to process 1500 tests a day. MTW has now tested more than 1,000 NHS and other frontline staff and our labs can process around 400 tests a day with the ability to scale up to approximately 750 tests a day.
   - MTW has opened a drive-through swabbing centre based at the Hop Farm, Paddock Wood, and two pods at both hospitals. This enables us to swab around 150 staff a day.
   - We have prioritised the welfare of our staff by setting up staff refuge areas in the academic centres to enable staff to take a break away from clinical areas; hosting online welfare and psychological support groups; question and answer sessions with senior leaders to ensure strong communications continues; offering free food and refreshments; opening a wobble room to give staff a quiet space if things get difficult; working with local nurseries to offer staff alternative childcare provision; and providing additional facilities for staff such as showers and comfortable furniture for rest areas.
   - Facilitating homeworking for priority vulnerable staff groups who are shielding/self-isolating

for 12 weeks by providing IT equipment to enable them to continue to work on key projects.

- We are now turning our attention to our recovery plan. We are assessing the adaptations and improvements we've rapidly implemented in response to coronavirus to see what's worked well and what could therefore be permanently adopted to further transform the services and care we provide. This could include supporting more remote working and looking at how some outpatient appointments could be carried out using video conference technology.

4. A huge thank you to our local communities and businesses for their support and generosity. Our staff have been overwhelmed and humbled by the fantastic offers and gestures of goodwill, from people fundraising for our Trust, to providing free food and treats, laundry bags and headbands, and messages of support and thanks. We are extremely grateful and encouraged by everyone's help and assistance.

5. The MTW Charity launched a fundraising appeal to support our NHS staff heroes on the frontline during the coronavirus pandemic. So far nearly £10,000 has been donated via Just Giving - https://www.justgiving.com/campaign/nhshero – the money is being used to fund welfare and wellbeing initiatives for staff.

6. MTW is participating in five high profile national research projects focused on investigating the effects of developing treatments for coronavirus (Covid-19). Thirty consultants have undertaken training and are involved in the trials. Our aim is for all patients with suspected or who have tested positive with coronavirus to be offered a place on at least one of these trials. So far nearly 300 patients have been recruited to participate.

7. MTW has delivered its financial plan for 2019/20 generating a surplus of £7m. This is the second year in a row we have achieved our financial target and means we will be able to continue to invest in improving our services for patients and staff.

8. Despite the unprecedented challenges our hospitals are facing, our emergency department teams continue to implement quality improvements to make sure those who need emergency care are seen promptly. As a result MTW has been placed the second best performing trust in the country for Emergency Department waiting times for the past two weeks – and has been in the top ten best trusts all winter.

9. The Executive structure for the newly formed Kent and Medway Clinical Commissioning Group has been shared with me. It will provide a strong and stable leadership to help establish and embed the new organisation within the region; take a lead responsibility for critical health and social care issues; and enable strong partnerships to be forged with other leaders on Integrated Care System priorities.

10. The Executive Directors and Chiefs of Service continue to meet weekly at Executive Team Meetings. Key areas of discussion over the past month have included:
    - Covid-19 response plans
    - Review of people and organisational development plan
    - Update on RTT, Emergency Department and Cancer waiting times performance
    - Update on implementation of the new Electronic Patient Record system
    - Review of financial plan

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

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

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

| **Integrated Performance Report, March 2020** | **Chief Executive / Members of the Executive Team** |
|---|---|

Enclosed is the Integrated Performance Report for month 12, 2019/20 (which includes the planned and actual ward staffing for March 2020).

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

- Finance and Performance Committee, 28/04/20 (in part)

**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

## March 2020

MTW
exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells NHS Trust

**Contents**



**Appendices** (Page 20 onwards)

- Finance Report
- Safe Staffing Report

**Scoring for Performance Wheel**

**Scoring within a Domain:**

Each category within the Balanced scorecard is given an overall RAG rating based on the rating of the KPIs within the domain on a YTD basis that appear on the balance scorecard (below) :

**Red** = 3 or more red KPIs within the domain
**Amber** = 2 red KPI rating within the domain
**Green** = No reds and 2 amber or less within the domain

**Overall Report Scoring:**

**Red** = 4 or more red domains
**Amber** = Up to 3 red domains
**Green** = No reds and 3 or less amber domains

*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

# Performance Wheel and Executive Summary

**Previous Month (Feb-20)**


**Current Month (Mar-20)**


**2019/2020 Full Year**


## Executive Summary

The Trust has achieved the National Cancer 62 Day FDT Standard of 85% for seven consecutive months at 85.6%. Both the 2 week wait cancer waiting times target and the 2 week wait Beast Symptoms were also achieved in February and have been above target for the last six months (with a slight dip for Breast Symptoms in January). In addition the Trust also achieved the trajectory for the A&E 4hr standard for March at 93.12% and was 1% below target for the year at 90.6%. The Referral to Treatment (RTT) standard achieved the year end target of 86.7% as at the end of February at 87.3%, prior to the impact of COVID-19.

The Trust has delivered the financial plan again in 2019/20 for the second year running during one of the most challenging periods the NHS has ever seen as well as improving the staff vacancy rate from 13.3% in April to 8.1% in March, against a plan of 8.0%.

The trajectory for C.Difficile for the year has been achieved once again, however the level of E.Coli Bacteraemia has increased but has shown a decreasing trend in recent months. Two cases of MRSA were reported for the the year (1 in March). The rate of Falls improved further in March to below the maximum limit at 5.93, however full year performance was just above the 6.0 maximum limit at 6.1. The number of hospital acquired pressure ulcers remained the same in March, but the rate increased, with the full year performance at 1.7, against a maximum limit of 1.3. The rates of falls, pressure ulcers and infection control will have been impacted by the COVID-19 pandemic in March due to the Trust having a lower level of occupied beddays and admissions. There have been no cases of Mixed Sex Breaches reported for the full year and the closure of SIs in a timely manner has continued to show an improving trend month on month throughout the year.

As expected due to the COVID-19 pandemic activity levels have decreased significantly for elective, Outpatient appointments, non-elective and A&E Attendances in March. However, A&E Attendances were 5.8% higher this year compared to last year, despite an estimate of 4,700 fewer in the second half of March and emergency admissions via A&E were around a third lower than usual in March. As expected performance for the Referral to Treatment (RTT) standard has been adversely affected in March by the cancellation of activity due to the COVID-19 Pandemic . The Trust continues to closely monitor the RTT Patient Pathways.

# Performance Wheel and Executive Summary

## Items for Escalation

- **Infection Control:** With the 4 cases of C.Diff reported in March the Trust has once again achieved the trajectory for the year with 52 cases reported against a maximum limit of 55. Cases of E.Coli have decreased again in March but the overall number and rate for the year was above the threshold. There have been 2 cases of MRSA reported (1 in March).

- **Falls:** The rate of Falls improved further in March to below the maximum limit at 5.93, however full year performance was just above the 6.0 maximum limit at 6.1. The rate was adversely affected by the reduction in the number of occupied beddays in March due to COVID-19 as if the levels had been similar to previous months the target may have been achieved.

- **Pressure Ulcers:** The number of hospital acquired pressure ulcers remained the same in March at 13, but the rate increased to 2.5 due to the lower level of occupied beddays. In line with NHSi guidelines the Trust has changed the way that pressure ulcers are recorded to include Deep Tissue Injuries (DTIs). The full year performance was 1.7, against a maximum limit of 1.3.

- **Stroke:** Performance against the metrics that constitute the Best Practice Tariff remains below the level the Trust aspires to achieve. Compliance with the tariff will improve as the consultant stroke rota is fully filled along with improvements in the timeliness of data capture and validation.

- **A&E 4 hour Standard:** A&E performance was above the submitted trajectory of 90.56% at 93.12% in March. Performance was 1% below target for the year at 90.6%. A&E Attendances were significantly lower in March due to the COVID-19 Pandemic with Minors down by around 60% to 65% and Majors down 30%. Emergency Admissions were also down by 30% to 35%.

- **Referral to Treatment (RTT) Incomplete Pathway:** The Referral to Treatment (RTT) standard achieved the year end target of 86.7% as at the end of February at 87.3%. As expected due to the COVID-19 pandemic activity levels have decreased significantly in March for both elective and outpatient appointments which will have adversely impacted the RTT performance for March (79.5%)

- **Cancer 2weeks (2ww):** Both the 2 week wait cancer waiting times target and the 2 week wait Beast Symptoms were also achieved in February and have been above target for the last six months (with a slight dip for Breast Symptoms in January). A Review of 2ww processes to accommodate COVID-19 government guidelines is taking place, ensuring patients have an appropriate clinical triage to review risk and communication is clear between GPs and patients.

- **Cancer 62 Day:** Performance against this target has been achieved for seven consecutive months (85.6%). This is a significant improvement throughout this year from the positon of 70.9% in April 2020. This report covers the 62 day standard for February 2020 treatments and had not had an impact from Covid-19 up to the end of February.

- **Diagnostics Waiting Times <6 weeks:** Performance deteriorated to 93.7% in March, which again was adversely impacted by COVID-19.

- **Finance:** The Trust was £0.1m adverse to plan in March but has delivered the year to date financial plan generating a surplus of £7m including PSF and MRET funding. The key variances to budget were: Underperformance in Private Patient Income (£2.4m net), RTT Income reserve (£1.2m), £2.7m CIP slippage (to internal savings plan), £1m overspend against outsourcing and overspends within expenditure budgets (£5m) which was mainly split between Medical Staffing (£2.8m) and non pay (£3m). These pressures have been partly offset by release of prior year provisions (£3.7m), release of £3.6m of reserves, QIPP income adjustment (£1.3m), PDC less than plan (£1m) and release of deferred income (£1m).

- **Workforce (various):** The overall staff fill rate has remained similar at 78.3% in March, which is the highest level all year. The Safe Staffing Nursing Fill Rate is currently showing 93%, however there may be some data anomalies due to COVID-19. Performance reflects high bed occupancy and escalated areas at the beginning of March with a change to closing wards, ward moves and re allocation of staff due to plans in place to support the COVID pandemic pathways in the latter part of the month.

- The overall sickness rate has reduced further in March but remains above the 3.3% maximum limit at 3.5%. The overall Trust vacancy rate reduced further in March to 8.1% against a target of 8%.

# Summary Scorecard

| Safe | | Curr Month | | Year to Date | | Year End | | Change on Prev Mth |
|---|---|---|---|---|---|---|---|---|
| ID | Key Performance Indicators | Plan | Actual | Prev Yr | Curr Yr | Plan | OT | |
| S1 | Rate C-Diff (Hospital only) | 19.0 | 23.7 | 22.8 | 21.4 | 22.4 | 21.4 | ↘ |
| S2 | Number of cases C.Difficile (Hospital) | 4 | 4 | 56 | 52 | 55 | 52 | → |
| S3 | Number of cases MRSA (Hospital) | 0 | 1 | 3 | 2 | 0 | 2 | ↘ |
| S4 | Rate of E. Coli Bacteraemia | 19.0 | 23.7 | 28.1 | 30.9 | 21.5 | 30.9 | ↗ |
| S5 | Rate of Hospital Pressure Ulcers | *1.26* | 2.5 | 1.3 | 1.7 | 1.3 | 1.7 | ↘ |
| S6 | Rate of Total Patient Falls | *6.00* | 5.93 | *6.21* | 6.09 | *6.00* | 6.09 | ↗ |
| S7 | Number of Never Events | *0* | 0 | 1 | 3 | 0 | 3 | → |
| S8 | Number of New SIs in month | 12 | 8 | 154 | 131 | 144 | 131 | ↗ |
| S9 | SIs not closed <60 Days Monthly Snapshot | 24 | 44 | - | 44 | 24 | 44 | ↗ |
| S10 | Overall Safe staffing fill rate | 93.5% | 93.0% | 96.8% | 95.9% | 93.5% | 95.9% | ↘ |

| Effective | | Curr Month | | Year to Date | | Year End | | Change on Prev Mth |
|---|---|---|---|---|---|---|---|---|
| ID | Key Performance Indicators | Plan | Actual | Prev Yr | Curr Yr | Plan | OT | |
| E1 | Hospital-level Mortality Indicator (SHMI) | Band 2 | 1.0080 | 1.0391 | 1.0080 | Band 2 | Band 2 | → |
| E2 | Standardised Mortality HSMR | Lower conf <100 | 91.8 | 99.4 | 91.8 | Lower conf <100 | 91.8 | → |
| E3 | % Total Readmissions | 14.1% | 14.6% | 13.6% | 14.8% | 14.1% | 14.8% | ↘ |
| E4 | Readmissions <30 days: Emergency | 14.8% | 15.2% | 14.1% | 15.3% | 14.8% | 15.3% | ↘ |
| E5 | Readmissions <30 days: Emergency (excl SDE | 14.0% | 15.7% | 13.9% | 14.7% | 14.0% | 14.7% | ↘ |
| E6 | Readmissions <30 days: Elective | 6.8% | 8.1% | 7.1% | 7.9% | 6.8% | 7.9% | ↗ |
| E7 | Stroke: Best Practice (BPT) Overall % | 50.0% | 37.0% | 50.0% | 41.7% | 50.0% | 41.7% | ↘ |
| E8 | Nat CQUIN: % Dementia Screening | 90.0% | 99.5% | 99.8% | 95.2% | 90.0% | 95.2% | → |
| E9 | Nat CQUIN: % Dementia Risk Asssessed | 90.0% | 97.6% | 93.5% | 101.7% | 90.0% | 101.7% | ↘ |
| E10 | Nat CQUIN: % Dementia Referred to Specialist | 90.0% | 97.6% | 99.1% | 99.1% | 90.0% | 99.1% | → |

| Caring | | Curr Month | | Year to Date | | Year End | | Change on Prev Mth |
|---|---|---|---|---|---|---|---|---|
| ID | Key Performance Indicators | Plan | Actual | Prev Yr | Curr Yr | Plan | OT | |
| C1 | Single Sex Accommodation Breaches | 0 | 0 | 35 | 0 | 0 | 0 | → |
| C2 | Rate of New Complaints | 3.92 | 3.62 | 2.30 | 2.43 | 2.93 | 2.43 | ↘ |
| C3 | % complaints responded to within target | 75.0% | 75.0% | 75.7% | 67.8% | 75.0% | 67.8% | ↑ |
| C4 | IP Resp Rate Recmd to Friends & Family | 25.0% | No data as not collected due to COVID-19 | 17.9% | 16.4% | 25.0% | 16.4% | ↗ |
| C5 | IP Friends & Family (FFT) % Positive | 95.0% | | 94.8% | 95.7% | 95.0% | 95.7% | → |
| C6 | A&E Resp Rate Recmd to Friends & Family | 15.0% | | 8.9% | 8.5% | 15.0% | 8.5% | ↑ |
| C7 | A&E Friends & Family (FFT) % Positive | 87.0% | | 92.0% | 87.7% | 87.0% | 87.7% | ↗ |
| C8 | Mat Resp Rate Recmd to Friends & Family | 25.0% | | 20.3% | 21.2% | 25.0% | 21.2% | ↓ |
| C9 | Maternity Combined FFT % Positive | 95.0% | | 98.4% | 95.5% | 95.0% | 95.5% | ↘ |
| C10 | OP Friends & Family (FFT) % Positive | 84.0% | | 81.2% | 82.6% | 84.0% | 82.6% | ↘ |

| Responsive | | Curr Month | | Year to Date | | Year End | | Change on Prev Mth |
|---|---|---|---|---|---|---|---|---|
| ID | Key Performance Indicators | Plan | Actual | Prev Yr | Curr Yr | Plan | OT | |
| R1 | Emergency A&E 4hr Wait | 90.6% | 93.1% | 92.1% | 90.6% | 91.7% | 90.6% | ↗ |
| R2 | Emergency A&E >12hr to Admission | 0 | 0 | 2 | 0 | 0 | 0 | → |
| R3 | Ambulance Handover Delays >30mins | 369 | 66 | 4487 | 5501 | 4428 | 5501 | ↑ |
| R4 | RTT Incomplete Pathway (October) | 86.7% | 79.5% | 83.1% | 79.5% | 86.7% | 79.5% | ↓ |
| R5 | RTT 52 Week Waiters (New in Month) | 8 | 16 | 77 | 81 | 96 | 81 | ↓ |
| R6 | % Diagnostics Tests WTimes <6wks | 99.0% | 93.7% | 99.2% | 93.7% | 99.0% | 99.0% | ↓ |
| R7 | Cancer two week wait | 93.0% | 93.2% | 89.2% | 93.2% | 93.0% | 93.2% | → |
| R8 | Cancer two week wait-Breast Symptoms | 93.0% | 93.5% | 74.7% | 93.5% | 93.0% | 93.5% | ↗ |
| R9 | Cancer 31 day wait - First Treatment | 96.0% | 98.9% | 96.2% | 98.9% | 96.0% | 98.9% | ↗ |
| R10 | Cancer 62 day wait - First Definitive | 85.0% | 85.6% | 56.0% | 85.6% | 85.0% | 85.6% | → |

| Responsive - Flow | | Curr Month | | Year to Date | | Year End | | Change on Prev Mth |
|---|---|---|---|---|---|---|---|---|
| ID | Key Performance Indicators | Plan | Actual | Prev Yr | Curr Yr | Plan | OT | |
| R11 | Average LOS Non-Elective | 6.40 | 7.82 | 6.94 | 6.95 | 6.40 | 6.95 | ↘ |
| R12 | Theatre Utilisation | 90.0% | 85.1% | 91.3% | 106.0% | 90.0% | 106.0% | ↗ |
| R13 | Primary and Non-Primary Refs | 17,241 | 10047 | 187,273 | 193711 | 199,052 | 193711 | ↘ |
| R14 | Cons to Cons Referrals | 4,495 | 4699 | 68,987 | 73560 | 51,898 | 73,560 | ↘ |
| R15 | OP New Activity | 19,586 | 14554 | 209,257 | 219593 | 226,133 | 219593 | ↘ |
| R16 | OP Follow Up Activity | 30,038 | 23535 | 316,538 | 338088 | 346,845 | 338088 | ↘ |
| R17 | Elective Inpatient Activity | 643 | 444 | 6,171 | 7024 | 7,426 | 7024 | ↘ |
| R18 | Day Case Activity | 4,349 | 2766 | 43,599 | 46925 | 50,210 | 46925 | ↘ |
| R19 | Non Elective Activity (inc Maternity) | 5,726 | 4776 | 64,187 | 66152 | 67,606 | 66152 | ↘ |
| R20 | A&E Attendances : Type 1 | 13,756 | 10337 | 155,838 | 164877 | 159,252 | 164877 | ↗ |

| Well-Led | | Curr Month | | Year to Date | | Year End | | Change on Prev Mth |
|---|---|---|---|---|---|---|---|---|
| ID | Key Performance Indicators | Plan | Actual | Prev Yr | Curr Yr | Plan | OT | |
| W1 | Surplus (Deficit) against B/E Duty | 1,872 | 1,815 | 12,006 | 7,003 | 6,896 | 7,003 | → |
| W2 | CIP Savings | 2,088 | 1,899 | 13,825 | 22,418 | 22,328 | 22,418 | ↘ |
| W3 | Cash Balance | 3,000 | 3,356 | 10,405 | 3,356 | 3,000 | 3,356 | → |
| W4 | Capital Expenditure | 2,188 | 10,909 | 19,185 | 16,001 | 14,448 | 16,001 | → |
| W5 | Finance use of Resources Rating | 3 | 3 | 3 | 3 | 3 | 3 | → |
| W6 | Staff Turnover Rate (%) | 10.0% | 12.3% | 9.1% | 12.3% | 10.0% | 12.3% | ↘ |
| W7 | Vacancy Rate (%) | 8.0% | 8.1% | 10.7% | 10.9% | 8.0% | 10.9% | ↗ |
| W8 | Total Agency Spend | 1,271 | 1,853 | 22,651 | 19,388 | 17.738 | 18.574 | ↘ |
| W9 | Statutory and Mandatory Training | 90.0% | 86.3% | 87.1% | 86.0% | 90.0% | 86.0% | ↗ |
| W10 | Sickness Absence | 3.3% | 3.5% | 3.4% | 3.5% | 3.3% | 3.5% | ↗ |

| Target Indicator Key: | |
|---|---|
| On or above Target | |
| Review and Corrective Action required | |
| Significantly below target - urgent action required | |
| KPI Used in Performance Wheel Scoring | |

| Change on Previous Indicator Key: | |
|---|---|
| Significant improvement on Previous (>5%) | ↑ |
| Improvement on previous (<5%) | ↗ |
| No Change | → |

| Change on Previous Indicator Key: | |
|---|---|
| Deterioration on previous (<5%) | ↘ |
| Significant deterioration on previous (>5%) | ↓ |

# Headlines

| Safe: | Positives: | Challenges: |
|---|---|---|
| **Lead Director(s):**<br>**Claire O'Brien/**<br>**Peter Maskell** | **Infection Control:**<br>There were four cases of C.difficile reported in March against a maximum trajectory of 4. Year to date there have been 52 cases reported against a maximum limit of 55, therefore achieving the Trust Trajectory for the year.<br><br>**Serious Incidents (SI)s:** SIs open at the end of the month decreased further which is the lowest number reported so far this year. Performance for those being closed within the 60 day target remained similar in March with 7 SIs currently open that have passed their breach date for closure.<br><br>The rate of Sis per 100,00 occupied beddays was 0.47 in March compared to 0.49 in February and has remained fairly consistent all year. | **Infection Control:** Cases of E.Coli have decreased in March. For the Year the rate was 30.9, therefore not achieving the target of reducing the rate to 19.0. One case of MRSA was reported in March (2 for the year).<br><br>The Trust has recently had a safety moment which focused on reducing the risk of UTIs. The Trust will further promote the HOUDINI criteria through the distribution of staff information cards.<br><br>**Falls:** The level of Falls has reduced slightly in March to 100 equating to a Rate of 5.93 per 1,000 occupied bed days, However the rate for the year is slightly above trajectory at 6.09. As part of the response to Covid-19, the Moving and handling Advisor outlined the required essential training to support staff and the organisation in the coming months as we strive to deliver safe care whilst working differently. Training on the use of equipment such as HoveJack used to transfer fallen patient from floor back to bed.<br><br>**Pressure Ulcers (Hospital Acquired):** In line with NHSi guidelines the Trust has changed the way that pressure ulcers are recorded to include Deep Tissue Injuries (DTIs). This coincided with an overall increase in the number of hospital acquired pressure ulcers (HPAU) reported in December. The number reported has reduced slightly in March with 13 reported equating to a rate of 2.5. The Rate for the year is 1.0 against a maximum limit of 1.3. Towards the end of March, the Tissue Viability Nurses began to report an emerging theme of providing advice to staff reporting pressure damage as a result of wearing prolonged PPE and also triangulate pressure damage for patients diagnosed with Covid 19. These themes will be reviewed each month going forward.<br><br>**Safe Staffing:** This is currently showing a fill rate of 93% in March. However there will be some anomalies in the data as staff are still allocated to their home roster rather than any new areas due to COVID-19. The performance reflects high bed occupancy and escalated areas at the beginning of March with a change to closing wards, ward moves and re allocation of staff due to plans in place to support the COVID pandemic pathways in the latter part of the month. |

# Headlines

| Effective: | Positives: | Challenges: |
|---|---|---|
| **Lead Director(s):**<br>**Peter Maskell** | **Mortality:** The Risk Adjusted Hospital Standardised Mortality Rate (HSMR) and SHMI both continue to remain within acceptable limits. The HSMR has been below 100 for the last nine reporting periods, being reported at 91.5 for the 12 months to December 2019.<br><br>The latest SHMI published for the period December 2018 – November 2019 is reported at 1.008 which is banded as level 2 "as expected".<br><br>**Patients with Dementia:** The percentage of patients screened for Dementia remained similar in February at 99.5% against the 90% national target and remains above target YTD (95.2%). The percentage of those that were risk assessed or referred to a specialist where required both continue to remain significantly above target (data runs one month behind) | **Emergency Readmissions:** Following discussion with the Medical Director it was decided to show the rate of emergency readmissions within 30 days of discharge (non-elective) excluding SDEC (those on a same day emergency care pathway) as well as the total rate of emergency readmissions within 30 days of discharge (non-elective) due to the increased use of short stay units. Performance is monitored against local targets based on improving to above the average of last year.<br><br>Performance worsened in February, but the latest month is prone to undercounting as patients tend not to appear until they have been discharged from their readmitting spell. At the end of February, Readmissions following NE spells are 15,2% which is the same as the equivalent period last year. The rate of non-elective readmissions excluding zero LoS spells is 15.7% versus 14.1% last year.<br><br>**Emergency readmissions (Elective):** The level or emergency readmissions within 30 days of discharge for those who were originally admitted on an elective pathway has increased this year compared to last year although this did shown an improvement in February at 8.1% Initial analysis has not identified any particular trends and therefore a deep dive at patient level is currently underway to see if there are any underlying trends.<br><br>**Stroke**: Performance against the metrics that constitute the Best Practice Tariff has remained fairly constant around 40-45%, slightly below 40% in February, which is below the level the Trust aspires to achieve, and below what we would have scored last year. Compliance with the tariff will improve as the consultant stroke rota is fully filled along with improvements in the timeliness of data capture and validation.<br><br>Monitoring compliance against BPT by the Stroke CNS Team has been put on hold at present due to block payments being issued during COVID-19.<br><br>Daily identification of the patients that have been moved to COVID-19 wards to ensure that MDT is aware of their location. |



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# Headlines

| Caring: | Positives: | Challenges: |
|---|---|---|
| **Lead Director(s):**<br>**Claire O'Brien/**<br>**Peter Maskell** | **Complaints:** The overall number of complaints received has remained fairly consistent month on month, slight increase in March.<br><br>Performance for the percentage of complaints responded to within their target date increased in March to 75%, therefore achieving the target.<br><br>Complaints performance has been consistently above the 75% target now since October 2019 (with a slight dip in February).<br><br>Divisional performance for the year was 83.1% which is above the 75% target.<br><br>**Friends and Family Survey:** Performance for percentage positive for the YTD is above target in all areas except for outpatients which is below target at 82.2% against a target of 84%.<br><br>**Single Sex Accommodation:** Delivery of the Same Sex Accommodation (SSA) remains a priority, promoting privacy and dignity for our patients. There have been no unjustified mixed sex breaches reported since December 2019. Justified mix sex breaches in acute clinical areas are recorded internally. These remain small numbers. | **Complaints:** Performance for the percentage of complaints responded to within their target date for the year was below target at 67.8%.<br><br>Complaints system is currently paused in line with NHSI/E recommendations. Team is working to close as many open complaints as possible without utilising frontline staff. Requests have been made to directorates/redeployment team for self-isolating/shielding staff to assist with clinical/operational enquiries.<br><br>**Friends and Family:** Due to the current COVID-19 situation the Friends and Family Data has not been collected or reported in March 2020.<br><br>Performance for response rates remains below plan YTD for all areas.<br><br>Performance for percentage positive is above target in all areas except for outpatients which is below target at 82.2% against a target of 84%.<br><br>The Trust will be in a position of readiness to re launch FFT post COVID-19. |

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# Headlines

| Responsive: | Positives: | Challenges: |
|---|---|---|
| **Lead Director(s):**<br>**Sean Briggs** | **4 hour Emergency Access Standard:**<br>A&E performance for 2019/20 was 90.65%. This was below the agreed trajectory of 91.67%, but attendances had been running 6-7% higher than agreed for most of the year, and we have consistently been in the top 25% performing Trusts in England, and around 5 percentage points above the national average.<br><br>**Ambulance Handovers:**<br>Throughout the whole of 2019/20, 11.4% of ambulances were delayed 30-60 mins and 1.2% over 60. However, in Q4, these dropped to 8.9% and 0.5%<br><br>**Inpatient Efficiency (Last minute cancellations):**<br>The rate of last minute reportable cancellations remains below the 0.8% maximum limit at 0.6% YTD. There were only 5 elective operations cancelled as being last minute reportable cancellations.<br><br>Due to the COVID-19 situation the majority of elective operations were cancelled with more than 24 hours' notice from mid-March 2020.<br><br>**OP DNA Rates:** Following the introduction of more text reminders throughout this year DNA Rates have improved from 7.3% last year to 5.7% for OP New and 5.2% for OP Follow Ups this year, just above the 5% target | **Type 1 ED Attendances:** 2019/20 came in 5.8% higher than 2018/19, and 3.5% up on the funding trajectory. The pandemic has brought ED attendances down by 50-60% in the second half of March, and without this effect, attendances would have been an estimated 2.8 percentage points higher still.<br><br>**Beds and Escalated Areas:** Bed Occupancy was averaging 92.9% for 2019/20, then dropped to around two thirds at the start of the COVID-19 pandemic, bringing the year in at 91.8%. We are currently reviewing the inclusion criteria for this metric. Many of the available beds are specialist beds not available for general acute admissions.<br><br>Last year, escalated beds were an average of 3.6% of our total occupancy, rising to 5.8% in Feb-19. This year we averaged 5.6%, with a spike in Jan & Feb.<br><br>Due to the need to free up beds for COVID-19 the current bed occupancy is around 42% and Medically Fit for Discharge (MFFD) is now 10-25 daily.<br><br>**Inpatient Efficiency (Theatre Utilisation):** Theatre Utilisation with TAT dropped a little this month to 85.1%.in March and remained below plan for the year. Given the current COVID-19 situation there has been an unavoidable decrease in theatre activity in Mar-20 (1091 operations) with 507 less operations being completed compared to Feb-20. The activity equated to 49.6 elective cases per working day, a decrease from 79.9 in Feb-20. The average cases per session in Mar-20 was 2.52.<br><br>**OP Appointment Cancellations and Utilisation:**<br>Due to the impact of COVID-19 the Trust has attempted to convert F2F outpatient appointments to either telephone or virtual appointments where clinically appropriate to avoid a high number of cancellations & DNAs. |



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# Headlines

| Responsive: | Positives: | Challenges: |
|---|---|---|
| **Lead Director(s):**<br>**Sean Briggs** | **RTT Incomplete Pathway:** The Referral to Treatment (RTT) standard achieved the year-end target of 86.7% as at the end of February 2020, prior to COVID-19.<br><br>**Cancer Waiting Times:**<br>The 62 day standard has now been achieved for seven consecutive months at 85.6% for February 2020.<br><br>This report covers the 62 day standard for February 2020 treatments and had not had an impact from Covid-19 up to the end of February.<br><br>Both the 2 week wait cancer waiting times target and the 2 week wait Beast Symptoms were also achieved in February and have been above target for the last six months (with a slight dip for Breast Symptoms in January). | **OP New and Elective Activity:** As expected due to the COVID-19 pandemic activity levels have decreased significantly in March for both elective and outpatient appointments which will have adversely impacted the RTT performance for March.<br><br>Large scale cancellations of elective activity has resulted in admitted electives reducing by 80-85% on normal levels, and daycases by 85-90%.<br><br>New Outpatient activity has reduced by around 60%, and follow up by around 50%, (though it is suspected that the last week's figures are still slightly undercounting as uncashed appointments are still in the system).<br><br>**RTT Incomplete Pathway:** As expected due to the cancellation of activity undertaken in March due to the COVID-19 Pandemic performance was below target for March at 79.5% .The Trust continues to closely monitor the RTT Patient Pathways.<br><br>**Diagnostic Waiting Times <6weeks:** Performance deteriorated to 93.7% in March, which was adversely impacted by COVID-19.<br><br>**Cancer Waiting Times:**<br>A Review of 2ww processes to accommodate COVID-19 government guidelines. Is taking place, ensuring patients have an appropriate clinical triage to review risk and communication is clear between GPs and patients.<br><br>There has been a significant decrease in number of referrals per day due to Covid-19. Up to the end of February there was a monthly average of 1682 referrals but this has decreased to 1544 average referrals by the first week in April 2020. |



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# Headlines

| Well Led: | Positives: | Challenges: |
|---|---|---|
| **Lead Director(s):**<br>**Steve Orpin/**<br>**Simon Hart** | **Finance:** The Trust has delivered the year to date financial plan generating a surplus of £7m including PSF and MRET funding.<br><br>The Trust delivered £22.4m savings in the year which was £0.1m favourable to the plan.<br><br>The capital programme spend was £16m, excluding donated assets.<br><br>The major spends relate to ICT; £5.3m on EPR/EPMA (EPMA funded from PDC), £0.4m on cyber security (PDC funded) and £0.6m on PCs/Laptops - Equipment; £2.6m (£2.1m PDC funded) for CTs x 2, MRI & Mammography, £0.8m on surgical reconfiguration and endoscopy, and Estates; £2.1m for backlog maintenance and Linac enabling work. The Trust has also spent £462k relating to Covid-19 including assessment pods, anaesthetic machines, video layrngoscopes and laptops for working from home. The Trust has been funded £50k in March for the Covid-19 pods and there is an expectation that PDC will be paid in 2020/21 relating to the remaining spend in 201920<br><br>**Vacancy Rate:** The overall Trust vacancy rate reduced further in March to 8.1% against a maximum limit of 8.0%. The rate remains 5% lower that at the beginning of the financial year.<br><br>**Annual Leave and Staff Fill Rate:** The overall staff fill rate has increased further to 78.3% in March which is the highest level all year and the annual leave rate it back to usual levels. | **Finance:** The Trust must ensure Financial Governance is maintained during the response to Covid-19. We must ensure decisions regarding additional spend on Covid-19 are made with the correct authority and that this is documented for audit and reporting purposes without causing a delay to decision making and actions.<br><br>**Sickness Rate:** The overall sickness rate has reduced slightly to 3.5% in March, above the maximum limit of 3.3% and just below the upper control limit. The flu vaccination campaign concluded at the end of February with a vaccination rate of 83% of frontline healthcare workers. We require 80% to obtain full CQUIN monies. The Trust target is 85%. |



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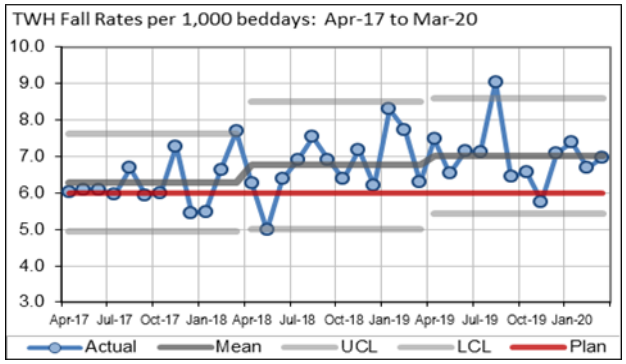
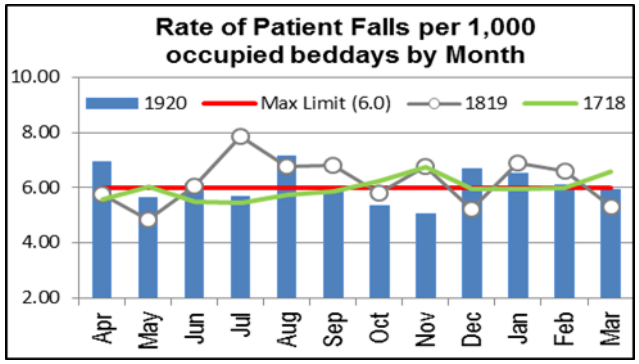
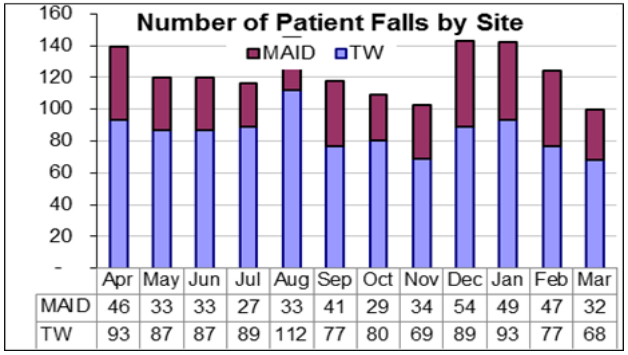
# Escalation: Harm Free Care



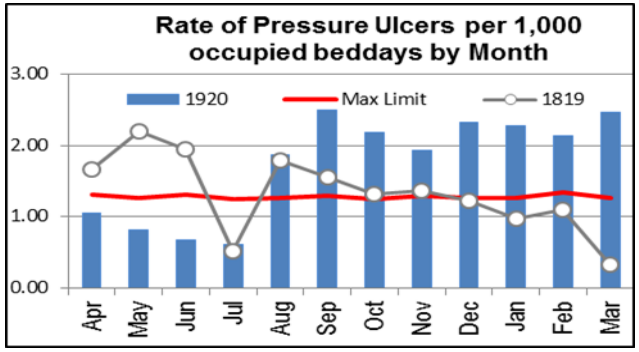




**Falls:** The level of Falls has reduced slightly in March to 100 equating to a Rate of 5.93 per 1,000 occupied bed days. The rate for the year is slightly above trajectory at 6.09, However the level of occupied beddays reduced in March due to COVID-19 which may have impacted the overall rate. There was a significant reduction in the numbers reported for Maidstone, particularly for the Acute and Geriatric Directorate. The number reported for TWH decreased further in March, particularly for the Acute and Geriatric Directorate, but this remains above trajectory for the year.




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MAID | 46 | 33 | 33 | 27 | 33 | 41 | 29 | 34 | 54 | 49 | 47 | 32 |
| TW | 93 | 87 | 87 | 89 | 112 | 77 | 80 | 69 | 89 | 93 | 77 | 68 |

**Severity of Falls:** Of the 100 Falls reported, 84 resulted in no harm, 13 resulted in low harm, 1 resulted in moderate harm and 2 resulted in severe harm

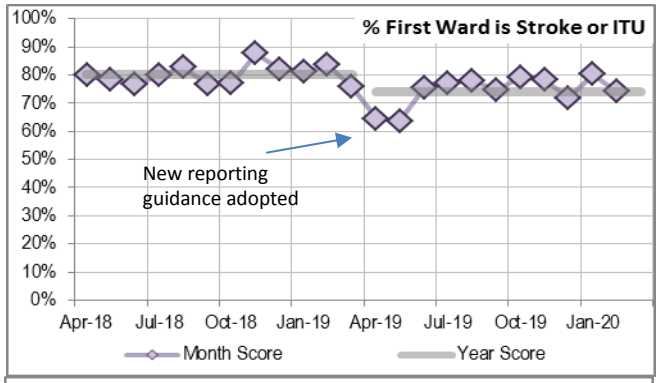


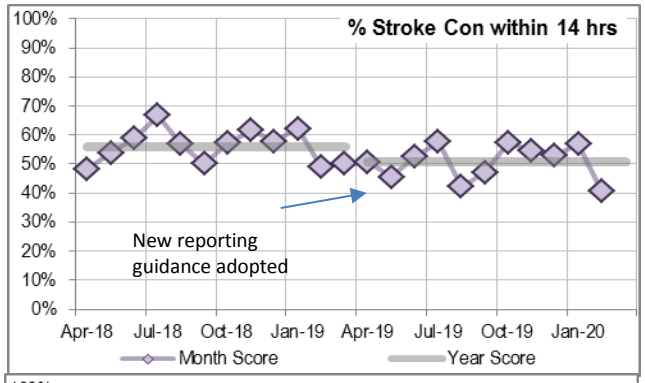

**SIs:** There were Two Serious Incidents relating to Falls declared in March.

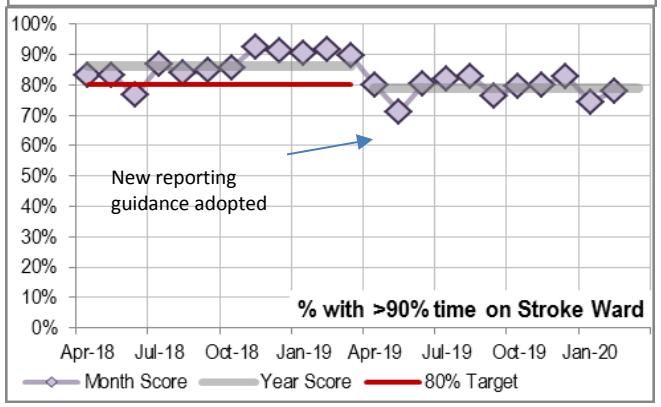
**Pressure Ulcers:** The level of hospital acquired pressure ulcers (HAPU) has remained similar in March with 13 reported equating to a rate of 2.5 against a maximum limit of 1.3. Once again the level of admissions was reduced in March due to COVID-19 In line with NHSi guidelines the Trust has changed the way that pressure ulcers are recorded to include Deep Tissue Injuries (DTIs). Both sites saw a slight increase in the numbers of DTIs in March. The average rate of all pressure ulcers (including those who already had a pressure ulcer on admission) decreased to 29.3 in March and has a rate of 24.0 for the year compared to an average of 16.0 last year.

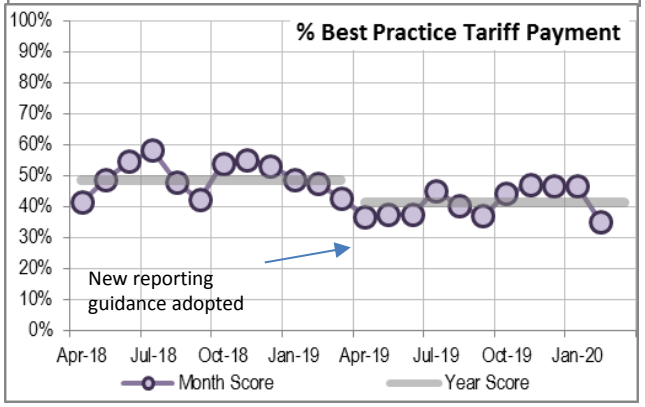
| Summary: | Actions: | Assurance: |
|---|---|---|
| The level of Falls has reduced slightly in March to 100 equating to a Rate of 5.93 per 1,000 occupied bed days. The rate for the year is slightly above trajectory at 6.09.<br><br>Two Serious Incidents relating to Falls were declared in March.<br><br>The level of hospital acquired pressure ulcers (HAPU) has remained similar in March with 13 reported equating to a rate of 2.5. The rate of all pressure ulcers is higher this year than last year. | As part of the response to Covid-19, the Moving and handling Advisor outlined the required essential training to support staff and the organisation in the coming months as we strive to deliver safe care whilst working differently. Training on the use of equipment such as HoveJack used to transfer fallen patient from floor back to bed. A Study day planned for 5th May for the Tissue Viability Champions has been cancelled due to COVID 19. A Tissue Viability Champions handbook and learning resource has been created and delivered to all inpatient areas to support learnings from both DATIX and the NHSI collaborative work which the Trust engaged in to support improvements in practice. | Opportunity for staff to train and be skilled in using appropriate Moving and Handling techniques and resources including the management of the fallen patient.<br><br>Towards the end of March, the Tissue Viability Nurses began to report an emerging theme of providing advice to staff reporting pressure damage as a result of wearing prolonged PPE and also triangulate pressure damage for patients diagnosed with Covid 19. |

# Escalation: Stroke Best Practice Indicators




Data is now reported one month behind (Feb-20) to allow time for the data to be fully captured and validated. There are three main stroke indicators that constitute Stroke Best Practice.

**1. First Ward must be a Stroke Ward (or ITU):** last year averaged 80.2%, but this year has reduced to 74.1% to end of Feb.

**2. Stroke Consultant within 14 hrs:** Performance has been lower in Aug, Sep Oct and Nov due to a combination of annual & compassionate leave, and data quality & completeness. The YTD position to the end of Feb is 50.8%

**3. 90% of Spell on Stroke Ward**. Changes in the guidance means that this metric is now calculated differently to last year. In 2018/19, we would have scored 86.2% under the new methodology, but this year is reported at 78.9% YTD.

**% Best Practice Tariff** : The percentage of patients passing all 3 of these tests is 41.5% to the end of Feb-20.

## Summary:

There are now three stroke indicators that constitute Stroke Best Practice. a) Admitted direct to a stroke or intensive treatment ward, b) See a stroke consultant within 14 hours of arrival (or their stroke if that happens on-site), c) Spend 90% of their spell on a stroke ward. 40.0% of patients this year have qualified by meeting all three indicators.

In 2018/19, the percentage passing all 3 tests & qualifying for a Best Practice Tariff payment would have been 48.8%. This year it is 41.5% so far.

It is too early to see any effects of Covid on these indicators

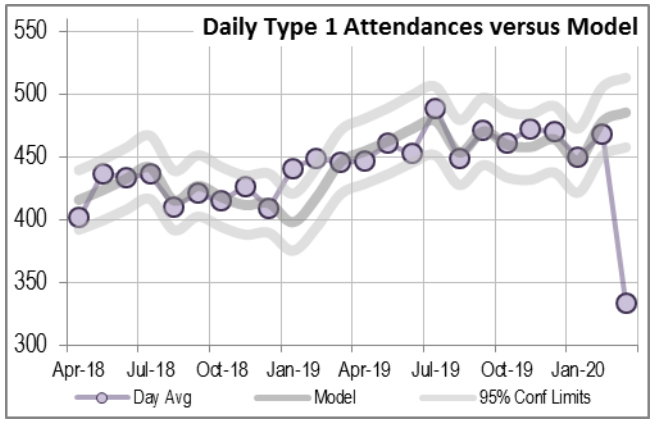
## Actions:

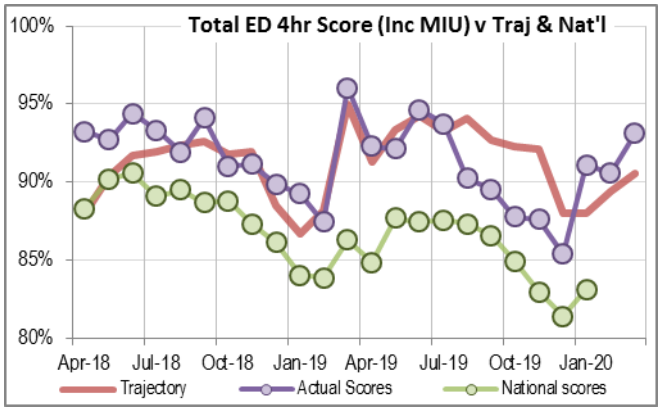
1. Stroke CNS team to monitor compliance against BPT and investigate non-compliance - on hold at present due to block payments being issued during COVID-19.
2. Time to Stroke Consultant impacted by number of patients being admitted out of hours and over weekend.
3. 90% spell on Stroke currently being affected by patients transferred to COVID-19 wards when positive however they are still receiving stroke therapy and stroke consultant reviews.
4. Stroke Assessment Bay has been opened on Stroke Unit with the aim to improve all indicators –this is currently open Monday-Friday 8am-8pm.

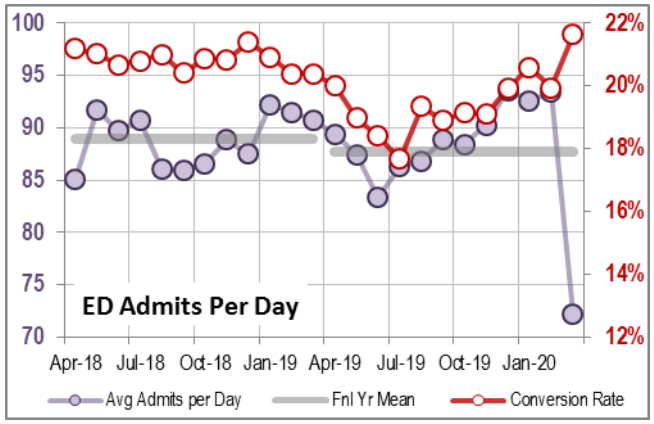
## Assurance:

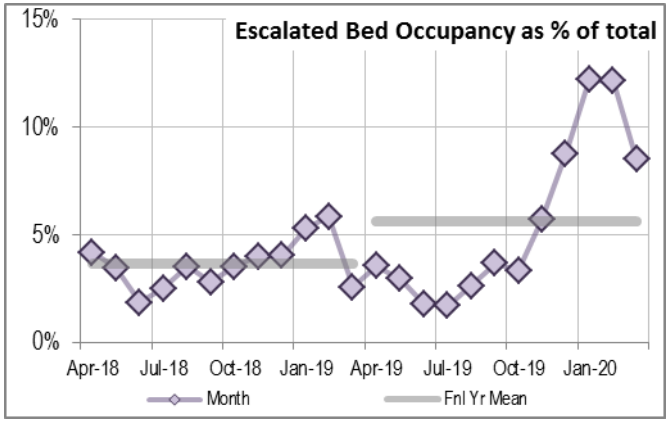
1. BPT report completed monthly by CNS and shared with relevant teams. Latest report to be presented at Clinical Governance when agenda space available. Coding validation to be completed as required rather than monthly due to COVID-19
2. We are covering 80% of weekends with stroke consultants and have full time cover during the week. We will need to recruit one further stroke consultant to get up to 100%. Stroke consultants have now extended hours to 12 hr days Monday-Wednesday.
3. Daily identification of the patients that have been moved to COVID-19 wards to ensure that MDT is aware of their location.
4. During the opening times 2 stroke assessors and one senior doctor are present within the bay to assess any new patients quickly.

# Escalation: A&E Performance




**Attendances**: Type 1 attendances came in at 164,877 for 2019/20, an average of 451.8 per day. 5.8% up on the previous year & 3.5% up on the funding trajectory. The pandemic has taken an estimated 4,700 off this figure, by reducing ED attendance to 40-50% of normal in the second half of March

**Primary Care Stream:** 19,464 patients were streamed to Primary Care in 2019/20, 11.8% of all ED attendance, and a 39% increase on the previous year. A new MIU stream at both sites had effectively doubled the number of patients being streamed to primary care between mid-Jan & mid-Mar, but this has gone on hold during the Pandemic

**ED admits per day:** 19.4% of ED attendances were admitted to the main hospital (beyond CDU) in 2019/20 compared to 20.8% in 2018/19. The pandemic has reduced ED admissions by around a third

**Bed occupancy (as per SitRep counting rules)** was averaging 92.9% for 2019/20, then dropped to around two thirds at the start of the pandemic, bringing the year in at 91.8%.

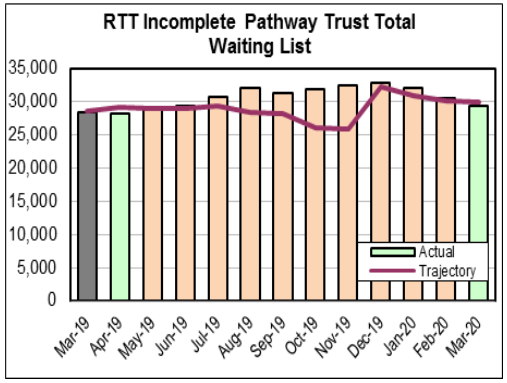
**Escalated Bed Occupancy**. Last year, escalated beds were an average of 3.6% of our total occupancy, rising to 5.8% in Feb-19. This year we averaged 5.6%, with a spike in Jan & Feb.

| Summary: | Actions: | Assurance: |
|---|---|---|
| Type 1 attendances grew by 5.8% in the year. Without the pandemic, this is estimated to have been 8.5% to 8.9%<br>In 2019/20, 26.0% of all Non-elective (NE) admissions were zero LoS (not counting CDU patients). Bed occupancy was consistently between 92% and 95% until mid March (though this may not accurately reflect how many beds are available for emergency patient admissions). Escalated beds were showing an improvement in Spring & Summer, but spiked dramatically in the Winter. Non-Elective length of stay is marginally lower than last year at 6.95 | SDEC running 7 days per week. Commencing trial of Medical Consultant in ED in Jan to support SDEC streaming. Ambulance handover plan in place with increased SECAmb / CCG/ MTW working. Improvement seen in handover performance. New ED Consultant in place with additional ED consultant starting March. Nursing planned to be fully recruited by June 2020. EDPs supporting "hello" nurse on ongoing trial on both sites. Further developing the GP in ED service to enable more patients to be streamed. Delay to RAP build at Maidstone due to delay on AMU build. | Work continuing to ensure all departments within Trust feel a part of the 4Hour Access Standard –Increased profile on ambulance handovers. Focused bed meetings on actions. Working with A&E Delivery Board on monthly basis to support region wide issues/ actions. System call put in on a daily basis where required when system is tight. Audit run in both EDs to identify opportunity for GP flow<br>Winter escalation wards are open to support flow and maintain ED Performance. Maintaining top 10 ED performance in the country consistently.<br>Regular site meetings/ winter huddles to support decision making. |

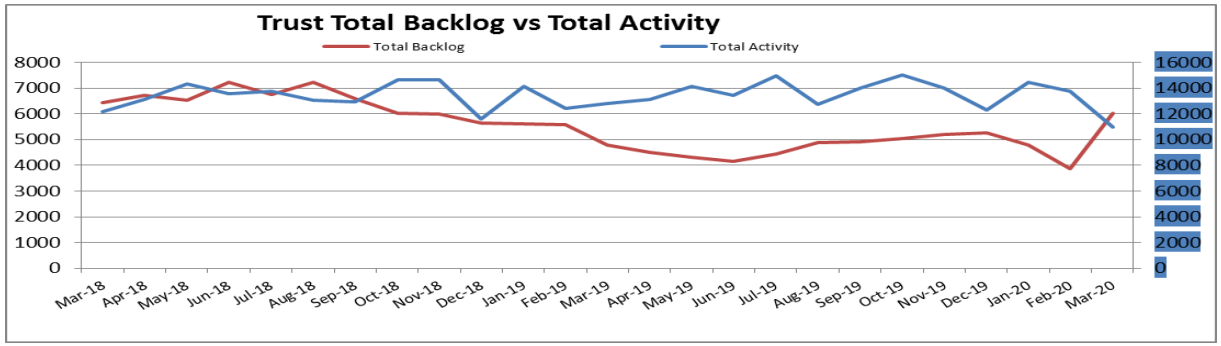
# Escalation: RTT Incomplete Pathways

| Trust | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trajectory Total WL | 28508 | 29152 | 28932 | 28908 | 29273 | 28433 | 28261 | 25964 | 25959 | 32154 | 30956 | 30102 | 30000 |
| Actual Total Waiting List | 28412 | 28268 | 29027 | 29269 | 30705 | 32085 | 31344 | 31828 | 32445 | 32725 | 31966 | 30414 | 29421 |
| Actual IP Waiting List | 6494 | 6045 | 6037 | 5978 | 6102 | 6009 | 5780 | 5742 | 5932 | 6113 | 6154 | 4935 | 5495 |
| Actual OP Waiting List | 21918 | 22029 | 22519 | 22607 | 23617 | 24894 | 24291 | 24880 | 25173 | 25237 | 24682 | 24459 | 22957 |
| Trajectory Backlog | 4146 | 4806 | 4578 | 4622 | 5089 | 4576 | 4543 | 3536 | 3740 | 5379 | 4648 | 4100 | 4000 |
| Actual Total Backlog | 4797 | 4510 | 4305 | 4163 | 4430 | 4868 | 4910 | 5052 | 5192 | 5257 | 4784 | 3860 | 6020 |
| Actual IP Backlog | 2611 | 2391 | 2157 | 2156 | 2158 | 2135 | 2004 | 1932 | 2079 | 2220 | 2153 | 1332 | 1985 |
| Actual OP Backlog | 2186 | 2119 | 2148 | 2006 | 2272 | 2722 | 2861 | 3045 | 3049 | 2931 | 2571 | 2485 | 3929 |
| Trajectory % Performance | 85.5% | 83.5% | 84.2% | 84.01% | 82.61% | 83.9% | 83.9% | 86.4% | 85.6% | 83.3% | 85.0% | 86.4% | 86.7% |
| Actual Total % Performance | 83.1% | 84.0% | 85.2% | 85.8% | 85.6% | 84.8% | 84.3% | 84.1% | 84.0% | 83.9% | 85.03% | 87.31% | 79.5% |

The Referral to Treatment (RTT) standard achieved the year end target of 86.7% as at the end of February at 87.3%, prior to the impact of COVID-19. but as expected performance did not achieve in March due to the cancellation of activity.




The overall waiting list has reduced to below he maximum limit in March. However, the overall backlog (patients who have been waiting over 18 weeks) has increased.




This shows the total Activity in March as well as the RTT admitted backlog which decreased in March.

**RTT Performance:** As expected due to the cancellation of activity undertaken in March, due to the COVID-19 Pandemic, performance was below target for March at 79.5%. The Trust continues to closely monitor the RTT Patient Pathways.

Due to the COVID response most of the elective activity has ceased apart from urgent cancers being undertaken internally and some intermediate surgery being undertaken in the IS.

**RTT 52 week Breaches**: 18 reported for March (16 new for March). All patients will have a harm review by the managing Consultant. 52 Week Panel established.

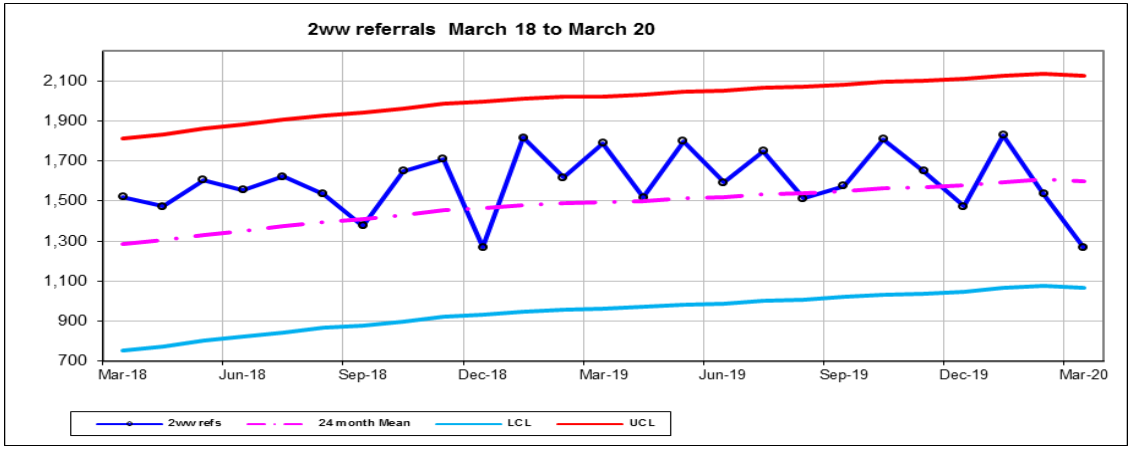
**RTT Data Quality:** The data quality project plan has been revised in line with the COVID response.

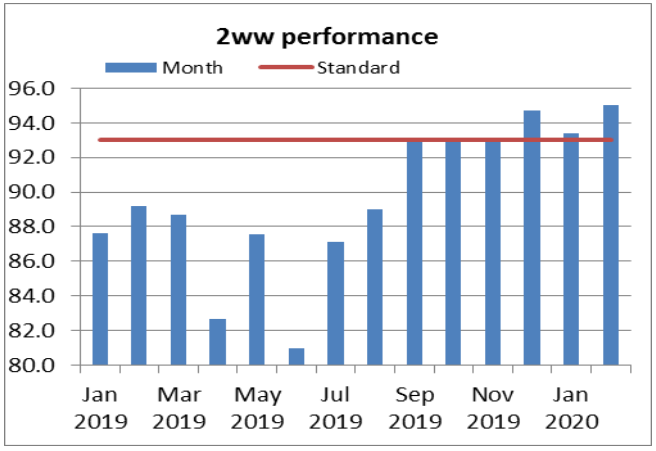
**Diagnostics <6weeks:** Performance deteriorated to 93.7% in March, which was adversely impacted by COVID-19.

**Theatre Utilisation:** Theatre Utilisation with TAT dropped a little this month to 85.1%.in March and remained below plan for the year. Given the current COVID-19 situation there has been an unavoidable decrease in theatre activity in Mar-20 (1091 operations) with 507 less operations being completed compared to Feb-20. The activity equated to 49.6 elective cases per working day, a decrease from 79.9 in Feb-20. The average cases per session in Mar-20 was 2.52.

| Summary: | Actions: | Assurance: |
|---|---|---|
| The Referral to Treatment (RTT) standard achieved the year end target of 86.7% as at the end of February at 87.3%, prior to the impact of COVID-19.<br><br>As expected due to the cancellation of activity undertaken in March, due to the COVID-19 Pandemic, performance was below target for March at 79.5%. The Trust continues to closely monitor the RTT Patient Pathways. | Due to the COVID response most of the elective activity has ceased apart from urgent cancers being undertaken internally and some intermediate surgery being undertaken in the IS (KIMS, Nuffield, Horder, Spire, Beneden) | Outpatient waiting times are being monitored as are the long waiting patients. All patients over 40+ weeks are having a clinical review and are being monitored closely. |

# Escalation: Cancer Waiting Times – 2 Weeks



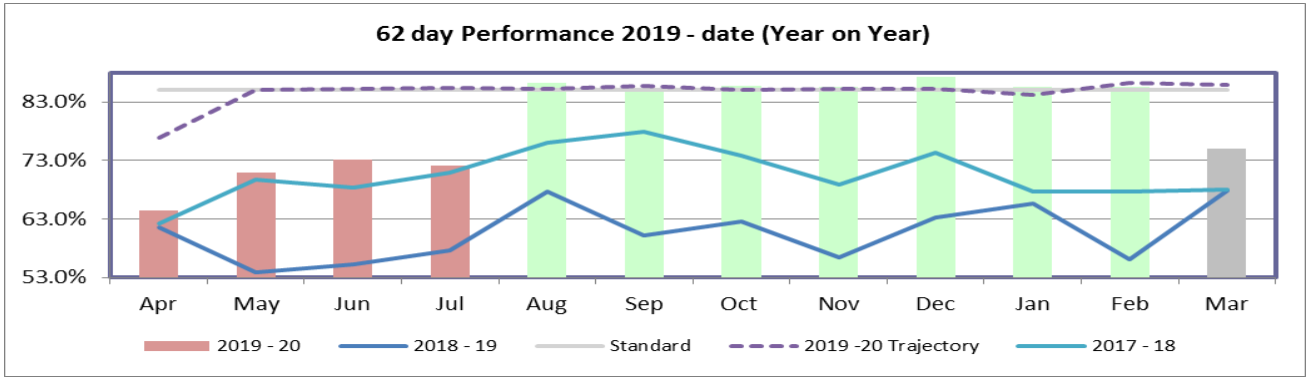

| 2ww GP referrals to MTW | Breast | Childre n | Gynae | Haem | Head & Neck | Lower GI | Lung | Other (inc | Upper GI | Urology | Total | BSYM | Breast total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017 | 319 | 4 | 119 | 9 | 109 | 261 | 47 | 8 | 139 | 154 | 1164 | 165 | 404 |
| 2018 | 343 | 9 | 141 | 17 | 123 | 310 | 48 | 4 | 146 | 207 | 1289 | 141 | 484 |
| 2019 | 393 | 14 | 157 | 26 | 146 | 359 | 53 | 5 | 145 | 208 | 1659 | 155 | 548 |
| 2020 (Jan - Mar ) | 349 | 15 | 168 | 19 | 126 | 353 | 49 | 8 | 131 | 211 | 1544 | 117 | 467 |
| % change last 12 mths | -11.0% | 3.5% | 7.3% | -26.1% | -13.7% | -1.7% | -7.5% | 54.8% | -9.6% | 1.1% | -6.9% | -24.4% | -14.8% |

**Demand:** 2ww referrals have decreased sharply in March due to Covid-19, with the lowest recorded number of referrals since February 2018. The numbers of referrals averaged 74 to 89 per day during February and then peaked at 112 referrals on Monday 9th March. Thereafter decreasing sharply to an average of 27 referrals per day in W/C 30th March. Breast, Gynae Urology and Lower GI continue to have the higher numbers of referrals with a total of 22 to 40 for these tumour sites during the last week of March

**2 Week Wait (2WW) Performance:**
The Trust is maintaining the achievement of the 2ww standard reporting 95% for February 2020, which is the 6 consecutive month. The Breast Symptoms performance has improved from last month and has achieved in February 2020 with 93.5%
All major tumour sites achieved the 93% standard in February except for Urology which reported 89.2%. Both Brain and Children's cancers reported below the standard with 66.7% and 92.3% respectively (over a total of 16 referrals). The current un-validated position for March is 92.1%

| Summary: | Actions: | Assurance: |
|---|---|---|
| The Trust has continued to achieve the 2ww standard with 95% for February 2020.<br><br>Significant decrease in number of referrals per day due to Covid-19<br>Up to the end of February there was a monthly average of 1682 referrals but this has decreased to 1544 average referrals by the first week in April 2020 | Review of 2ww processes to accommodate COVID-19 government guidelines. Ensuring patients have an appropriate clinical triage to review risk and communication is clear between GPs and patients.<br><br>Reviewing and implementing changes to 2ww referral pathways to ensure we are able to achieve 7-10 day booking in preparation for the implementation of the 28 day FDS.<br>Review of booking paper free from 2ww ERS worklist to minimise risk of missing referrals. | A report has been developed, and is reviewed daily, to highlight any un-booked 2ww appointments and any appointments booked after 7, 10 and 14 days.<br><br>A 2ww action log monitors transformation and development, and holds services to account.<br><br>County wide calls to ensure local agreements are communicated appropriately and are consistently implemented. Frequent updates with CCG representatives. |

# Escalation: Cancer Waiting Times – 62 Day



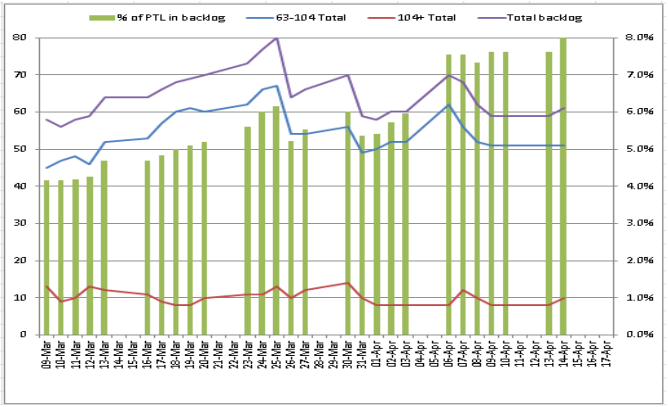

**Trust Performance:**
The Trust continues to report achievement of the 62 day standard with 85.6% for February 2020.
This is the seventh consecutive month of achievement and a significant improvement over last year when only 55.8% of our patients were treated in 62 days

**Tumour Specific Performance:**
Breast, Gynae, Haematology and Other Cancers all reported 100% for February with no breaches. Lower GI achieved 95.7% with half an accountable breach over 11.5 accountable treatments
Lung, Urology and Upper GI reported in the 70's% with Head & Neck reporting 54.5% with 2.5 accountable breaches over 5.5 accountable treatments.

The current, un-validated position for February 2020 is 75%.

**This report covers the 62 day standard for February 2020 treatments and had not had an impact from Covid-19 up to the end of February**

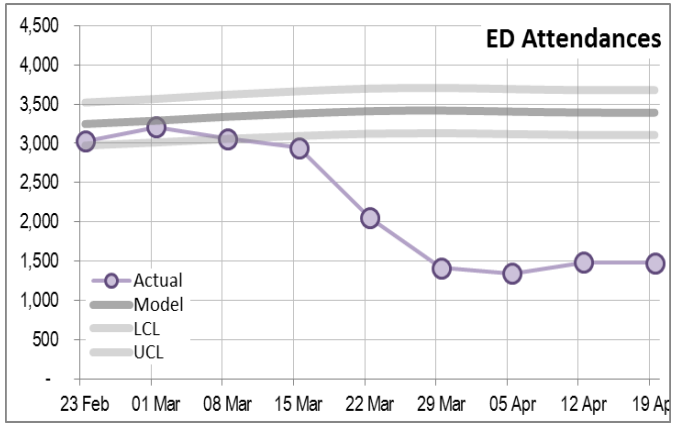
| 62 Day Performance | | | | | | |
|---|---|---|---|---|---|---|
| February 2020 | All reportable patients | | | MTW only patients | | |
| | Total | Breach | % | Total | Breach | % |
| Breast | 16.0 | 0.0 | 100.0 | 16.0 | 0.0 | 100.0 |
| Gynae | 11.0 | 0.0 | 100.0 | 9.0 | 0.0 | 100.0 |
| Haematology | 3.0 | 0.0 | 100.0 | 3.0 | 0.0 | 100.0 |
| Head & Neck | 5.5 | 2.5 | 54.5 | 4.0 | 1.0 | 75.0 |
| Lower GI | 11.5 | 0.5 | 95.7 | 11.0 | 0.0 | 100.0 |
| Lung | 11.5 | 2.5 | 78.3 | 8.0 | 1.0 | 87.5 |
| Other | 2.5 | 0.0 | 100.0 | 2.0 | 0.0 | 100.0 |
| Upper GI | 6.5 | 1.5 | 76.9 | 6.5 | 1.5 | 76.9 |
| Urology | 30.0 | 7.0 | 76.7 | 23.0 | 1.0 | 95.7 |
| TOTAL | 97.5 | 14.0 | 85.6 | 82.5 | 4.5 | 94.5 |

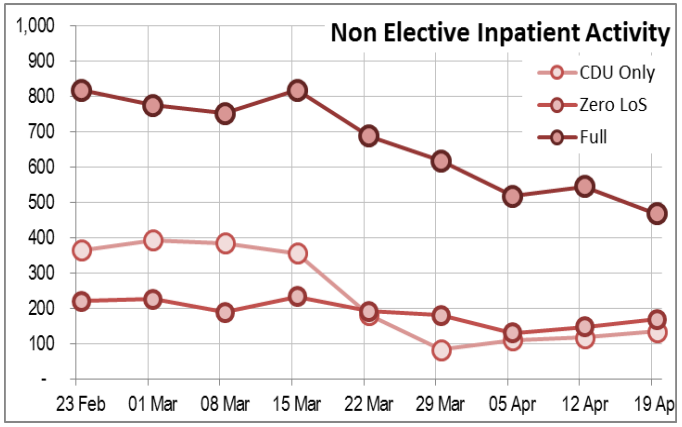


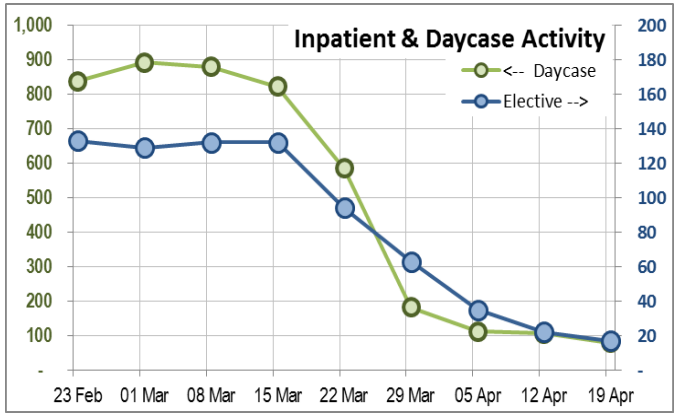

**PTL Backlog-** As at the beginning of April, the 62 day PTL backlog is being maintained with approximately 61 patients over day 63, with 10 of these patients over day 104. This remains consistent with previous month's backlogs.

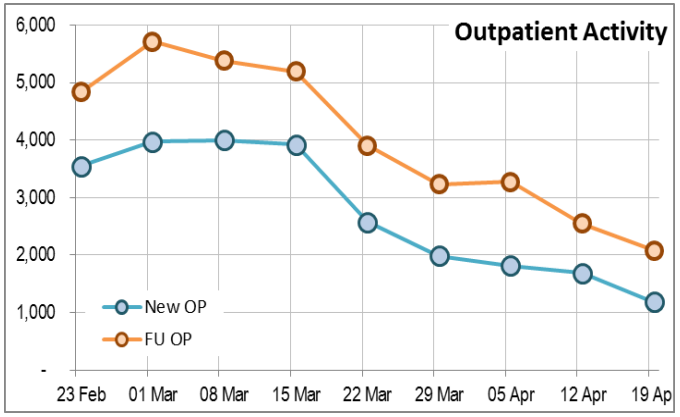
| Summary: | Actions: | Assurance: |
|---|---|---|
| With 4 tumour sites achieving 100% for patients treated in 62 days, the higher numbers of treatments in Breast and Gynae have contributed to the Trust's achievement of 85.6% for the 62 day standard<br><br>Whilst Urology has the highest number of treatments only 76.7% were treated within 62 days<br><br>PTL Backlog:- The current backlog is being maintained at approx 61 patients over day 63. The change is % is due to the significant decrease in the total overall PTL numbers and not due to an increase in the backlog | Action plans for each pathway have been developed for each tumour site with timeframes and accountability clearly assigned.<br>Increased imaging capacity has been identified and is supporting a reduction in the time between request and scan and between scan and report in order to deliver faster diagnosis and staging so that patients can be treated more quickly.<br>Recruitment to new supporting roles: Rapid access triage nurse (gynaecology), lung CNS, and pathology/radiology/ urology/endoscopy navigators to help support the front end of the pathway.<br>All options' clinic for the prostate pathway and doubling the number of brachytherapy lists each week. | Daily huddles with each tumour site team are in place and daily PTLs to give oversight and hold services to account for patient next steps.<br>Additional funding has been secured from the CCG and Cancer Alliance to support proposed actions and posts required to continue cancer pathway improvements.<br>Daily PTLs with GMs and DDOs for all tumour sites with endoscopy, radiology, pathology and oncology presence. These are circulated to allow for services to easily pick up high risk patients for additional focus.<br>Harm reviews are conducted for all patients treated over 104 days.<br>Weekly cancer performance meeting to review breach risks and outstanding tumour site issues. |

# Escalation: COVID-19




**ED Attendances** : Attendances were already running a few percent below model in February, and the week ending 08-Mar was 8.4% down, a level normally seen once in every 40 weeks. 13-Mar , the day after the UK threat level was increased to 'high', saw daily attendances fall below the normal ranges, and this reduction continued for about 10 days before levelling off shortly after the lockdown (at 55-60% down on normal). Minor attendances have reduced more than Majors, with Ambulance arrivals around 30% down, whilst non ambulance are 60-65% down.

**Emergency Admissions** : Non-zero emergency admissions have been around 35% down on normal over the past 3 weeks, whilst zero LoS admissions are down around 30%. CDU Only is down almost 70%, but this is due to a reduction in use of CDU. Similar to ED, the activity took 2-3 weeks to reduce.

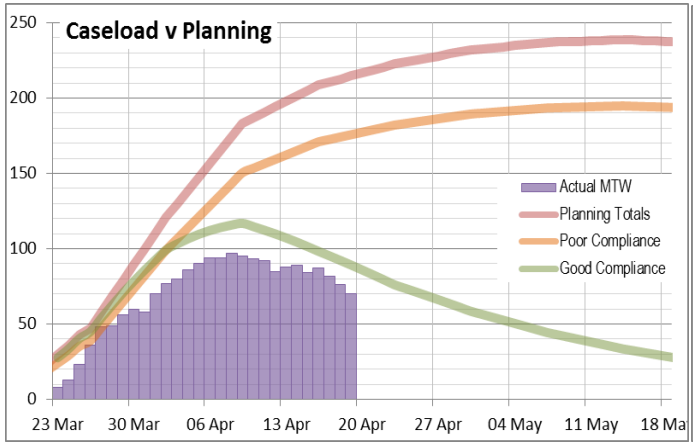
**Elective / Daycase Activity** : Large scale cancellations of elective activity has resulted in admitted electives reducing by 80-85% on normal levels, and daycases by 85-90%. Elective activity has taken longer to reduce than non-elective, as it reflects our cancellation / postponement practices rather than patient's behaviour. Daycases activity declined more sharply.

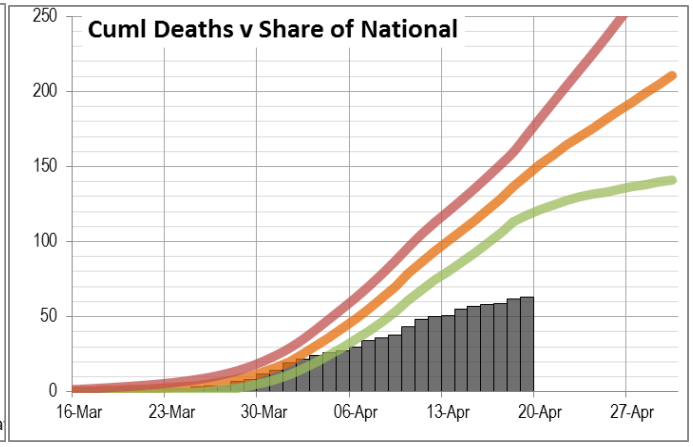
**Outpatient Activity** : New Outpatient activity has reduced by around 60%, and follow up by around 50%, (though it is suspected that the last weeks figures are still slightly undercounting as uncashed appointments are still in the system). As with elective activity, the week-by-week reduction has been slower than seen in emergency activity.

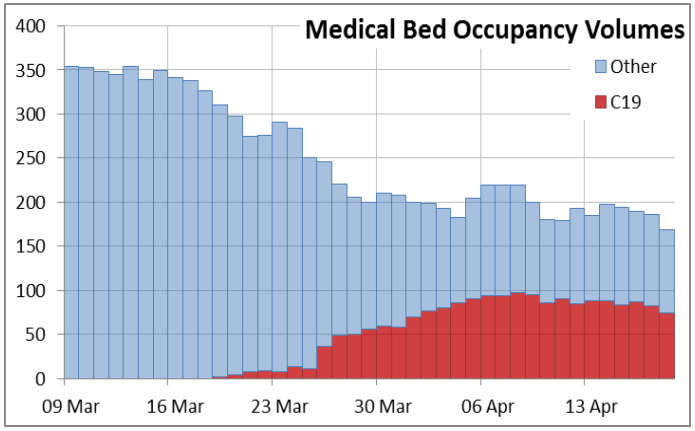
**Summary** : All activity is down

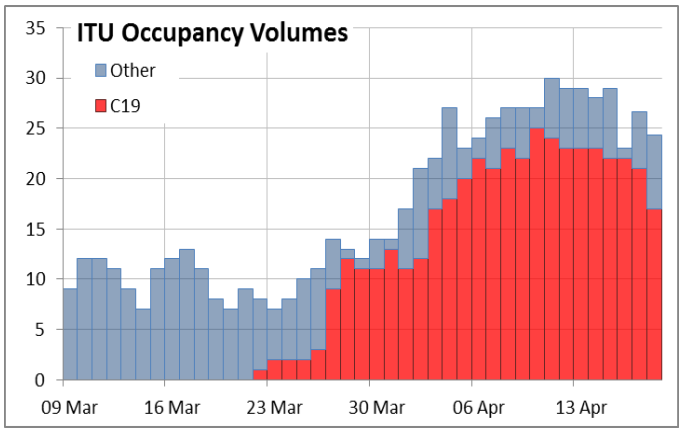
- Minor ED attendances down 60-65%,
- Major ED down ~30%
- Emergency admissions down 30-35%
- Daycase & elective activity down 80-90%
- Outpatient activity down 50-60%

# Escalation: COVID-19




**Caseload v Planning** : New bed planning figures were released on 07-Apr which accounted for new data & the effects of a lockdown. They had two scenarios – good compliance with lockdown creating a peak around 07-08 April followed by a rapid falloff, and poor compliance creating a higher peak in mid May, followed by slower falloff. Bed planning totals were set at this plus around 22%. So far, MTW has consistently tracked 10-20% below the good compliance totals

**Deaths** : The national total being quoted daily is hospital deaths. Since our local population is 0.88% of the national total, then if deaths were spread evenly throughout the country, then by Sun 19-Apr, we would have expected our cumulative total to be 140-145. In reality it was less than half that at 63. This, along with our caseload, indicates that our local area has not been hit as badly as others.

**Bed Occupancy** : Medical bed occupancy started to reduce from its normal level of 330-360 patients around 16-Mar, as a combination of reduced emergency demand, and the emergency plan to clear beds & reduce elective activity took effect. Occupancy was below 300 as the first cases came in, and has levelled off at 180-220. In the past 2 weeks, 45% of medical bed occupancy has been Covid Patients

**ITU Occupancy** : This was around normal levels of 8-12 for the two weeks before the first patients arrived, before rising sharply to 25-30. In the past 2 weeks, over 80& of ITU occupancies have been Covid positive

**Summary** :
MTW caseloads & deaths have both been tracking well below what we would expect, indicating that our region has been hit less than others. Covid patients currently account for 45% of medical & 80% of ITU bed occupancy

NHS
Maidstone and Tunbridge Wells NHS Trust

# Appendices

MTW
exceptional people, outstanding care

| Safe | | 2018/19 | 2019/20 | Q2 | | | Q3 | | | Q4 | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | YTD | FOT | YTD Var from Plan |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ID | Key Performance Indicators | Outturn | Target | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | | |
| S1 | Rate of Cdifficile per 100,000 beddays | 22.8 | 22.4 | 35.5 | 39.2 | 46.4 | 19.2 | 15.1 | 9.7 | 32.1 | 19.9 | 28.4 | 44.6 | 0.0 | 25.6 | 14.8 | 29.6 | 35.1 | 19.6 | 29.4 | 4.7 | 13.7 | 19.6 | 23.7 | 21.4 | 21.4 | -4.3% |
| S2 | CDifficile (Post 72hrs) - Hospital | 56 | 55 | 7 | 8 | 9 | 4 | 3 | 2 | 7 | 4 | 6 | 9 | 0 | 5 | 3 | 6 | 7 | 4 | 6 | 1 | 3 | 4 | 4 | 52 | 52 | -3 |
| S3 | MRSA Bacteraemia (Post 48hrs) Hospital | 3 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 2 | 2 |
| S3.1 | % Elective MRSA Screening | 98.0% | 98.0% | 98.7% | 98.5% | 98.7% | 99.0% | 99.0% | 99.0% | 98.0% | 99.0% | 98.0% | 99.0% | 99.1% | 99.0% | 99.0% | 99.0% | 99.0% | 98.9% | 99.4% | 98.8% | 100.0% | 96.6% | 0.0% | 0.0% | 0.0% | -98.0% |
| S3.2 | % Non-Elective MRSA Screening | 93.1% | 95.0% | No data | No data | No data | 93.0% | 95.2% | 95.0% | 86.0% | 92.5% | 93.1% | 89.0% | 92.0% | 90.0% | 92.3% | 95.0% | 92.9% | 91.6% | 90.8% | 94.1% | 92.3% | 95.8% | 94.3% | 94.3% | 94.3% | -0.7% |
| S4 | Rate of E. Coli Bacteraemia per 100,000 beddays | 28.1 | 21.5 | 35.5 | 34.3 | 15.5 | 24.0 | 50.3 | 24.3 | 13.8 | 19.9 | 33.2 | 29.8 | 14.1 | 35.8 | 19.8 | 34.5 | 55.1 | 63.5 | 19.6 | 14.0 | 36.6 | 24.6 | 23.7 | 30.9 | 30.9 | 9.7 |
| S4.1 | MSSA Bacteraemia (Post 48hrs) | 19 | 19 | 2 | 5 | 0 | 1 | 0 | 1 | 2 | 0 | 2 | 1 | 3 | 0 | 4 | 1 | 6 | 0 | 3 | 6 | 1 | 0 | 2 | 27 | 27 | 8 |
| S4.2 | E. Coli Bacteraemia (Post 48hrs) | 69 | 52 | 7 | 7 | 3 | 5 | 10 | 5 | 3 | 4 | 7 | 6 | 3 | 7 | 4 | 7 | 11 | 13 | 4 | 3 | 8 | 5 | 4 | 75 | 75 | 23 |
| S4.3 | Cases of Gram Negative Bactareamia | 113 | 113 | 10 | 10 | 7 | 11 | 12 | 9 | 5 | 8 | 11 | 8 | 4 | 7 | 8 | 8 | 14 | 16 | 5 | 6 | 8 | 7 | 4 | 95 | 95 | -18 |
| S4.4 | Catheters inserted | 1,160 | 225 | 222 | No data | No data | 310 | 209 | No data | No data | No data | 205 | 213 | 224 | 245 | 181 | 212 | 191 | 278 | - | - | 207 | 226 | 185 | 185 | 185 | - 40 |
| S5 | Rate of Hospital Acquired Pressure Ulcers | 1.32 | 1.26 | 0.51 | 1.79 | 1.56 | 1.31 | 1.36 | 1.23 | 0.97 | 1.09 | 0.32 | 1.05 | 0.81 | 0.68 | 0.61 | 1.86 | 2.49 | 2.19 | 1.93 | 2.32 | 2.28 | 2.14 | 2.49 | 1.74 | 1.74 | 0.5 |
| S5.1 | Rate of All Pressure Ulcers | 16.5 | 16.0 | 18.6 | 15.1 | 15.8 | 18.2 | 16.5 | 17.2 | 16.5 | 18.6 | 14.4 | 23.0 | 20.9 | 23.7 | 22.1 | 22.5 | 24.3 | 27.6 | 21.9 | 20.9 | 23.7 | 33.4 | 29.3 | 24.4 | 24.4 | 8.4 |
| S5.2 | Pressure Ulcers Grade 2 | 49 | 36 | 1 | 5 | 2 | 4 | 2 | 4 | 3 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 4 | 5 | 0 | 6 | 6 | 3 | 4 | 33 | 33 | - 3 |
| S5.3 | Pressure Ulcers Grades 3 | 3 | - | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | - |
| S5.4 | Pressure Ulcers Grades 4 | 3 | - | 0 | 1 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 2 | 2 | 2 |
| S5.5 | Pressure Ulcers Deemed "Un-gradeable" | 13 | 24 | 2 | 4 | 3 | 0 | 0 | 0 | - | - | 0 | 3 | 0 | 1 | 0 | 2 | 4 | 4 | 3 | 5 | 2 | 1 | 2 | 27 | 27 | 3 |
| S5.6 | Pressure Ulcers DTIs | 25 | 36 | 0 | 0 | 4 | 4 | 6 | 3 | 1 | 5 | 2 | 2 | 4 | 2 | 3 | 8 | 7 | 5 | 8 | 3 | 7 | 9 | 7 | 65 | 65 | 29 |
| S5.7 | Pressure Ulcers MASD | - | - | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | - |
| S5.8 | Pressure UlcersTotal | 93 | 96 | 3 | 11 | 9 | 8 | 8 | 7 | 6 | 6 | 2 | 6 | 5 | 4 | 4 | 11 | 15 | 14 | 12 | 15 | 15 | 13 | 13 | 127 | 127 | 31 |
| S6 | Rate of Patient Falls | 6.21 | 6.00 | 7.86 | 6.76 | 6.80 | 5.81 | 6.79 | 5.21 | 6.88 | 6.58 | 5.31 | 6.94 | 5.66 | 6.14 | 5.68 | 7.14 | 5.91 | 5.33 | 5.04 | 6.69 | 6.50 | 6.09 | 5.93 | 6.09 | 6.09 | 0.09 |
| S6.1 | Rate of Patient Falls TWH | 6.75 | 6.30 | 6.90 | 7.53 | 6.90 | 6.38 | 7.18 | 6.19 | 8.29 | 7.73 | 6.28 | 7.48 | 6.53 | 7.14 | 7.11 | 9.03 | 6.44 | 6.58 | 5.75 | 7.09 | 7.39 | 6.69 | 6.97 | 7.02 | 7.02 | 0.72 |
| S6.2 | Rate of Patient Falls MH | 5.31 | 5.05 | 9.57 | 5.44 | 6.62 | 4.84 | 6.11 | 3.60 | 4.64 | 4.76 | 3.78 | 5.96 | 4.18 | 4.48 | 3.49 | 4.18 | 5.13 | 3.49 | 4.04 | 6.11 | 5.29 | 5.31 | 4.50 | 4.70 | 4.70 | -0.30 |
| S6.3 | Falls resulting in "No Harm" | 1,170 | 1,116 | 122 | 93 | 97 | 99 | 97 | 82 | 115 | 102 | 89 | 93 | 92 | 97 | 78 | 119 | 93 | 90 | 78 | 117 | 116 | 106 | 84 | 1163 | 1163 | 47 |
| S6.4 | Falls resulting in "Low Harm" | 312 | 300 | 39 | 35 | 29 | 18 | 34 | 22 | 31 | 26 | 16 | 37 | 21 | 20 | 30 | 19 | 20 | 19 | 22 | 22 | 23 | 16 | 13 | 262 | 262 | - 38 |
| S6.5 | Falls resulting in "Moderate Harm" | 33 | 24 | 7 | 5 | 2 | 2 | 3 | 2 | 2 | 2 | 6 | 6 | 3 | 2 | 3 | 2 | 2 | 0 | 3 | 0 | 3 | 0 | 1 | 25 | 25 | 1 |
| S6.6 | Falls resulting in "Severe Harm" | 22 | 24 | 0 | 5 | 3 | 2 | 1 | 1 | 3 | 1 | 1 | 2 | 4 | 1 | 5 | 5 | 3 | 0 | 0 | 4 | 0 | 1 | 2 | 27 | 27 | 3 |
| S6.7 | Falls resulting in "Death" | 2 | - | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 2 | 2 | 2 |
| S6.8 | Total Number of Patient Falls | 1,525 | 1,464 | 155 | 138 | 132 | 121 | 135 | 107 | 150 | 132 | 112 | 140 | 120 | 120 | 115 | 145 | 118 | 109 | 103 | 143 | 142 | 124 | 100 | 1479 | 1479 | 15 |
| S6.9 | Total Number of Patient Falls TWH | 1,033 | 996 | 87 | 97 | 85 | 84 | 90 | 79 | 111 | 95 | 81 | 93 | 87 | 87 | 89 | 112 | 77 | 80 | 69 | 89 | 93 | 77 | 68 | 1021 | 1021 | 25 |
| S6.10 | Total Number of Patient Falls MH | 492 | 468 | 68 | 41 | 47 | 37 | 45 | 28 | 39 | 37 | 31 | 46 | 33 | 33 | 27 | 33 | 41 | 29 | 34 | 54 | 49 | 47 | 32 | 458 | 458 | - 10 |
| S7 | Never Events | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 3 | 3 | 3 |
| S8 | Number of New SIs in month | 154 | 144 | 11 | 18 | 17 | 19 | 11 | 5 | 10 | 8 | 8 | 17 | 15 | 8 | 9 | 17 | 7 | 10 | 6 | 13 | 11 | 10 | 8 | 131 | 131 | - 13 |
| S8.1 | Serious Incidents rate | 0.63 | 0.59 | 0.56 | 0.88 | 0.88 | 0.91 | 0.55 | 0.24 | 0.46 | 0.40 | 0.38 | 0.84 | 0.71 | 0.41 | 0.44 | 0.84 | 0.35 | 0.49 | 0.29 | 0.61 | 0.50 | 0.49 | 0.47 | 0.54 | 0.54 | 0.00 |
| S8.2 | Number of Open Sis | 85 | 95 | 96 | 96 | 110 | 97 | 90 | 104 | 87 | 81 | 85 | 97 | 99 | 93 | 84 | 83 | 80 | 82 | 62 | 59 | 48 | 46 | 44 | 44 | 44 | - 51 |
| S9 | SIs not closed <60 Days Monthly Snapshot | | 24 | | | | | | | | | | 97 | 99 | 93 | 84 | 80 | 78 | 82 | 62 | 58 | 48 | 45 | 44 | 44 | 44 | 20 |
| S10 | Overall Safe staffing fill rate | 96.8% | 93.5% | 95.8% | 94.3% | 95.0% | 99.2% | 99.5% | 95.3% | 98.0% | 95.8% | 95.5% | 94.8% | 94.2% | 94.0% | 94.4% | 93.4% | 92.5% | 97.4% | 101.2% | 98.1% | 100.3% | 97.3% | 93.0% | 95.9% | 95.9% | 2.4% |
| S11 | Safety Thermometer % of Harm Free Care | 97.4% | 95.0% | 98.2% | 98.3% | 97.6% | 97.3% | 97.5% | 98.4% | 97.9% | 98.5% | 97.4% | 97.5% | 98.5% | 98.0% | 97.8% | 98.3% | 82.8% | 85.7% | 88.5% | 89.3% | 86.7% | 88.0% | No data | | | -95.0% |
| S11.1 | Safety Thermometer % of New Harms | 2.6% | 3.0% | 1.8% | 1.7% | 2.4% | 2.6% | 2.3% | 1.6% | 2.1% | 1.5% | 2.6% | 2.4% | 1.5% | 1.9% | 2.3% | 1.7% | 8.8% | 6.5% | 5.6% | 5.4% | 7.4% | 5.4% | | | | -3.0% |
| S12 | Number of Central Alerting System Alerts Overdue | 8 | 12 | 0 | 2 | 0 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 2 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 5 | 0 | 1 | 15 | 15 | 3 |
| S13 | Medication Errors - Low Harm | 86 | 72 | 8 | 10 | 3 | 2 | 8 | 3 | 6 | 6 | 17 | 7 | 4 | 12 | 12 | 8 | 8 | 9 | 5 | 13 | 4 | 5 | 0 | 87 | 87 | 15 |
| S13.1 | Medication Errors - Moderate Harm | 11 | 12 | 1 | 3 | 0 | 0 | 1 | 1 | 0 | 4 | 1 | 3 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 2 | 0 | 8 | 8 | -4 |
| S13.2 | Medication Errors - Severe Harm | 4 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| S14 | Number of Incidents reported in month | 11,737 | 11,700 | 1,083 | 1,088 | 950 | 1,026 | 1,033 | 850 | 1,084 | 947 | 939 | 954 | 934 | 886 | 945 | 950 | 969 | 1130 | 1104 | 1121 | 1209 | 1189 | 875 | 12266 | 12266 | 566 |
| S14.1 | Rate of Incidents that are Harmful | 1.01 | 1.23 | 1.11 | 1.10 | 1.47 | 1.07 | 0.77 | 0.47 | 1.01 | 0.53 | 0.96 | 1.05 | 1.39 | 1.13 | 1.38 | 1.89 | 1.03 | 0.71 | 0.27 | 0.89 | 0.33 | 0.76 | 0.46 | 0.91 | 0.91 | -0.32 |
| S14.2 | Number of Incidents open >45 days | 1,931 | 1,931 | 2,273 | 1,959 | 1,515 | 2,135 | 1,469 | 2,095 | 2,046 | 2,205 | 1,416 | 1448 | 1931 | 2025 | 1940 | 1478 | 2844 | 2946 | 1665 | 2088 | 1724 | 1461 | 1058 | 1058 | 1058 | -873 |

| Effective | | 2018/19 | 2019/20 | Q2 | | | Q3 | | | Q4 | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | YTD | FOT | YTD Var From Plan |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ID | Key Performance Indicators | Outturn | Target | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | | |
| E1 | Hospital-level Mortality Indicator (SHMI) | Band 2 | Band 2 | 1.0440 | 1.0219 | 1.0219 | 1.0371 | 1.0244 | 1.0244 | 1.0391 | 1.0391 | 1.0391 | 1.0391 | 1.0296 | 1.0235 | 1.0165 | 1.0224 | 1.0363 | 1.0412 | 1.0348 | 1.0331 | 1.0249 | 1.0132 | 1.0080 | 1.0080 | 1.0080 | Band 2 |
| E2 | Standardised Mortality HSMR | Lower Confidence <100 | | 106.70 | 105.80 | 104.80 | 103.70 | 102.40 | 103.30 | 102.30 | 101.20 | 99.40 | 96.30 | 97.20 | 92.70 | 93.10 | 91.50 | 91.50 | 91.70 | 92.70 | 91.00 | 91.70 | 91.80 | 91.80 | 91.8 | 91.8 | -8.2 |
| E2.1 | Crude Mortality | 1.00% | 1.00% | 0.94% | 0.90% | 1.14% | 0.88% | 0.77% | 1.02% | 1.25% | 1.11% | 1.07% | 1.01% | 0.85% | 0.70% | 0.86% | 0.83% | 0.99% | 0.86% | 0.94% | 0.99% | 1.07% | 1.01% | 0.73% | 0.92% | 0.92% | -0.1% |
| E3 | % Total Readmissions | 14.13% | 14.13% | 14.24% | 14.21% | 13.69% | 14.60% | 13.99% | 15.27% | 14.39% | 14.59% | 14.71% | 14.91% | 13.53% | 14.94% | 15.23% | 14.60% | 15.47% | 14.61% | 15.59% | 15.21% | 13.56% | 14.58% | 10.5% | 14.76% | 14.76% | 0.6% |
| E4 | Readmissions <30 days: Emergency | 14.76% | 14.76% | 14.78% | 14.75% | 14.33% | 15.42% | 14.83% | 16.04% | 14.84% | 15.23% | 15.34% | 15.56% | 14.29% | 15.31% | 15.95% | 15.08% | 16.15% | 15.21% | 16.22% | 15.67% | 13.89% | 15.17% | 10.7% | 15.32% | 15.32% | 0.6% |
| E5 | Readmissions <30 days: Emergency (excl SDEC) | 14.00% | 14.00% | 15.04% | 13.79% | 13.08% | 14.15% | 13.84% | 14.27% | 14.63% | 14.11% | 14.42% | 15.24% | 13.86% | 14.10% | 14.88% | 14.87% | 16.18% | 14.69% | 15.26% | 14.60% | 13.69% | 15.74% | 9.4% | 14.73% | 14.73% | 0.0% |
| E6 | Readmissions <30 days: Elective | 6.84% | 6.84% | 7.77% | 8.08% | 6.08% | 5.43% | 6.00% | 5.96% | 8.04% | 6.58% | 7.43% | 7.73% | 5.34% | 10.21% | 6.58% | 9.00% | 7.12% | 7.62% | 8.26% | 8.49% | 9.40% | 8.06% | 7.0% | 7.91% | 7.91% | 1.1% |
| E7 | Stroke: Best Practice Tariff Overall % | 43.1% | 50.0% | 58.3% | 48.1% | 42.3% | 54.3% | 55.4% | 53.3% | 49.1% | 47.5% | 43.1% | 36.9% | 37.9% | 37.7% | 45.5% | 40.6% | 37.3% | 44.4% | 47.3% | 46.9% | 47.1% | 37.0% | | 41.7% | 41.7% | -8.3% |
| E7.1 | Stroke BPT Part 1: First Ward | 75.9% | 80.0% | 80.0% | 82.7% | 76.9% | 77.1% | 87.7% | 82.2% | 81.1% | 83.6% | 75.9% | 64.6% | 63.6% | 75.4% | 77.3% | 78.1% | 74.5% | 79.4% | 78.2% | 71.9% | 80.4% | 74.1% | Data runs one month behind | 74.1% | 74.1% | -5.9% |
| E7.2 | Stroke BPT Part 2: Cons <=14 Hours | 50.0% | 58.0% | 66.7% | 56.8% | 50.0% | 57.1% | 61.5% | 57.8% | 62.3% | 49.2% | 50.0% | 50.8% | 45.5% | 52.5% | 57.6% | 42.2% | 47.1% | 57.1% | 54.5% | 53.1% | 56.9% | 42.6% | | 50.9% | 50.9% | -7.1% |
| E7.3 | Stroke BPT Part 3: 90% Time on Stroke Ward | 89.7% | 80.0% | 86.67% | 83.95% | 84.62% | 85.71% | 92.31% | 91.11% | 90.57% | 91.80% | 89.66% | 80.0% | 71.2% | 80.3% | 81.8% | 82.8% | 76.5% | 79.4% | 80.0% | 82.8% | 74.5% | 77.8% | | 78.9% | 78.9% | -1.1% |
| E7.4 | % TIA <24hrs | 64.7% | 60.0% | 29.2% | 65.2% | 63.2% | 66.7% | 70.6% | 58.3% | 91.7% | 61.9% | 42.1% | 60.6% | 53.3% | 54.5% | 57.7% | 51.9% | 36.4% | 71.4% | 70.8% | 68.2% | No data | No data | | 58.1% | 58.1% | 5.2% |
| E8 | Nat CQUIN: % Dementia Screening | 98.8% | 90.0% | 99.6% | 100.0% | 99.8% | 99.6% | 99.8% | 100.0% | 100.0% | 99.8% | 98.8% | 94.3% | 92.3% | 84.4% | 91.0% | 95.5% | 98.7% | 98.4% | 98.8% | 99.6% | 99.1% | 99.5% | Data runs one month behind | 95.2% | 95.2% | -6.5% |
| E9 | Nat CQUIN: % Dementia Risk Asssessed | 98.7% | 90.0% | 94% | 96% | 90.0% | 95.5% | 100.0% | 99.0% | 100.0% | 100.0% | 98.7% | 98.2% | 93.9% | 92.2% | 96.4% | 89.6% | 700.0% | 97.3% | 96.2% | 82.1% | 100.0% | 97.6% | | 101.7% | 101.7% | 0.7% |
| E10 | Nat CQUIN: % Dementia Referred to Specialist | 100.0% | 90.0% | 98% | 100% | 98.6% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 98.1% | 100.0% | 100.0% | 96.2% | 100.0% | 100.0% | 100.0% | 98.0% | 100.0% | 100.0% | 97.6% | | 99.1% | 99.1% | -3.8% |
| E10.1 | NE LOS for Patients with Dementia | | | | | | | | | | | | 7.7 | 9.0 | 7.9 | 9.3 | 8.8 | 8.8 | 8.2 | 8.8 | 8.3 | 8.8 | 8.3 | 8.4 | 8.6 | 0.0 | 0.0 |
| E10.2 | Readmissions <30 Days for Pt with Dementia | | | | | | | | | | | | 21.0% | 20.7% | 22.4% | 29.4% | 27.7% | 23.0% | 22.6% | 22.6% | 24.1% | 21.2% | 9.3% | Mth behind | 23.4% | 23.4% | -1.4% |
| E11 | C-Section Rate (elective or non-elective) | 27.9% | 25.0% | 26.9% | 28.8% | 24.0% | 29.7% | 30.2% | 26.5% | 31.3% | 29.5% | 27.0% | 31.1% | 32.3% | 27.5% | 28.6% | 27.5% | 29.6% | 30.8% | 29.3% | 27.8% | 25.2% | 26.6% | 28.6% | 14.7% | 28.8% | -10.3% |
| E11.1 | % Mothers initiating Breastfeeding | 82.2% | 78.0% | 79.14% | 84.02% | 81.74% | 77.72% | 83.50% | 80.45% | 84.37% | 84.01% | 85.19% | 83.3% | 83.8% | 79.3% | 82.6% | 80.9% | 80.5% | 81.5% | 84.9% | 80.0% | 83.9% | 77.9% | 83.2% | 81.9% | 81.9% | 3.9% |
| E11.2 | % Stillbirths Rate | 0.17% | 0.47% | 0.20% | 0.19% | 0.20% | 0.00% | 0.20% | 0.00% | 0.42% | 0.23% | 0.21% | 0.48% | 0.39% | 0.21% | 0.00% | 0.43% | 0.83% | 0.00% | 0.21% | 0.47% | 0.22% | 1.36% | 0.66% | 0.43% | 0.43% | 0.0% |

| Caring | | 2018/19 Outturn | 2019/20 Target | Q2 | | | Q3 | | | Q4 | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | YTD | FOT | YTD Var from Plan |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ID | Key Performance Indicators | | | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | | |
| C1 | Single Sex Accommodation Breaches | 35 | 0 | 5 | 12 | 0 | 10 | 8 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| C2 | Rate of New Complaints | 2.30 | 2.93 | 1.93 | 1.67 | 2.22 | 2.84 | 2.41 | 2.34 | 2.39 | 2.04 | 3.17 | 2.28 | 2.21 | 2.71 | 2.27 | 2.51 | 1.85 | 2.93 | 2.25 | 2.01 | 2.20 | 2.60 | 3.62 | 2.43 | 2.43 | -0.50 |
| C3 | % complaints responded to within target | 75.7% | 75.0% | 73.3% | 62.8% | 54.3% | 65.3% | 75.0% | 66.7% | 82.8% | 73.3% | 75.7% | 66.7% | 37.5% | 45.7% | 65.4% | 65.1% | 71.4% | 85.4% | 74.0% | 80.0% | 80.4% | 67.5% | 75.0% | 67.8% | 67.8% | -7.2% |
| C3.1 | Total Open Complaints | 149 | 140 | 155 | 137 | 144 | 139 | 129 | 129 | 130 | 120 | 149 | 155 | 173 | 154 | 134 | 149 | 132 | 143 | 145 | 127 | 125 | 141 | 160 | 160 | 160 | 20 |
| C3.2 | Number of new complaints received | 564 | 720 | 38 | 34 | 43 | 59 | 48 | 48 | 52 | 41 | 67 | 46 | 47 | 53 | 46 | 51 | 37 | 60 | 46 | 43 | 48 | 53 | 61 | 591 | 591 | -129 |
| C3.3 | Number of Nursing Complaints | 107 | 108 | 8 | 5 | 7 | 9 | 13 | 12 | 10 | 12 | 10 | 5 | 9 | 11 | 7 | 10 | 5 | 5 | 9 | 2 | 7 | 10 | 10 | 90 | 90 | -18 |
| C3.4 | Number of Medical Complaints | 353 | 336 | 24 | 21 | 26 | 41 | 32 | 32 | 31 | 23 | 43 | 30 | 26 | 33 | 31 | 26 | 23 | 39 | 22 | 28 | 34 | 32 | 38 | 362 | 362 | 26 |
| C3.5 | Number of Complaints open 60-90 days | 182 | 180 | 15 | 18 | 11 | 12 | 10 | 11 | 13 | 12 | 19 | 14 | 25 | 18 | 16 | 22 | 13 | 9 | 10 | 13 | 6 | 13 | 9 | 168 | 168 | -12 |
| C3.6 | Number of Complaints open >90 days | 349 | 348 | 36 | 37 | 43 | 29 | 25 | 20 | 19 | 18 | 20 | 30 | 33 | 33 | 27 | 32 | 24 | 24 | 25 | 23 | 29 | 22 | 22 | 324 | 324 | -24 |
| C4 | % IP Response Rate Friends & Family | 17.9% | 25.0% | 19.5% | 18.7% | 20.1% | 15.3% | 24.5% | 19.6% | 18.7% | 18.2% | 17.9% | 18.7% | 20.4% | 16.5% | 16.0% | 15.4% | 16.6% | 8.0% | 19.5% | 17.1% | 16.0% | 16.7% | No data as not collected or reported in March due to COVID-19 | 16.4% | 16.4% | -8.6% |
| C5 | IP Friends & Family (FFT)% positive | 94.8% | 95.0% | 94.2% | 95.9% | 93.8% | 94.2% | 93.7% | 93.9% | 93.5% | 95.6% | 94.8% | 94.2% | 95.6% | 96.7% | 95.1% | 93.9% | 94.0% | 98.5% | 95.7% | 96.5% | 96.3% | 97.8% | | 95.7% | 95.7% | 0.7% |
| C6 | % A&E Response Rate Friends & Family | 8.9% | 15.0% | 12.1% | 8.1% | 12.3% | 4.2% | 21.2% | 12.9% | 5.4% | 7.6% | 8.9% | 11.0% | 14.6% | 12.3% | 9.6% | 10.1% | 9.1% | 0.8% | 2.3% | 12.1% | 1.9% | 10.0% | | 8.5% | 8.5% | -6.5% |
| C7 | A&E Friends & Family (FFT) % positive | 92.0% | 87.0% | 89.4% | 92.6% | 90.9% | 91.4% | 91.0% | 89.9% | 90.5% | 91.3% | 92.0% | 81.2% | 86.1% | 91.6% | 91.5% | 88.1% | 85.7% | 96.4% | 88.7% | 87.3% | 87.2% | 89.5% | | 87.7% | 87.7% | 0.7% |
| C8 | % Maternity Combined Q2 Response Rate | 20.3% | 25.0% | 27.0% | 9.9% | 43.8% | 18.2% | 11.8% | 23.9% | 37.6% | 26.2% | 20.3% | 20.1% | 6.0% | 45.5% | 44.5% | 33.4% | 17.3% | 7.8% | 12.0% | 16.3% | 20.1% | 10.6% | | 21.2% | 21.2% | -3.8% |
| C9 | Maternity Combined FFT % Positive | 98.4% | 95.0% | 93.5% | 98.0% | 92.1% | 95.0% | 99.1% | 90.4% | 95.8% | 96.5% | 98.4% | 93.8% | 97.1% | 94.2% | 94.0% | 93.6% | 94.7% | 97.0% | 97.8% | 99.7% | 96.9% | 96.0% | | 95.5% | 95.5% | 0.5% |
| C10 | OP Friends & Family (FFT) % Positive | 81.2% | 84.0% | 85.2% | 81.7% | 83.9% | 82.7% | 84.1% | 84.2% | 84.4% | 84.3% | 81.2% | 82.5% | 82.5% | 81.5% | 82.1% | 83.0% | 81.3% | 82.3% | 84.2% | 82.2% | 83.6% | 83.2% | | 82.6% | 82.6% | -1.4% |
| C10.1 | OP Friends & Family (FFT) Response Rate | 68.5% | 68.0% | 66.2% | 66.2% | 67.4% | 68.6% | 68.8% | 67.4% | 69.0% | 68.5% | 68.5% | 49.3% | 62.5% | 56.9% | 55.4% | 56.5% | 51.3% | 59.0% | 67.7% | 48.8% | 59.2% | 61.2% | | 57.1% | 57.1% | -10.9% |
| C11 | VTE Risk Assessment (%) | 96.4% | 95.0% | 97.2% | 95.4% | 96.1% | 96.9% | 97.2% | 96.5% | 97.2% | 97.4% | 96.4% | 97.0% | 96.9% | 97.1% | 97.3% | 96.7% | 96.7% | 96.9% | 95.9% | 95.6% | 96.4% | 95.8% | Mth behind | 96.6% | 96.6% | 1.6% |

| Responsive | | 2018/19 | 2019/20 | Q2 | | | Q3 | | | Q4 | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | YTD | FOT | YTD Var From Plan |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ID | Key Performance Indicators | Outturn | Target | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | | |
| R1 | A&E % 4hrs Arrival to Exit - Trust (Inc MIU) | 92.09% | 91.67% | 93.16% | 91.79% | 93.93% | 90.75% | 90.93% | 89.6% | 88.91% | 87.16% | 95.85% | 92.29% | 92.16% | 94.65% | 93.73% | 90.27% | 89.54% | 87.78% | 87.63% | 85.41% | 91.13% | 90.59% | 93.12% | 90.64% | 90.64% | -1.0% |
| R1.1 | A&E % 4hrs Arrival to Exit - Maidstone | 95.07% | 95.23% | 94.41% | 93.42% | 97.17% | 96.26% | 95.21% | 92.22% | 92.87% | 90.80% | 97.81% | 94.35% | 94.00% | 95.95% | 96.79% | 89.89% | 92.96% | 88.79% | 89.04% | 86.17% | 91.05% | 88.11% | 92.77% | 91.65% | 91.65% | -3.6% |
| R1.2 | A&E % 4hrs Arrival to Exit - TWells | 86.25% | 85.08% | 88.79% | 86.60% | 88.45% | 82.33% | 84.05% | 83.58% | 81.32% | 78.91% | 92.60% | 87.11% | 87.30% | 91.10% | 88.36% | 86.15% | 81.83% | 81.94% | 81.78% | 79.61% | 87.80% | 89.14% | 90.77% | 85.90% | 85.90% | 0.8% |
| R1.3 | A&E Conversion Rate | 20.8% | 20.8% | 20.8% | 21.0% | 20.4% | 20.9% | 20.8% | 21.4% | 20.9% | 20.4% | 20.4% | 20.0% | 19.0% | 18.4% | 17.7% | 19.4% | 18.9% | 19.2% | 19.1% | 19.9% | 20.6% | 19.9% | 21.6% | 19.4% | 19.4% | -1.4% |
| R1.4 | A&E Left without being Seen Rate (%) | 2.8% | 2.8% | 3.4% | 3.2% | 2.5% | 2.3% | 2.4% | 2.5% | 2.6% | 3.3% | 2.4% | 2.8% | 2.4% | 2.5% | 2.8% | 2.8% | 2.8% | 2.4% | 2.7% | 3.2% | 2.0% | 2.2% | 1.6% | 2.5% | 2.5% | -0.2% |
| R1.5 | A&E Time to Assessment 15 mins | 95.3% | 95.0% | 95.9% | 94.9% | 97.0% | 95.2% | 95.9% | 95.3% | 94.7% | 91.5% | 95.2% | 94.5% | 90.0% | 92.0% | 90.9% | 89.0% | 87.0% | 87.4% | 88.4% | 76.0% | 89.2% | 56.8% | 57.0% | 81.7% | 81.7% | -13.3% |
| R1.6 | A&E Time to Treatment 60 mins | 55.9% | 55.9% | 53.5% | 54.7% | 57.5% | 55.4% | 58.1% | 55.3% | 56.7% | 52.9% | 57.2% | 55.7% | 56.4% | 58.9% | 58.8% | 58.1% | 57.8% | 60.1% | 57.3% | 51.0% | 60.1% | 59.6% | 68.7% | 58.3% | 58.3% | 2.4% |
| R1.7 | A&E Unplanned Re-Attendance Rate (%) | 8.0% | 8.0% | 8.3% | 8.7% | 7.6% | 8.4% | 8.1% | 8.1% | 7.8% | 8.3% | 8.0% | 8.3% | 8.5% | 8.4% | 8.3% | 8.7% | 9.1% | 8.3% | 8.8% | 8.5% | 8.7% | 8.9% | 0.0% | 8.0% | 8.0% | 0.0% |
| R1.8 | A&E Average Time in Department (Hours) | 0.14 | 0.14 | 0.14 | 0.14 | 0.13 | 0.15 | 0.14 | 0.15 | 0.15 | 0.16 | 0.13 | 0.14 | 0.14 | 0.13 | 0.14 | 0.15 | 0.15 | 0.15 | 0.17 | 0.17 | 0.15 | 0.14 | 0.13 | 0.15 | 0.15 | 0.05 |
| R2 | A&E 12hr Breaches | 2 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| R3 | Ambulance Handover Delays >60mins | 596 | 540 | 22 | 60 | 31 | 67 | 82 | 70 | 74 | 83 | 13 | 57 | 59 | 26 | 42 | 56 | 77 | 57 | 50 | 75 | 14 | 21 | 5 | 539 | 539 | -0.2% |
| R3.1 | Ambulance Handover Delays >30mins | 4,487 | 4,428 | 250 | 400 | 284 | 486 | 442 | 441 | 613 | 444 | 280 | 494 | 531 | 384 | 528 | 490 | 581 | 508 | 492 | 641 | 370 | 416 | 66 | 5501 | 5501 | 24.2% |
| R4 | RTT Incomplete Pathway | 83.12% | 86.67% | 80.4% | 79.4% | 79.7% | 80.67% | 81.01% | 81.61% | 81.10% | 81.29% | 83.12% | 84.05% | 85.17% | 85.78% | 85.57% | 84.83% | 84.34% | 84.12% | 84.00% | 83.91% | 85.03% | 87.3% | 79.5% | 79.5% | 79.5% | -7.1% |
| R4.1 | RTT Incomplete Admitted Backlog | 2,606 | 2,315 | 3,434 | 3,348 | 3,065 | 2,930 | 2,867 | 2,779 | 2,829 | 2,781 | 2,606 | 2391 | 2157 | 2156 | 2171 | 2135 | 2004 | 1932 | 2079 | 2224 | 2153 | 1332 | 1986 | 1986 | 1986 | -14.2% |
| R4.2 | RTT Incomplete Non-Admitted Backlog | 2,182 | 872 | 3,298 | 3,911 | 3,578 | 3,200 | 3,235 | 2,886 | 2,781 | 2,807 | 2,182 | 2119 | 2148 | 2007 | 2259 | 2733 | 2906 | 3120 | 3113 | 3042 | 2631 | 2529 | 4036 | 4036 | 4036 | 363.0% |
| R4.3 | RTT Specialties Not Achieved Nat Target | 9 | 0 | 11 | 12 | 10 | 10 | 9 | 9 | 9 | 9 | 9 | 9 | 10 | 9 | 9 | 11 | 11 | 12 | 11 | 11 | 11 | 10 | 12 | 126 | 126 | 126 |
| R4.4 | RTT Incomplete Total Backlog | 4,788 | 3,186 | 6,732 | 7,259 | 6,643 | 6,130 | 6,102 | 5,665 | 5,610 | 5,588 | 4,788 | 4510 | 4305 | 4163 | 4430 | 4868 | 4910 | 5052 | 5192 | 5266 | 4784 | 3,861 | 6,022 | 6,022 | 6,022 | 89.0% |
| R5 | RTT 52 Week Waiters (New in Month) | 8 | 96 | 6 | 4 | 8 | 8 | 11 | 5 | 7 | 8 | 8 | 6 | 10 | 3 | 3 | 6 | 8 | 5 | 14 | 2 | 5 | 3 | 16 | 81 | 81 | -15 |
| R6 | % Diagnostics Tests WTimes <6wks | 99.2% | 99.0% | 99.7% | 99.6% | 99.4% | 99.5% | 99.4% | 99.1% | 99.1% | 99.5% | 99.2% | 99.1% | 99.1% | 98.7% | 98.5% | 96.5% | 98.7% | 99.3% | 99.1% | 98.0% | 98.2% | 99.5% | 93.7% | 93.7% | 99.0% | -5.3% |
| R7 | *Cancer two week wait | 88.7% | 93.0% | 82.3% | 76.4% | 78.0% | 86.5% | 90.0% | 88.1% | 87.6% | 89.2% | 88.7% | 82.6% | 87.6% | 81.0% | 87.1% | 89.0% | 93.1% | 93.0% | 93.0% | 94.7% | 93.4% | 93.2% | | 93.2% | 93.2% | 0.2% |
| R8 | *Cancer WT - Breast Symptons 2WW | 73.2% | 93.0% | 67.5% | 58.5% | 71.3% | 83.1% | 81.7% | 58.3% | 69.4% | 74.7% | 73.2% | 56.4% | 65.2% | 63.4% | 81.7% | 91.5% | 98.2% | 94.1% | 95.2% | 94.4% | 89.5% | 93.5% | | 93.5% | 93.5% | 0.5% |
| R9 | *Cancer 31 day wait - First Treatment | 96.1% | 96.0% | 97.9% | 96.2% | 95.1% | 96.2% | 96.8% | 97.2% | 95.9% | 96.2% | 96.1% | 96.5% | 96.0% | 96.8% | 97.7% | 97.2% | 96.4% | 97.5% | 97.2% | 99.5% | 96.7% | 98.9% | | 98.9% | 98.9% | 2.9% |
| R9.1 | *Cancer 31 day - Subs Treatment - Surgery | 92.9% | 94.0% | 96.4% | 96.2% | 82.4% | 92.0% | 79.4% | 100.0% | 82.4% | 96.0% | 92.9% | 87.1% | 96.3% | 96.7% | 100.0% | 86.2% | 95.8% | 97.0% | 96.7% | 85.7% | 85.3% | 89.7% | Data runs one month behind | 89.7% | 89.7% | -4.3% |
| R9.2 | *Cancer 31 day - Subs Treatment - Drugs | 99.0% | 98.0% | 100.0% | 99.1% | 98.7% | 99.3% | 98.7% | 98.3% | 96.7% | 98.2% | 99.0% | 100.0% | 100.0% | 100.0% | 98.9% | 100.0% | 99.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100.0% | 100.0% | 2.0% |
| R9.3 | *Cancer 31 day Subs Treatment Radio | 92.8% | 94.0% | 95.4% | 97.6% | 93.7% | 98.2% | 96.7% | 99.2% | 90.5% | 94.5% | 92.8% | 92.5% | 91.4% | 94.3% | 93.1% | 93.4% | 92.7% | 95.0% | 95.3% | 97.3% | 89.9% | 97.2% | | 97.2% | 97.2% | 3.2% |
| R10 | *Cancer 62 day wait - First Definitive | 67.9% | 85.0% | 57.5% | 67.7% | 60.1% | 62.6% | 56.4% | 63.3% | 65.6% | 56.0% | 67.9% | 64.5% | 70.9% | 73.1% | 72.2% | 86.3% | 85.4% | 85.8% | 85.6% | 87.3% | 85.6% | 85.6% | | 85.6% | 85.6% | 0.6% |
| R10.1 | *Cancer 62 day wait - First Definitive - MTW | 72.8% | 85.0% | 59.3% | 70.9% | 65.1% | 63.8% | 58.8% | 65.6% | 69.2% | 58.8% | 72.8% | 68.6% | 80.4% | 80.0% | 78.4% | 90.1% | 88.9% | 86.8% | 90.5% | 89.3% | 91.7% | 94.5% | | 94.5% | 94.5% | 9.5% |
| R10.2 | *Cancer WT - 62 Day Screening Referrals | 74.4% | 90.0% | 79.5% | 83.7% | 69.0% | 88.2% | 97.3% | 84.8% | 80.6% | 55.2% | 74.4% | 84.6% | 87.8% | 94.7% | 80.0% | 89.7% | 91.7% | 95.3% | 94.9% | 94.1% | 95.7% | 85.7% | | 85.7% | 85.7% | -4.3% |
| R10.3 | *Cancer WT - 62 Day Cons Specialist | 82.4% | 85.0% | 61.5% | 76.5% | 40.0% | 86.4% | 72.2% | 69.2% | 64.0% | 86.7% | 82.4% | 100.0% | 41.7% | 67.7% | 65.5% | 56.3% | 55.6% | 55.0% | 41.7% | 54.5% | 58.8% | 57.1% | | 57.1% | 57.1% | -27.9% |

| Well-Led | | 2018/19 | 2019/20 | Q2 | | | Q3 | | | Q4 | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | YTD | FOT | YTD Var From Plan |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ID | Key Performance Indicators | Outturn | Target | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | | |
| W1 | Surplus (Deficit) against B/E Duty | 12,006 | 6,896 | 574 | 82 | -1,014 | 3,075 | 2,030 | 136 | -2,567 | -457 | 13,359 | -2,001 | -71 | -1,272 | 2,569 | 1,036 | 407 | 1,535 | 24 | 2,039 | 1,720 | -798 | 1,815 | 7,003 | 7,003 | 1.5% |
| W2 | CIP Savings | 13,825 | 22,328 | 1,200 | 1,151 | 917 | 1,221 | 1,151 | 678 | 1,428 | 986 | 2,574 | 725 | 1,012 | 1,291 | 1,868 | 3,882 | 1,792 | 1,728 | 1,812 | 1,847 | 1,781 | 2,396 | 1,899 | 22,418 | 22,418 | 0.4% |
| W3 | Cash Balance | 10,405 | 3,000 | 18,207 | 14,126 | 13,493 | 12,640 | 8,566 | 12,766 | 7,956 | 10,625 | 10,405 | 41,294 | 39,537 | 44,793 | 56,821 | 45,854 | 42,824 | 30,327 | 28,428 | 23,239 | 17,669 | 21,922 | 3,356 | 3,356 | 3,356 | 11.9% |
| W4 | Capital Expenditure | 19,185 | 14,448 | 327 | 365 | 82 | 547 | 1,106 | 2,420 | 295 | 430 | 12,900 | 358 | 45 | 380 | 149 | 250 | 442 | 378 | 197 | 2,033 | 539 | 321 | 10,909 | 16,001 | 16,001 | 10.7% |
| W4.1 | Income | 465,038 | 502,732 | 41,154 | 38,606 | 36,805 | 40,695 | 40,821 | 38,634 | 37,148 | 34,981 | 44,309 | 40,150 | 41,400 | 40,363 | 43,400 | 41,228 | 40,971 | 42,902 | 39,701 | 44,349 | 43,346 | 38,567 | 57,025 | 513,401 | 513,401 | 2.1% |
| W4.2 | EBITDA | 28,347 | 37,810 | 2,998 | 2,515 | 1,545 | 5,533 | 4,475 | 2,603 | -104 | -1,934 | 6,386 | 540 | 2,452 | 1,895 | 5,133 | 3,575 | 2,838 | 4,063 | 2,465 | 5,071 | 4,177 | 1,623 | 3,484 | 37,315 | 37,315 | -1.3% |
| W5 | Finance use of Resources Rating | 3 | 3 | 4 | 4 | 4 | 3 | 3 | 3 | 3 | 4 | 3 | | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 0 |
| W6 | Staff Turnover Rate | 9.1% | 10.0% | 9.9% | 9.7% | 9.39% | 9.09% | 9.22% | 9.10% | 8.90% | 8.86% | 9.12% | 9.54% | 9.79% | 10.14% | 10.79% | 10.89% | 11.43% | 11.7% | 11.9% | 12.3% | 12.6% | 12.7% | 12.3% | 12.3% | 12.3% | 2.3% |
| W7 | Vacancy Rate (%) | 10.0% | 8.0% | 10.3% | 11.1% | 10.65% | 9.63% | 9.57% | 10.83% | 10.33% | 10.26% | 9.99% | 13.31% | 13.27% | 13.11% | 12.60% | 11.97% | 10.40% | 9.1% | 8.5% | 8.3% | 9.0% | 7.8% | 8.1% | 10.9% | 10.9% | 2.9% |
| W7.1 | Contracted WTE | 5,153 | 5,482 | 5,049 | 5,069 | 5,064 | 5,148 | 5,017 | 5,124 | 5,139 | 5,145 | 5,153 | 5,147 | 5,105 | 5,122 | 5,169 | 5,219 | 5,323 | 5,393 | 5,425 | 5,444 | 5,472 | 5,474 | 5,474 | 5,474 | 5,474 | -0.2% |
| W7.2 | Establishment WTE | 5,670 | 6,131 | 5,617 | 5,627 | 5,628 | 5,632 | 5,631 | 5,685 | 5,684 | 5,684 | 5,670 | 5,906 | 5,891 | 5,921 | 5,972 | 6,016 | 6,033 | 6,065 | 6,031 | 6,117 | 6,134 | 6,131 | 6,124 | 6,124 | 6,124 | 0.0% |
| W7.3 | Substantive Staff Used | 5,012 | 5,600 | 4,907 | 4,937 | 4,949 | 4,996 | 5,036 | 5,002 | 4,995 | 5,009 | 5,012 | 4,998 | 5,019 | 5,032 | 5,040 | 5,101 | 5,152 | 5,240 | 5,285 | 5,357 | 5,364 | 5,369 | 5,376 | 5,376 | 5,376 | -4.1% |
| W7.4 | Worked WTE | 5,826 | 6,131 | 5,597 | 5,732 | 5,654 | 5,688 | 5,631 | 5,733 | 5,747 | 5,784 | 5,826 | 5,623 | 5,808 | 5,667 | 5,733 | 5,938 | 5,810 | 5,927 | 6,014 | 6,126 | 6,072 | 6,102 | 6,148 | 6,148 | 6,148 | 0.4% |
| W7.5 | Vacancies WTE | 517 | 649 | 568 | 558 | 564 | 483 | 614 | 561 | 545 | 539 | 517 | 758 | 786 | 799 | 803 | 797 | 710 | 672 | 606 | 673 | 662 | 657 | 650 | 650 | 650 | 2.1% |
| W8 | Total Agency Spend | 22,651 | 18 | 2,113 | 2,072 | 1,901 | 1,787 | 1,734 | 1,747 | 1,901 | 2,097 | 1,408 | 1,649 | 1,655 | 1,531 | 1,852 | 1,770 | 1,786 | 1,653 | 1,075 | 1,520 | 1,618 | 1,426 | 1,853 | 19,388 | 19 | 0 |
| W8.1 | Nurse Agency Spend | -9,434 | -5,472 | -853 | -847 | -822 | -823 | -661 | -728 | -862 | -860 | -963 | -577 | -563 | -468 | -474 | -612 | -641 | -706 | -473 | -649 | -628 | -475 | -522 | -6,787 | -6,787 | 25.0% |
| W8.2 | Medical Locum & Agency Spend | -19,052 | -16,377 | -1,567 | -1,585 | -1,517 | -1,261 | -1,456 | -1,806 | -1,663 | -1,674 | -1,933 | -1,656 | -1,699 | -1,718 | -1,957 | -1,886 | -1,902 | -1,573 | -1,484 | -1,740 | -1,685 | -1,440 | -2,112 | -20,852 | -20,852 | 27.8% |
| W8.3 | Bank Staff Used | 500 | 303 | 338 | 448 | 383 | 372 | 365 | 416 | 433 | 442 | 500 | 332 | 511 | 356 | 426 | 574 | 392 | 426 | 502 | 529 | 467 | 507 | 549 | 549 | 549 | 84.6% |
| W8.4 | Agency Staff Used | 277 | 228 | 310 | 302 | 277 | 271 | 229 | 270 | 283 | 286 | 277 | 249 | 241 | 243 | 233 | 229 | 234 | 226 | 196 | 206 | 210 | 186 | 188 | 188 | 188 | -15.0% |
| W8.5 | Overtime Used | 36 | No data | 42 | 46 | 46 | 49 | - | 45 | 37 | 47 | 36 | 45 | 37 | 35 | 35 | 33 | 33 | 35 | 32 | 34 | 30 | 40 | 35 | 35 | 35 | No data |
| W8.6 | Temp costs & overtime as % of total pay bill | No data | 11.9% | 16.6% | 18.4% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 16.0% | 16.1% | 15.9% | 17.1% | 18.2% | 17.8% | 0 | 0 | 0 | 0 | 0 | 0 | 13.4% | 13.4% | 5.6% |
| W9 | Statutory and Mandatory Training | 83.3% | 90.0% | 89.0% | 85.8% | 82.9% | No data | No data | No data | No data | No data | 83.3% | 83.5% | 84.5% | 86.1% | 87.2% | 88.9% | 85.8% | 86.4% | 86.6% | 85.8% | 85.3% | 85.9% | 86.3% | 86.0% | 86.0% | -4.0% |
| W10 | Sickness Absence | 3.6% | 3.3% | 3.2% | 3.3% | 3.4% | 3.4% | 3.4% | 3.9% | 3.4% | 3.8% | 3.6% | 3.1% | 3.5% | 3.3% | 3.2% | 3.5% | 3.4% | 3.6% | 3.7% | 3.9% | 3.9% | 3.7% | 3.5% | 3.5% | 3.5% | 0.2% |
| W11 | Staff FFT % recommended work | 82.2% | 57.0% | 50.0% | 50.0% | 50.0% | 50.0% | 50.0% | 50.0% | 82.2% | 82.2% | 82.2% | 53.3% | 53.3% | 53.3% | 72.2% | 72.2% | 72.2% | 66.0% | 66.0% | 66.0% | 66.0% | 66.0% | 66.0% | 66.0% | 66.0% | 9.0% |
| W11.1 | Staff Friends & Family (FFT) % rec care | 89.0% | 80.0% | 78.2% | 78.2% | 78.2% | 78.2% | 78.2% | 78.2% | 89.0% | 89.0% | 89.0% | 75.3% | 75.3% | 75.3% | 77.8% | 77.8% | 77.8% | 74.0% | 74.0% | 74.0% | 74.0% | 74.0% | 74.0% | 74.0% | 74.0% | -6.0% |
| W12 | Appraisal Completeness | 92.0% | 95.0% | 76.5% | 82.6% | 84.7% | 86.2% | 88.1% | 90.2% | 91.0% | 92.1% | 92.0% | 2.6% | 11.7% | 26.7% | 78.2% | 87.4% | 89.8% | 91.1% | 91.8% | 91.8% | 90.5% | 90.4% | 90.8% | 90.8% | 90.8% | -4.2% |

**REVIEW OF LATEST FINANCIAL PERFORMANCE**

- The Trust was £0.1m adverse to plan in March but was £0.1m favourable to the annual plan therefore fully achieving £7.6m PSF.
- The Trust's normalised run rate (excluding PSF and MRET funding) in March was £1.6m deficit which was £2.1m adverse to plan.
- In March the Trust operated with an EBITDA surplus of £3.5m which was £1m adverse plan.
- The Trust incurred £1.85m additional revenue costs and had income pressures of £0.23m associated with COVID 19, this was detailed in a COVID 19 impact return to NHSI which resulted in NHSI funding in full the identified pressure (£2.08m).
- Year to date the Trust was £0.1m favourable to plan, the key variances to budget were: Underperformance in Private Patient Income (£2.4m net), RTT Income reserve (£1.2m), £2.7m CIP slippage (to internal savings plan), £1m overspend against outsourcing and overspends within expenditure budgets (£5m) which was mainly split between Medical Staffing (£2.8m) and non pay (£3m). These pressures have been partly offset by release of prior year provisions (£3.7m), release of £3.6m of reserves, QIPP income adjustment (£1.3m), PDC less than plan (£1m) and release of deferred income (£1m).
- The key current month variances are as follows:
    - Income adjusted for pass-through items is £3m favourable to plan. Clinical Income excluding HCDs was above plan in March by £2.1m which was mainly due to COVID 19 funding (£2.1m). Clinical income (excluding COVID income) is £0.2m adverse to plan, significant adverse variances across most areas due to the impact of covid-19. These are largely mitigated through coverage from the Aligned Incentive Contract with West Kent and Sussex Commissioners. In addition the Trust has successfully negotiated positive year end settlements with all other key commissioners to further mitigate the impact of Covid-19 on March activity (All CCGs in Kent and NHSE Specialised Commissioning). Medical Education and Sexual Health deferred income review (£1.5m gross, £1m net benefit) partly offset by Private Patient Unit activity below planned levels (£0.3m).
    - Pay budgets adjusted for pass-through items overspent by £1.2m in March of which £1.1m related to additional costs associated with COVID 19 (Offset by income). Medical staffing overspent by £0.8m, Medicine and Emergency (£0.6m) and £0.2m within Surgery Division. This pressure was due to COVD 19 and £0.2m provision for debt associated with salary recharges older than 1 year. Nursing overspent by £0.4m which was within Medicine and Emergency division due to increase in staffing required to support COVID 19.
    - Non Pay budgets adjusted for pass through items and release of reserves overspent by £2.9m in March. The main pressure related to £0.9m overspend associated with higher than planned use of outsourcing for elective activity, £0.6m COVID 19 related costs (offset by income) and £0.5m medical education costs (offset by income).
- The closing cash balance at the end of March 2020 was £3.36m which is in line with the cash plan value of £3m. This includes the £2m agreed carry forward of £2m asset sale receipts (to be used for capital projects in 2020/21) and £1m baseline requirement.
- The cashflow for 2020/21 is based on the I&E plan submitted in early March. Due to the current Covid 19 crisis the periods April 2020 to July 2020; all clinical activity will be paid via block payments to ensure that NHS providers have sufficient cash to cover this period. The cash flow is updated daily to ensure that the Trust can meet all its commitments as well as working towards ensuring prompt payment to suppliers as per the Cabinet Offices Procurement Policy of paying suppliers within 7 days.
- The overall capital programme spend is £16m, excluding donated assets. This includes internally generated capital of £4.85m and £6.4m asset sales carried forward from 2018/19. The internally generated capital of £4.85m has reduced in year by c.£0.4m as a result of an underspend on depreciation resulting from the reduction in the overall programme value (removal of a external financing items) and slippage in the timing of schemes due to the planning issues around the national capital position.

The major spends in-year relate to ICT; £5.3m on EPR/EPMA (EPMA funded from PDC), £0.4m on cyber security (PDC funded) and £0.6m on PCs/Laptops - Equipment; £2.6m (£2.1m PDC funded) for CTs x 2, MRI & Mammography, £0.8m on surgical reconfiguration and endoscopy, and Estates; £2.1m for backlog maintenance and Linac enabling work. The Trust has also spent £462k relating to Covid-19 including assessment pods, anaesthetic machines, video laryngoscopes and laptops for working from home. The Trust has been funded £50k in March for the Covid 19 pods and there is an expectation that PDC will be paid in 2020/21 relating to the remaining spend in 2019/20.

Maidstone and Tunbridge Wells NHS Trust

# Finance Committee Pack

## Month 12
## 2019/20

Maidstone and Tunbridge Wells NHS Trust

# Finance Committee Pack for March 2020

# 1a. Dashboard

March 2019/20

| | Current Month | | | | | | Year to Date | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Actual* £m | *Plan* £m | *Variance* £m | Pass-through £m | *Revised Variance* £m | *RAG* | *Actual* £m | *Plan* £m | *Variance* £m | Pass-through £m | *Revised Variance* £m | *RAG* |
| Income | 57.0 | 54.1 | 3.0 | (0.1) | 3.0 | | 513.4 | 512.4 | 1.0 | (0.1) | 1.0 | |
| Expenditure | (53.5) | (49.6) | (3.9) | 0.1 | (4.0) | | (476.1) | (474.6) | (1.4) | 0.1 | (1.5) | |
| EBITDA (Income less Expenditure) | 3.5 | 4.5 | (1.0) | (0.0) | (1.0) | | 37.3 | 37.8 | (0.5) | 0.0 | (0.5) | |
| Financing Costs | (4.2) | (3.0) | (1.2) | 0.0 | (1.2) | | (32.1) | (32.0) | (0.1) | 0.0 | (0.1) | |
| Technical Adjustments | 2.6 | 0.4 | 2.1 | 0.0 | 2.1 | | 1.7 | 1.1 | 0.7 | 0.0 | 0.7 | |
| **Net Surplus / Deficit (Incl PSF and MRET)** | **1.8** | **1.9** | **(0.1)** | **(0.0)** | **(0.1)** | | **7.0** | **6.9** | **0.1** | **0.0** | **0.1** | |
| CIPs | 1.9 | 2.1 | (0.2) | | (0.2) | | 22.4 | 22.3 | 0.1 | | 0.1 | |
| Cash Balance | 3.4 | 3.0 | 0.4 | | 0.4 | | 3.4 | 3.0 | 0.4 | | 0.4 | |
| Capital Expenditure | 10.9 | 2.2 | (8.7) | | (8.7) | | 16.0 | 14.4 | (1.6) | | (1.6) | |

**Summary:**

- The Trust was £0.1m adverse to plan in March but was £0.1m favourable to the annual plan therefore fully achieving £7.6m PSF.
- The key variances to budget were: Underperformance in Private Patient Income (£2.4m net), RTT Income reserve (£1.2m), £2.7m CIP slippage (to internal savings plan), £1m overspend against outsourcing and overspends within expenditure budgets (£5m) which was mainly split between Medical Staffing (£2.8m) and non pay (£3m). These pressures have been partly offset by release of prior year provisions (£3.7m), release of £3.6m of reserves, QIPP income adjustment (£1.3m), PDC less than plan (£1m) and release of deferred income (£1m).
- The Trust has delivered £22.4m savings which is £0.1m favourable to plan but £2.7m short of the internal stretch savings target of £25.1m.

**Key Points:**

- The Trust incurred £1.85m additional revenue costs and had income pressures of £0.23m associated with COVID 19, this was detailed in a COVID 19 impact return to NHSI which resulted in NHSI funding in full the identified pressure (£2.08m). An extract of the return has been included in section 2b of this report.
- The Trust has managed to agree year end settlements with all main commissioners and has therefore mitigated the financial risk associated with the high and unexpected reductions in activity during March.
- The Trusts normalised run rate in March was £1.6m deficit pre PSF which was £2.1m adverse to plan (pre PSF).
- An adjustment of £11.3m has been made relating to employers pension (6.3% increase), this impacts substantive pay costs but has been funded nationally.

**Risks:**

- These are the figures submitted as Key Data; Draft Accounts will be submitted by the 11th May which is an extension to the previous deadline due to Covid 19 impact. The Trust does not foresee any risks to this position or expect any changes to be made before the draft accounts are submitted. Risks highlighted in previous months have either not materialised or been covered by other mitigations. The values reported are subject to audit review.

## 1b. Summary Income & Expenditure (Exceptional Items)

Income & Expenditure March 2019/20

| | Current Month | | | | | Year to Date | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | *Actual* £m | *Plan* £m | *Variance* £m | Pass-through £m | *Revised Variance* £m | *Actual* £m | *Plan* £m | *Variance* £m | Pass-through £m | *Revised Variance* £m |
| Income | 43.3 | 52.7 | (9.3) | (0.1) | (9.3) | 495.1 | 498.6 | (3.5) | (0.1) | (3.4) |
| Expenditure | (41.4) | (49.6) | 8.2 | 0.1 | 8.1 | (477.2) | (474.6) | (2.6) | 0.1 | (2.6) |
| Trust Financing Costs | (4.2) | (3.0) | (1.2) | 0.0 | (1.2) | (32.1) | (32.0) | (0.1) | 0.0 | (0.1) |
| Technical Adjustments | 2.6 | 0.4 | 2.1 | 0.0 | 2.1 | 1.7 | 1.1 | 0.7 | 0.0 | 0.7 |
| **Net Revenue Surplus / (Deficit) before Exceptional Items** | **0.2** | **0.5** | **(0.2)** | **(0.0)** | **(0.2)** | **(12.4)** | **(7.0)** | **(5.4)** | **0.0** | **(5.4)** |
| Exceptional Items | 0.2 | | 0.2 | | 0.2 | 5.0 | | 5.0 | | 5.0 |
| **Net Position** | **0.4** | **0.5** | **(0.1)** | **(0.0)** | **(0.1)** | **(7.4)** | **(7.0)** | **(0.5)** | **0.0** | **(0.5)** |
| PSF and MRET Funding | 1.4 | 1.4 | (0.0) | 0.0 | (0.0) | 14.4 | 13.8 | 0.6 | 0.0 | 0.6 |
| **Net Revenue Surplus / (Deficit) Incl PSF, MRET and Exceptional Items** | 1.8 | 1.9 | (0.1) | (0.0) | (0.1) | 7.0 | 6.9 | 0.1 | 0.0 | 0.1 |

**Key messages:**
The Trust has benefited by £5m of exceptional items which included release of old year provisions (£3.7m) ,and QIPP adjustment (£1.3m).

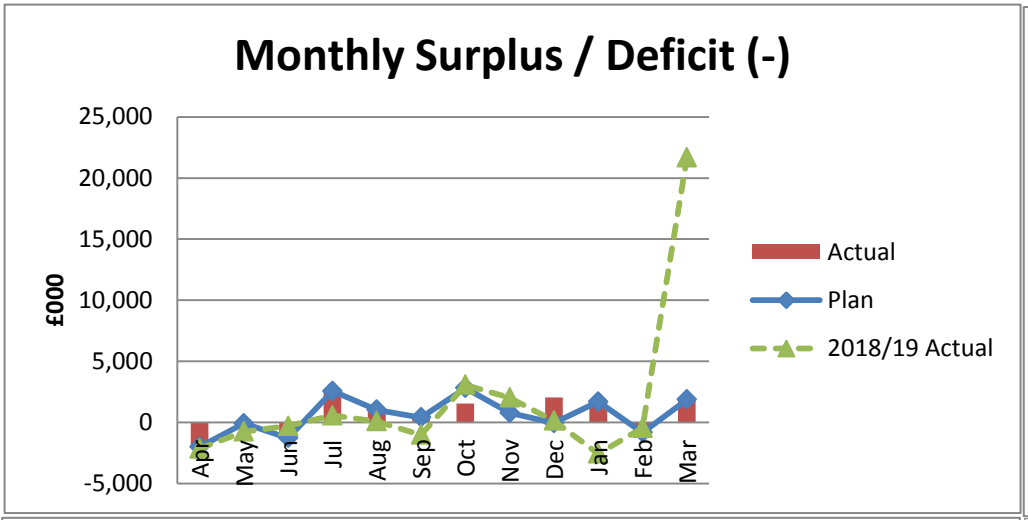
**Income:**
Income YTD net of pass-through related costs and exceptional items is £3.4m adverse to plan. The main pressures relate to under delivery of Private Patient income (£3.4m) and slippage within Cancer and RTT recovery plan funding (£1.8m) partly offset by £1m benefit from Medical Education and Sexual Health deferred income reviews.

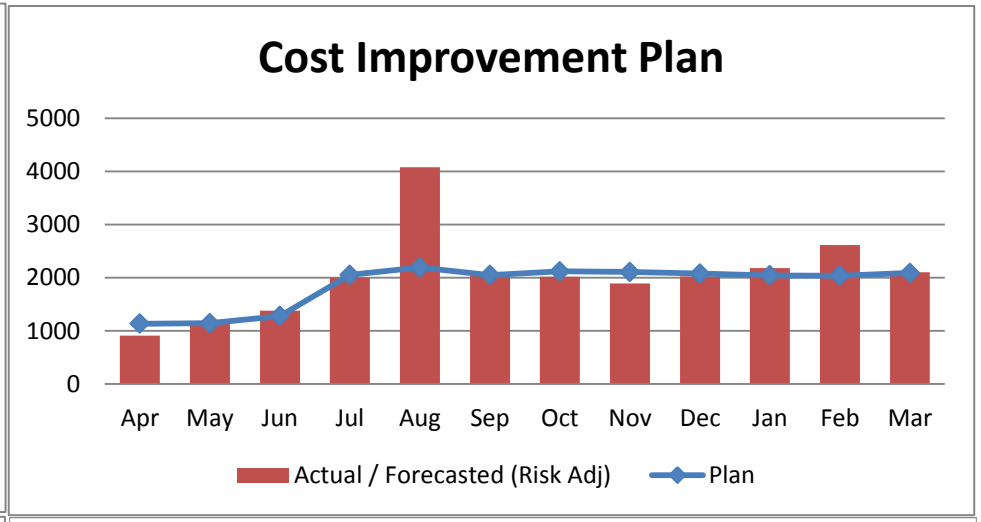
**Expenditure:**
Expenditure budgets net of pass-through and exceptional items are £2.6m adverse, the key favourable variances relate to: release of reserves (£3.6m), underspends relating to Cancer recovery plans (£0.6m), and Private Patient activity underperformance (£1m). The key pressures within expenditure budgets relate to Medical Staffing (£2.8m), CIP slippage (£1.8m), £1.2m overspend relating to services from NHS bodies mainly relating to additional pathology and radiology charges for Cancer activity , increase in MIU activity above expenditure plan, and a increase in expected number of send away tests, £1m increase in Outsourcing costs for Elective activity, £0.9m costs associated with Car parking and AMU developments and drug overspend (£0.8m).

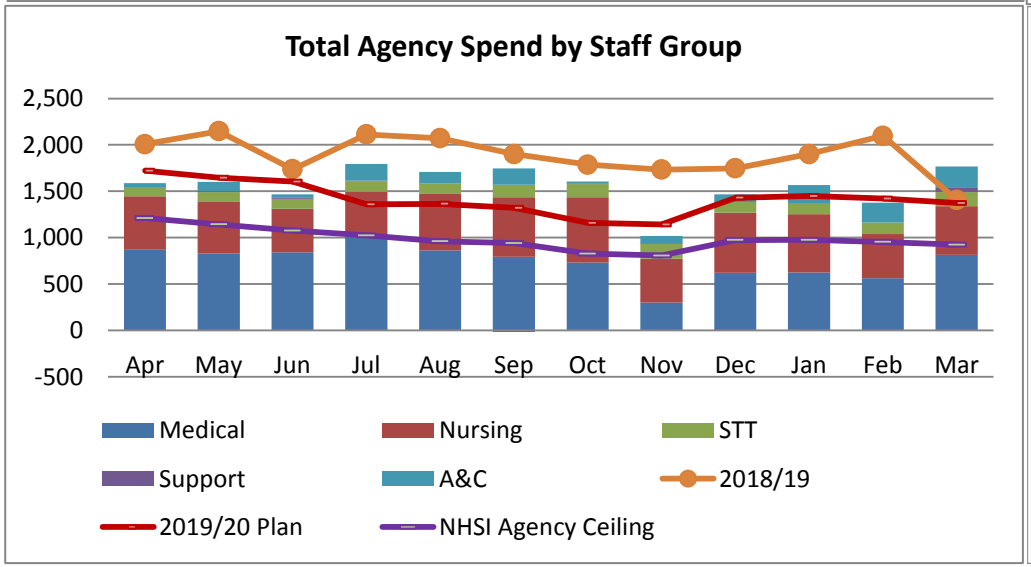
**Reserves:** The Trust released £3.6mm of reserves to partly offset overspends within expenditure budgets.

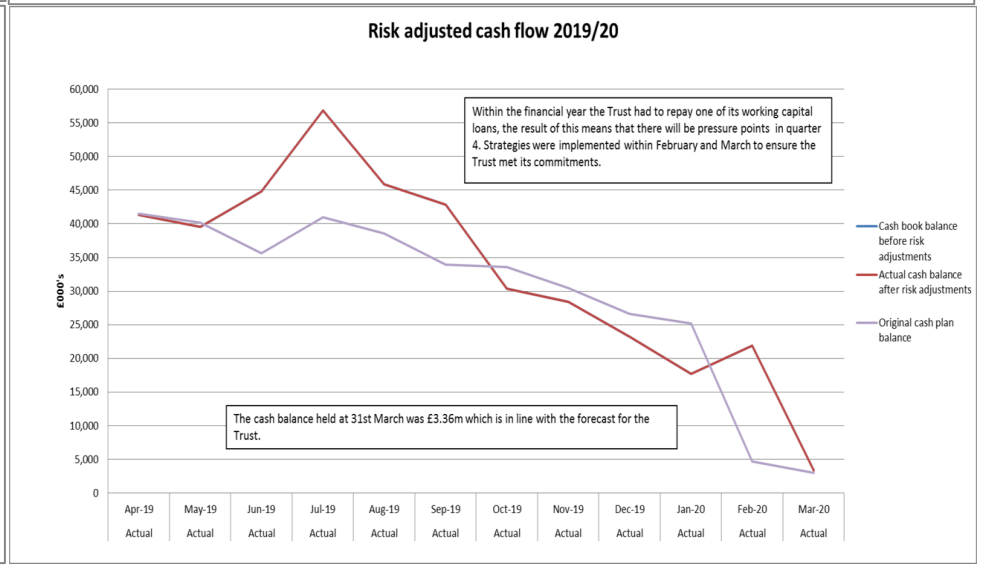
**PSF**: The Trust received £0.6m bonus PSF relating to 2018/19 which is treated as a technical adjustment and therefore does not contribute to the delivery of the 2019/20 control total.

## 1c. Executive Summary KPI's March 2020



## 1d. Key Variances
## Income & Expenditure

| | | Year to Date | | | | | |
|---|---|---|---|---|---|---|---|
| | | Income | Pay | Non Pay | Other (Finance costs) | Technical | Total |
| | | £000 | £000 | £000 | £000 | £000 | £000 |
| **Reported Variance Incl PSF** | Reported Variance Incl PSF | 1.0 | 2.0 | (3.5) | (0.1) | 0.7 | 0.1 |
| **Pass- Through** | High Cost Drugs | 2.8 | 0.0 | (2.8) | 0.0 | 0.0 | 0.0 |
| | High Cost Devices | (0.4) | 0.0 | 0.4 | 0.0 | 0.0 | 0.0 |
| | STP | (2.5) | 0.6 | 1.8 | 0.0 | 0.0 | 0.0 |
| | Education and Training (MPET) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | Other | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | **Total Pass-Through** | **(0.1)** | **0.6** | **(0.5)** | **0.0** | **0.0** | **0.0** |
| | **Revised Variance (Pass through Adjusted)** | **1.0** | **1.4** | **(2.9)** | **(0.1)** | **0.7** | **0.1** |
| **CIP** | CIP Variance | (0.9) | (0.5) | (1.3) | 0.0 | 0.0 | (2.7) |
| | **Revised Variance (Excl CIP and Passthrough)** | **2.0** | **1.9** | **(1.6)** | **(0.1)** | **0.7** | **2.8** |
| **Other Key Issues** | Drugs Overspend | 0.0 | 0.0 | (0.8) | 0.0 | 0.0 | (0.8) |
| | 2018/19 Adjustments | 0.7 | 2.0 | 1.0 | 0.0 | 0.0 | 3.7 |
| | Clinical Income Activity Performance (Non West Kent) | (0.1) | 0.0 | 0.0 | 0.0 | 0.0 | (0.1) |
| | A&C Staffing (Net of CIP) | 0.0 | 2.0 | 0.0 | 0.0 | 0.0 | 2.0 |
| | Medical Staffing (Net of CIP) | 0.0 | (2.8) | 0.0 | 0.0 | 0.0 | (2.8) |
| | Nursing Staffing (Net of CIP) | 0.0 | (0.1) | 0.0 | 0.0 | 0.0 | (0.1) |
| | STT Staffing (Net of CIP) | 0.0 | 0.3 | 0.0 | 0.0 | 0.0 | 0.3 |
| | Private Patient Income | (3.4) | 0.0 | 1.0 | 0.0 | 0.0 | (2.4) |
| | Cancer Recovery Plan | (0.6) | 0.6 | 0.0 | 0.0 | 0.0 | (0.0) |
| | RTT Income Reserve | (1.2) | 0.0 | 0.0 | 0.0 | 0.0 | (1.2) |
| | Technical Adjustment (realignment) | 0.4 | 0.0 | 0.0 | (1.1) | 0.7 | 0.0 |
| | Release of Reserves | 0.0 | 0.9 | 2.7 | 0.0 | 0.0 | 3.6 |
| | PSF | 0.6 | 0.0 | 0.0 | 0.0 | 0.0 | 0.6 |
| | COVID 19 Additional Costs | 1.9 | (1.1) | (0.8) | 0.0 | 0.0 | 0.0 |
| | Release of Defered Income | 1.0 | 0.0 | 0.0 | 0.0 | 0.0 | 1.0 |
| | PDC less than plan | 0.0 | 0.0 | 0.0 | 1.0 | 0.0 | 1.0 |
| | Overseas Recruitment costs above fudned levels | 0.0 | 0.0 | (0.2) | 0.0 | 0.0 | (0.2) |
| | Overspends with Servcies from NHS Bodies: Pathology (£0.4m), Oncology (£0.4m) and Acute and Emergency (£0.4m) | 0.0 | 0.0 | (1.2) | 0.0 | 0.0 | (1.2) |
| | Text Reminder Servcies | 0.0 | 0.0 | (0.2) | 0.0 | 0.0 | (0.2) |
| | Car Parking and AMU unfunded costs | 0.0 | 0.0 | (0.9) | 0.0 | 0.0 | (0.9) |
| | Overspends in Clinical Supplies particularly within: Imaging (£0.25m) and Pathology (£0.25m) | 0.0 | 0.0 | (0.5) | 0.0 | 0.0 | (0.5) |
| | Increase in Outsourcing | 0.0 | 0.0 | (1.0) | 0.0 | 0.0 | (1.0) |
| | QIPP adjustment | 1.3 | 0.0 | 0.0 | 0.0 | 0.0 | 1.3 |
| | Other | 1.4 | (0.0) | (0.8) | 0.1 | 0.0 | 0.6 |
| | **Total Other Core Issues** | **2.0** | **1.9** | **(1.6)** | **(0.1)** | **0.7** | **2.8** |

**Comment:**
The Trust is £0.1m favourable to plan, the key variances to budget were: Underperformance in Private Patient Income (£2.4m net), RTT Income reserve (£1.2m), £2.7m CIP slippage (to internal savings plan), £1m overspend against outsourcing and overspends within expenditure budgets (£5m) which was mainly split between Medical Staffing (£2.8m) and non pay (£3m). These pressures have been partly offset by release of prior year provisions (£3.7m), release of £3.6m of reserves, QIPP income adjustment (£1.3m), PDC less than plan (£1m) and release of deferred income (£1m).

**Key Variances:**
**Income**: Income adjusted for pass-through items and CIP slippage (£0.9m) is £2.0m favourable to plan. The main areas adverse to plan are: Private Patient Income (£3.4m) and Cancer and RTT recovery plan income (£1.8m). These pressures are offset by COVID 19 income (£1.9m), QIPP adjustment (£1.3m), previous year income £0.7m, additional 2018/19 PSF bonus (£0.6m) and other income over performance (£1.4m) mainly within Interest receivable (£0.2m), Bowel screening (£0.1m) and Injury Recovery income (£0.3m).

**Pay:** Pay budgets adjusted for pass-through items are £1.9m favourable to plan. The key favourable variances relate to £2m release of old year provision, release of reserves (£0.9m), underspends within Admin and Clerical budgets (£2m), STT Staffing (£0.3m) and £0.6m cancer recovery plan reserve (offset by income reduction).
The key adverse variances within pay relate to Medical Staffing which is £2.8m adverse to budget net of CIP (c£0.5m) and COVID costs (£c0.5m). The gross overspend within medical staffing budgets is £3.8m which is mainly within Medicine and Emergency Division (£2.9m), Womens and Childrens Division (£0.9m) and Surgery Division (£0.5m).

**Non Pay**: Non Pay budgets adjusted for pass-through and CIP slippage (£1.3m) are £1.6m adverse to plan. Underspends within Private Patient Income (£1m), release of £2.7m reserves and £1m benefit from release of old year provisions are offset by overspends within budgets of £6.4m due to the following key pressures:
- £1.2m overspend relating to services from NHS bodies mainly relating to additional pathology and radiology charges for Cancer activity , a increase in MIU activity above expenditure plan and a increase in expected number of send away tests.
- £1m increase in Outsourcing costs for Elective activity
- £0.8m costs associated with COVID 19 (this is offset by additional income)
- £0.9m additional costs relating to Car Park (£0.6m) and AMU developments (£0.3m)
- £0.5m overspend within clinical supplies due to increase in MRI and CT maintenance costs (including repairs) and a steady rise in consumables associated with increasing in complexity of workload within Radiology as well as an increase in pathology send away tests to non NHS organisations.
- Drugs £0.8m

## 1e. Year to Date Variance by Division

Income & Expenditure March 2019/20

| | Year to Date Variance by Division | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Medicine and Emergency Services | Cancer Services | Diagnostics and Clinical Support | Surgery | Women's, Children's and Sexual Health | Estates & Facilities | Corporate | Corporate - Central | TOTAL |
| | £m | £m | £m | £m | £m | £m | £m | £m | £m |
| Clinical Income Incl HCD | (1.1) | 4.4 | (0.2) | (3.4) | (0.9) | 0.0 | 2.1 | 2.9 | 3.9 |
| Other Operating Income | 0.3 | (0.1) | 0.3 | 0.2 | 0.2 | (0.4) | (5.5) | 2.1 | (2.9) |
| **Total Revenue** | **(0.8)** | **4.3** | **0.1** | **(3.2)** | **(0.6)** | **(0.4)** | **(3.4)** | **5.0** | **1.0** |
| Medical | (2.9) | (0.2) | 0.2 | (0.5) | (0.9) | 0.0 | 0.3 | 0.2 | (3.9) |
| Nursing | (1.3) | (0.5) | (0.1) | (0.2) | 0.6 | 0.0 | (0.2) | 1.8 | 0.2 |
| Scientific and Technical | 0.4 | 0.1 | 1.3 | 0.0 | 0.0 | 0.0 | (0.0) | 0.2 | 2.0 |
| Support | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.2 | 0.0 | 0.2 |
| Admin and Clerical | 0.3 | (0.2) | 0.1 | (0.0) | 0.1 | 0.1 | 1.4 | 0.2 | 2.0 |
| Reserves Pay | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | (0.0) | 1.5 | 1.5 |
| Total Pay | (3.5) | (0.7) | 1.4 | (0.7) | (0.2) | 0.2 | 1.6 | 3.9 | 2.0 |
| Drugs & Medical Gases | 0.2 | (3.3) | (0.0) | (0.4) | 0.0 | (0.0) | (0.0) | (0.2) | (3.6) |
| Supplies and Services | 0.2 | (0.2) | (0.3) | 0.3 | (0.1) | (0.2) | 0.4 | (1.1) | (1.0) |
| Purchase of Healthcare from Non-NHS | 0.2 | (0.0) | 0.0 | (1.1) | (0.1) | 0.0 | (0.1) | (6.1) | (7.2) |
| Other Non-Pay Costs | (0.2) | (0.6) | (0.9) | (0.1) | (1.0) | (0.3) | 2.6 | 0.9 | 0.4 |
| Non-Pay Reserves | (0.7) | (0.6) | (0.6) | (1.2) | 0.0 | (0.3) | (0.6) | 11.8 | 7.9 |
| Total Non Pay | (0.3) | (4.7) | (1.7) | (2.5) | (1.0) | (0.8) | 2.3 | 5.3 | (3.5) |
| Total Expenditure | (3.8) | (5.3) | (0.3) | (3.2) | (1.2) | (0.6) | 3.9 | 9.1 | (1.4) |
| Total Finance Costs | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | (0.1) | (0.1) |
| **Net Surplus / Deficit (-)** | (4.6) | (1.0) | (0.2) | (6.4) | (1.8) | (1.0) | 0.4 | 14.1 | (0.5) |
| Technical Adjustments | | | | | | | | 0.7 | 0.7 |
| **Surplus/ Deficit (-) to B/E Duty** | **(4.6)** | **(1.0)** | **(0.2)** | **(6.4)** | **(1.8)** | **(1.0)** | **0.4** | **14.7** | **0.1** |
| **CIP Variance** | (1.3) | (0.9) | 0.4 | (3.0) | (0.1) | (0.3) | (0.0) | 5.3 | 0.1 |
| **Non CIP Related Variance** | (3.3) | (0.1) | (0.6) | (3.4) | (1.7) | (0.7) | 0.5 | 9.4 | 0.0 |
| **SLR Surplus / Deficit(-)** | **2.1** | **1.7** | **1.2** | **0.9** | **(0.0)** | **0.0** | **0.0** | **0.0** | **7.0** |
| **Surplus/ Deficit (-) to B/E Duty as a % of Revenue** | **2%** | **2%** | **1%** | **2%** | **0%** | **0%** | **0%** | **0%** | **1%** |
| **% Contribution towards clinical support and other overheads** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** |

**Commentary:**

**Medicine and Emergency Services:**
The Division is £4.6m adverse to plan year to date, the main drivers are SLA income underperformance (£1.1m), CIP slippage (£1.3m) and pay overspends by £3.5m. Income underperformance is due to reduction in non-elective activities outside of AIC mainly in Cardiology, A&E , General Medicine and Drugs offset with underspent in drug expenses. Pay is £3.5m adverse to plan which is mainly within Medical staffing (£2.9m) and Nursing (£1.3m) main driver were Covid 19 cost of £0.8m, one extra escalation wards (£0.3m), PTU trial, overseas nurses double running and un-achieving ward closure CIP . Non pay is £0.3m adverse to plan mainly due to unidentified CIP (£0.7m).

**Cancer Services**
The Division was overspent by £1m by the year end. Clinical Income over performance (£4.4m) is offsetting £3.3m overspend associated with high cost drugs. Pay expenditure overspent by £0.7m due to pressures in Medical locum expenditure above plan and Nursing temporary expenditure covering maternity leave, sickness and trained Chemotherapy vacancies. Scientific and Technical staff budgets are underspent to date due to vacancies in Radiotherapy and Medical Physics. Non pay overspent by £4.7m, £3.3m relating to Drug expenditure offset by a HCD clinical income over performance. There has been £0.6m CIP slippage to date

**Diagnostics and Clinical Support**
The Division overspent by £0.2m. Pay is underspent by £1.4m with the majority of the underspend within the Pathology, Radiology and Therapies Directorates. The key pressures relate to non pay which is overspent by £1.7m (incl CIP) due to send away tests in Pathology (CIP slippage and volume increase) and the Crowborough Outpatients recharges from NHS Property services . The unallocated CIP reserves are reporting a year to date adverse variance of £0.6m.

**Surgery**
The Division is £6.4m adverse for the year 19-20, this is driven by SLA income performance (£3.4m adverse to plan) and CIP slippage (£3m). £2.8m of the income position is due to unprotected AIC income (variance between the trusts internal plan and the CCG contract plan for the division), the remaining £0.6m is due to underperformance against those CCGs still under PbR.

**Womens, Childrens and Sexual Health:**
The Division is £1.8m adverse to plan. Clinical income £0.9m adverse mainly due to Neonatal (£0.6m) and Maternity pathway (£0.3m), Medical overspend (£0.9m) is due to Medical staffing pressures within Paediatrics to high number of vacancies offset by Nursing underspend (£0.6m). Non pay budgets overspend by £1m mainly due to Pathology and overhead recharges for Sexual Health contract.

**Estates and Facilities**
The Division is £1m adverse to plan year to date. CIP slippage £0.3m and additional costs associated with Car Parking and AMU development (£0.5m)

**Corporate:** The corporate division is £0.4m favourable to plan which is due to £1.4m of COVID income reported within corporate but offsetting spend within divisions therefore the underlying position is a deficit of £1m. Overspend within Private Patient Unit (£2.4m net) and unfunded text reminder servcies (£0.2m) is partly offset by underspends accross all other corporate directorates. The largest underspend relates to ICT (£1m) which is mainly due to the capitalisation of EPR costs.

**Corporate Central**
Favourable by £14.9m which includes £6.4m benefit from release of reserves (£3.6m release of contingency reserve and £2.8m internal CIP stretch savings target reserve), £3.7m release of old year accruals, QIPP adjustment (£1.3m), PDC (£1m) and £1m Sexual Health Pathology and overhead recharges.

## 2.a Income & Expenditure

Income & Expenditure March 2019/20

| | Current Month | | | | | Year to Date | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | *Actual* £m | *Plan* £m | *Variance* £m | Pass-through £m | *Revised Variance* £m | *Actual* £m | *Plan* £m | *Variance* £m | Pass-through £m | *Revised Variance* £m |
| Clinical Income | 46.9 | 44.8 | 2.1 | 0.0 | 2.1 | 403.3 | 401.4 | 1.9 | 0.0 | 1.9 |
| High Cost Drugs and Devices | 3.9 | 3.7 | 0.2 | 0.4 | (0.2) | 47.1 | 45.2 | 2.0 | 2.4 | (0.4) |
| **Total Clinical Income** | **50.8** | **48.5** | **2.2** | **0.4** | **1.9** | **450.4** | **446.5** | **3.9** | **2.4** | **1.5** |
| PSF and MRET | 1.4 | 1.4 | (0.0) | 0.0 | (0.0) | 14.4 | 13.8 | 0.6 | 0.0 | 0.6 |
| Other Operating Income | 4.8 | 4.1 | 0.7 | (0.4) | 1.2 | 48.6 | 52.1 | (3.5) | (2.5) | (1.0) |
| **Total Revenue** | **57.0** | **54.1** | **3.0** | **(0.1)** | **3.0** | **513.4** | **512.4** | **1.0** | **(0.1)** | **1.0** |
| Substantive | (31.9) | (33.0) | 1.0 | (0.0) | 1.0 | (252.7) | (265.6) | 13.0 | 0.4 | 12.6 |
| Bank | (1.7) | (0.8) | (0.8) | 0.0 | (0.8) | (15.4) | (10.2) | (5.3) | 0.0 | (5.3) |
| Locum | (1.3) | (0.6) | (0.7) | 0.0 | (0.7) | (12.0) | (8.4) | (3.6) | 0.0 | (3.6) |
| Agency | (1.9) | (1.3) | (0.6) | 0.0 | (0.6) | (19.4) | (15.8) | (3.6) | 0.2 | (3.8) |
| Pay Reserves | (0.1) | (0.1) | (0.0) | 0.0 | (0.0) | (0.5) | (2.0) | 1.5 | 0.0 | 1.5 |
| **Total Pay** | **(36.9)** | **(35.7)** | **(1.2)** | **(0.0)** | **(1.2)** | **(299.9)** | **(302.0)** | **2.0** | **0.6** | **1.4** |
| Drugs & Medical Gases | (4.7) | (4.3) | (0.4) | (0.4) | (0.0) | (55.0) | (51.4) | (3.6) | (2.8) | (0.8) |
| Blood | (0.1) | (0.2) | 0.0 | 0.0 | 0.0 | (2.3) | (2.2) | (0.1) | 0.0 | (0.1) |
| Supplies & Services - Clinical | (4.0) | (2.8) | (1.2) | 0.0 | (1.3) | (34.7) | (33.9) | (0.8) | 0.4 | (1.2) |
| Supplies & Services - General | (0.7) | (0.5) | (0.3) | 0.0 | (0.3) | (5.5) | (5.3) | (0.2) | 0.0 | (0.2) |
| Services from Other NHS Bodies | (0.1) | (0.4) | 0.3 | 0.4 | (0.1) | (7.1) | (7.6) | 0.4 | 1.2 | (0.8) |
| Purchase of Healthcare from Non-NHS | (1.4) | (0.4) | (0.9) | 0.0 | (0.9) | (15.8) | (8.6) | (7.2) | (0.1) | (7.1) |
| Clinical Negligence | (1.5) | (1.5) | (0.0) | 0.0 | (0.0) | (17.6) | (17.6) | 0.0 | 0.0 | 0.0 |
| Establishment | (0.1) | (0.3) | 0.2 | (0.0) | 0.2 | (3.5) | (3.4) | (0.1) | 0.0 | (0.1) |
| Premises | (2.8) | (2.3) | (0.5) | (0.0) | (0.5) | (26.4) | (26.1) | (0.3) | (0.0) | (0.3) |
| Transport | (0.2) | (0.1) | (0.0) | 0.0 | (0.0) | (1.8) | (1.6) | (0.1) | (0.0) | (0.1) |
| Other Non-Pay Costs | (1.1) | (0.4) | (0.7) | 0.1 | (0.7) | (7.0) | (7.5) | 0.5 | 0.7 | (0.2) |
| Non-Pay Reserves | 0.0 | (0.8) | 0.8 | 0.0 | 0.8 | 0.4 | (7.5) | 7.9 | 0.0 | 7.9 |
| **Total Non Pay** | **(16.7)** | **(13.9)** | **(2.8)** | **0.1** | **(2.9)** | **(176.2)** | **(172.7)** | **(3.5)** | **(0.5)** | **(2.9)** |
| **Total Expenditure** | **(53.5)** | **(49.6)** | **(3.9)** | **0.1** | **(4.0)** | **(476.1)** | **(474.6)** | **(1.4)** | **0.1** | **(1.5)** |
| **EBITDA** | **3.5** | **4.5** | **(1.0)** | **(0.0)** | **(1.0)** | **37.3** | **37.8** | **(0.5)** | **0.0** | **(0.5)** |
| | *0.0* | *0.0* | *(0.0)* | *%* | | *7.3%* | *7.4%* | *-51.5%* | *-1.9%* | *-47.6%* |
| Depreciation | (1.1) | (1.1) | 0.0 | 0.0 | 0.0 | (13.0) | (13.5) | 0.4 | 0.0 | 0.4 |
| Interest | (0.1) | (0.1) | 0.0 | 0.0 | 0.0 | (1.4) | (1.6) | 0.2 | 0.0 | 0.2 |
| Dividend | 0.8 | (0.1) | 1.0 | 0.0 | 1.0 | (0.6) | (1.6) | 1.0 | 0.0 | 1.0 |
| PFI and Impairments | (3.9) | (1.6) | (2.3) | 0.0 | (2.3) | (17.0) | (15.4) | (1.7) | 0.0 | (1.7) |
| **Total Finance Costs** | **(4.2)** | **(3.0)** | **(1.2)** | **0.0** | **(1.2)** | **(32.1)** | **(32.0)** | **(0.1)** | **0** | **(0.1)** |
| **Net Surplus / Deficit (-)** | **(0.7)** | **1.5** | **(2.2)** | **(0.0)** | **(2.2)** | **5.3** | **5.8** | **(0.5)** | **0.0** | **(0.5)** |
| **Technical Adjustments** | 2.6 | 0.4 | 2.1 | 0.0 | 2.1 | 1.7 | 1.1 | 0.7 | 0.0 | 0.7 |
| **Surplus/ Deficit (-) to B/E Duty Incl PSF and MRET** | **1.8** | **1.9** | **(0.1)** | **(0.0)** | **(0.1)** | **7.0** | **6.9** | **0.1** | **0.0** | **0.1** |
| **Surplus/ Deficit (-) to B/E Duty Excl PSFand MRET** | **0.4** | **0.5** | **(0.1)** | **(0.0)** | **(0.1)** | **(6.8)** | **(7.0)** | **0.1** | **0.0** | **0.1** |

**Commentary**

The Trust in March was £0.1m adverse to plan however the Trust was £0.1m favourable to the annual plan and therefore fully delivered £7.6m of PSF income.

Pass-through adjustments have been applied to account for: High Cost Drugs and devices and STP associated costs.

Clinical Income excluding HCDs was above plan in March by £2.1m which was mainly due to COVID 19 funding (£2.1m). Clinical income (excluding COVID income) is £0.2m adverse to plan, significant adverse variances across most areas due to the impact of covid-19. These are largely mitigated through coverage from the Aligned Incentive Contract with West Kent and Sussex Commissioners. In addition the Trust has successfully negotiated positive year end settlements with all other key commissioners to further mitigate the impact of Covid-19 on March activity (All CCGs in Kent and NHSE Specialised Commissioning).

The Trust received £0.6m additional bonus PSF in June relating to 2018/19, the bonus PSF is treated as a technical adjustment and therefore does not support the 2019/20 I&E position.

Other Operating Income excluding pass-through costs was on £1.2m favourable in March. The main benefits relates to Medical Education and Sexual Health deferred income review (£1.5m gross, £1m net benefit) partly offset by Private Patient Unit activity below planned levels (£0.3m).

Pay budgets adjusted for pass-through items overspent by £1.2m in March of which £1.1m related to additional costs associated with COVID 19 (Offset by income). Medical staffing overspent by £0.8m, Medicine and Emergency (£0.6m) and £0.2m within Surgery Division. This pressure was due to COVD 19 and £0.2m provision for debt associated with salary recharges older than 1 year. Nursing overspent by £0.4m which was within Medicine and Emergency division due to increase in staffing required to support COVID 19.

Non Pay budgets adjusted for pass through items and release of reserves overspent by £2.9m in March. The main pressure related to £0.9m overspend associated with higher than planned use of outsourcing for elective activity,

## 2.b COVID 19 Expenditure and Income Impact

### 2019/20 Summary of Cost Reimbursement

| Total Revenue (£s): | 1,855,226 |
|---|---|

| Breakdown by Allowable Cost Type | £s |
|---|---|
| 111 | 0 |
| Decontamination | 105,005 |
| Diagnostic Sampling (in Community) | 0 |
| Diagnostic Sampling (in Hospital) | 234,036 |
| Direct Provision of Isolation Pod | 2,000 |
| Field Hospital related | 0 |
| HCID centres: Backfill and additional staffing capacity as requested Specialised services | 0 |
| Hospital discharge programme (£1.3bn) | 0 |
| Hotel accommodation | 5,705 |
| Increase administrative capacity | 18,432 |
| Increase hospital assisted respiratory support capacity, particularly mechanical ventilation | 25,199 |
| OOH capacity increase | 0 |
| Other action (provide commentary) | 202,847 |
| Other action on instruction of national incident response team (provide commentary) | 0 |
| Plans to release bed capacity | 0 |
| PPE | 132,820 |
| Preparation for ITU capacity | 157,906 |
| Remote management of patients | 0 |
| Segregation of patient pathways | 418,859 |
| Sickness / isolation cover | 552,416 |
| Support stay at home model | 0 |
| Swabbing services | 0 |
| Transportation of patients | 0 |

### Summary: Loss of income

| Total (£s): | 229,052 |
|---|---|

| Breakdown by income type | £s |
|---|---|
| Car parking income | 88,732 |
| Catering | 6,780 |
| Education and training | 0 |
| Non-NHS: overseas patients (non-reciprocal, chargeable to patient) | 0 |
| Non-NHS: private patients | 77,876 |
| Property rental (not lease income) | 0 |
| Research and development (both IFRS 15 and non-IFRS 15 income) | 0 |
| Staff accommodation rental | 0 |
| Other - please provide details | 55,664 |

### Grand Total

| Total (£s): | 2,084,278 |
|---|---|

**Commentary:**
The Trust submitted two returns to NHSI which detailed the impact on expenditure (£1.85m) and income (£0.23m) due to COVID 19.

The Trust was notified by NHSI that income to match the identified pressures (£2.08m) could be accrued in full but sample audits are being commissioned to review the level of expenditure and once these are completed payments will be made by NHSE.

The main cost includes purchase of PPE, pathology testing, staff welfare such as providing meals, purchase of IT equipment an software licenses to enable staff working from home. Additional shifts required in ED, Covid resting pod and escalation areas. Additional on calls and extended opening hours for support teams. An assessment for additional temporary staffing requests to cover sickness has been incorporated into the impact list.

## 3a. Cost Improvement Plan

### Savings by Division

| | Current Month | | | Year to Date | | |
|---|---|---|---|---|---|---|
| | *Actual* | *Original Plan* | *Variance* | *Actual* | *Original Plan* | *Variance* |
| | £m | £m | £m | £m | £m | £m |
| Cancer Services | 0.06 | 0.12 | (0.06) | 0.55 | 1.45 | (0.90) |
| Diagnostics and Clinical Support | 0.26 | 0.25 | 0.02 | 3.53 | 3.11 | 0.42 |
| Medicine and Emergency Care | 0.35 | 0.50 | (0.15) | 4.13 | 5.46 | (1.33) |
| Surgery | 0.56 | 0.66 | (0.11) | 5.15 | 8.15 | (3.00) |
| Women's, Children's and Sexual Health | 0.19 | 0.26 | (0.07) | 2.46 | 2.56 | (0.10) |
| Estates and Facilities | 0.21 | 0.14 | 0.07 | 1.98 | 2.30 | (0.32) |
| Corporate | 0.13 | 0.18 | (0.05) | 2.07 | 2.09 | (0.02) |
| **Total** | **1.76** | **2.10** | **(0.34)** | **19.87** | **25.12** | **(5.24)** |
| Internal Savings Plan stretch | 0.14 | (0.01) | 0.15 | 2.54 | (2.79) | 5.33 |
| **Total** | **1.90** | **2.09** | **(0.19)** | **22.42** | **22.33** | **0.09** |

**Comment**

The Trust was adverse to plan in the month by £0.2m, but fully delivered the £22.3m annual savings plan for 2019/20.

The Trust delivered the plan which is mainly due to over performance within workforce savings (£2.7m) and Best use of Resources (£2m) offset by slippage within patient flow (£4.6m).

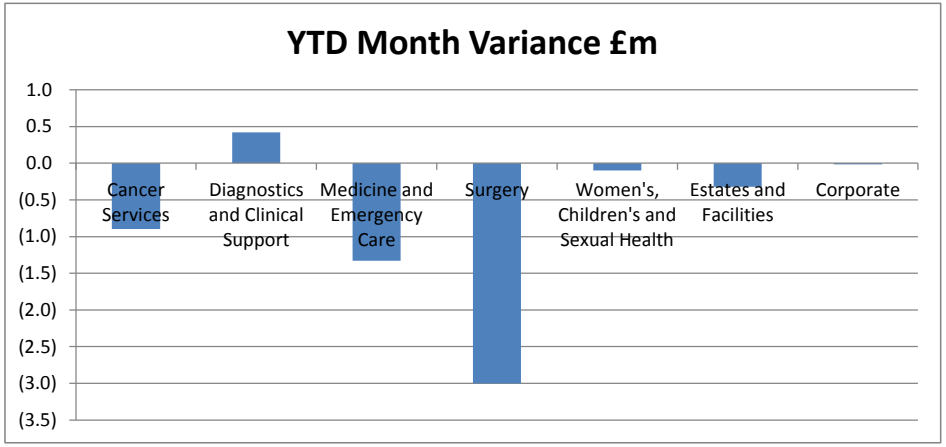
The Trust had an internal CIP plan of £25.1m with an external plan of £22.3m, therefore creating a savings stretch of £2.8m which was not delivered in 2019/20.

### Savings by Subjective Category

| | Current Month | | | Year to Date | | |
|---|---|---|---|---|---|---|
| | *Actual* | *Original Plan* | *Variance* | *Actual* | *Original Plan* | *Variance* |
| | £m | £m | £m | £m | £m | £m |
| Pay | 0.66 | 0.45 | 0.20 | 7.08 | 4.58 | 2.50 |
| Non Pay | (0.05) | 0.38 | (0.43) | (0.46) | 2.54 | (3.00) |
| Income | 1.29 | 1.25 | 0.04 | 15.79 | 15.20 | 0.59 |
| **Total** | **1.90** | **2.09** | **(0.19)** | **22.42** | **22.33** | **0.09** |

### Savings by NHSI RAG

| | Current Month | | | Year to Date | | |
|---|---|---|---|---|---|---|
| | *Actual* | *Original Plan* | *Variance* | *Actual* | *Original Plan* | *Variance* |
| | £m | £m | £m | £m | £m | £m |
| Green | 1.41 | 1.32 | 0.09 | 17.57 | 15.46 | 2.11 |
| Amber | 0.35 | 0.22 | 0.13 | 3.87 | 2.57 | 1.30 |
| Red | 0.14 | 0.54 | (0.41) | 0.98 | 4.30 | (3.32) |
| **Total** | **1.90** | **2.09** | **(0.19)** | **22.42** | **22.33** | **0.09** |

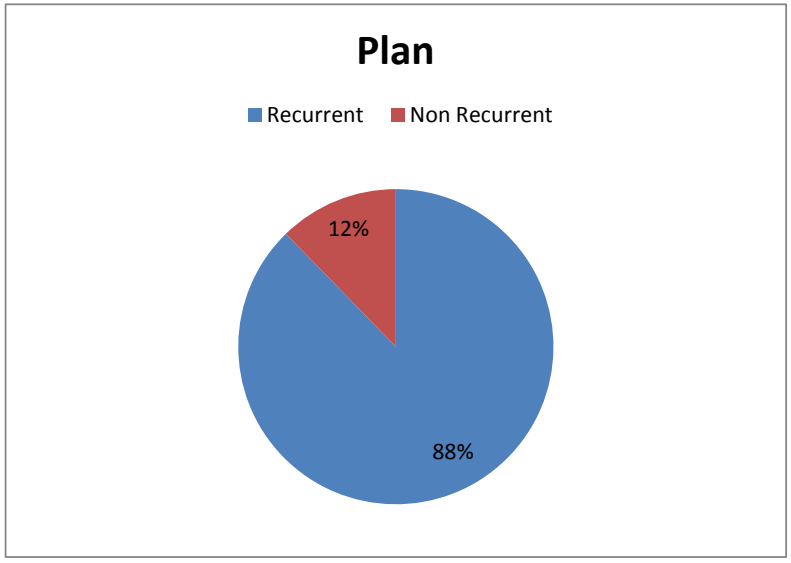


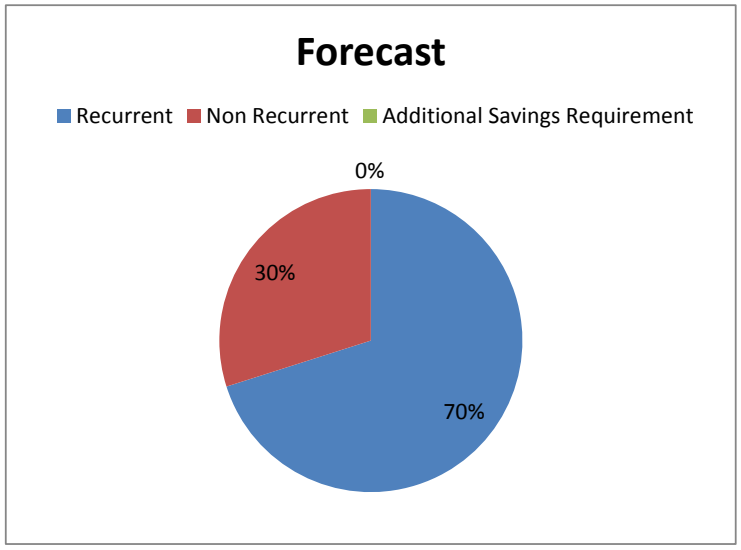
## 3b. Recurrent and Non Recurrent Savings

| | Cost Improvement Plan | | | Outturn | | |
|---|---|---|---|---|---|---|
| | *Non Recurrent* | *Recurrent* | *Total* | *Non Recurrent* | *Recurrent* | *Total* |
| | £m | £m | £m | £m | £m | £m |
| Cancer Services | 0.5 | 0.9 | 1.4 | 0.3 | 0.2 | 0.5 |
| Diagnostics and Clinical Support | 0.7 | 2.4 | 3.1 | 1.6 | 2.0 | 3.5 |
| Medicine and Emergency Care | 0.0 | 5.5 | 5.5 | 1.5 | 2.7 | 4.1 |
| Surgery | 0.0 | 8.1 | 8.1 | 0.2 | 5.0 | 5.1 |
| Women's, Children's and Sexual Health | 0.9 | 1.7 | 2.6 | 1.2 | 1.3 | 2.5 |
| Estates and Facilities | 0.2 | 2.1 | 2.3 | 0.6 | 1.4 | 2.0 |
| Corporate | 0.4 | 1.7 | 2.1 | 1.5 | 0.6 | 2.1 |
| Other | 0.0 | (2.8) | (2.8) | 0.0 | 2.5 | 2.5 |
| **Total** | **2.7** | **19.6** | **22.3** | **6.7** | **15.7** | **22.4** |
| | *12%* | *88%* | | *30%* | *70%* | |

The Trust is delivered £22.4m savings in 2019/20 of which £6.7m was non recurrent (30%) an increase of £4m compared to the original plan.

The main non recurrent schemes are:
- Workforce reviews = £3.1m
-Maternity CNST = £0.88m
- ICT Contract reviews = £0.7m
- Estates Rebates (PFI Insurance and RHI rebate) = £0.4m an increase of £0.1m
- Procurement = £0.2m



## 4a. Balance Sheet

**March 2020**

The Trust Balance Sheet is produced on a monthly basis and reflects changes in the asset values, as well as movement in liabilities.

| £m's | Reported | March Plan | Variance | February Reported | Full year Plan | Revised FOT |
|---|---|---|---|---|---|---|
| Property, Plant and Equipment (Fixed Assets) | 291.1 | 310.1 | (19.0) | 286.9 | 307.6 | 310.1 |
| Intangibles | 4.0 | 2.8 | 1.2 | 2.5 | 2.8 | 2.8 |
| PFI Lifecycle | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Debtors Long Term | 1.9 | 1.9 | 0.0 | 1.8 | 1.4 | 1.9 |
| **Total Non-Current Assets** | **297.0** | **314.8** | **(17.8)** | **291.2** | **311.8** | **314.8** |
| **Current Assets** | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Inventory (Stock) | 8.8 | 7.8 | 1.0 | 8.4 | 7.8 | 7.8 |
| Receivables (Debtors) - NHS | 23.6 | 24.7 | (1.1) | 30.2 | 24.7 | 24.7 |
| Receivables (Debtors) - Non-NHS | 23.9 | 8.7 | 15.2 | 11.0 | 9.2 | 8.7 |
| Cash | 3.4 | 3.0 | 0.4 | 21.9 | 3.0 | 3.0 |
| Assets Held For Sale | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| **Total Current Assets** | **59.7** | **44.2** | **15.5** | **71.5** | **44.7** | **44.2** |
| **Current Liabilities** | | | | | | |
| Payables (Creditors) - NHS | (7.7) | (5.1) | (2.6) | (7.7) | (5.1) | (5.1) |
| Payables (Creditors) - Non-NHS | (42.7) | (32.0) | (10.7) | (41.9) | (31.2) | (32.0) |
| Deferred Income | (3.1) | (2.6) | (0.5) | (10.5) | (2.6) | (2.6) |
| Capital Loan | (1.6) | (2.2) | 0.6 | (2.3) | (2.2) | (2.2) |
| Working Capital Loan | (26.2) | (26.1) | (0.1) | (12.3) | (26.1) | (26.1) |
| Other loans | (0.4) | (0.4) | 0.0 | (0.4) | (0.4) | (0.4) |
| Borrowings - PFI | (5.4) | (5.3) | (0.1) | (5.4) | (5.3) | (5.3) |
| Provisions for Liabilities and Charges | (2.6) | (1.5) | (1.1) | (1.6) | (1.5) | (1.5) |
| **Total Current Liabilities** | **(89.7)** | **(75.2)** | **(14.5)** | **(82.1)** | **(74.4)** | **(75.2)** |
| Net Current Assets | (30.0) | (31.0) | 1.0 | (10.6) | (29.7) | (31.0) |
| non-current liabilities: Borrowings - PFI > 1yr | (181.9) | (182.2) | 0.3 | (182.0) | (182.2) | (182.2) |
| Capital Loans | (6.4) | (5.8) | (0.6) | (6.9) | (6.6) | (5.8) |
| Working Capital Facility & Revenue loans | 0.0 | 0.0 | 0.0 | (14.1) | 0.0 | 0.0 |
| Other loans | (1.3) | (1.3) | 0.0 | (1.3) | (1.3) | (1.3) |
| Provisions for Liabilities and Charges- Long term | (0.8) | (1.0) | 0.2 | (0.8) | (1.0) | (1.0) |
| **Total Assets Employed** | **76.6** | **93.5** | **(16.9)** | **75.5** | **91.0** | **93.5** |
| Financed By: | | | | | | |
| Capital & Reserves | | | | | | |
| Public dividend capital | 216.4 | 216.1 | 0.3 | 213.0 | 213.2 | 216.1 |
| Revaluation reserve | 30.2 | 46.2 | (16.0) | 31.8 | 46.2 | 46.2 |
| Retained Earnings Reserve | (170.0) | (168.8) | (1.2) | (169.3) | (168.4) | (168.8) |
| **Total Capital & Reserves** | **76.6** | **93.5** | **(16.9)** | **75.5** | **91.0** | **93.5** |

**Commentary:**
The overall working capital within the month results in a increase in Debtors of £14.1m against plan with an increase in creditors of £13.8m compared to the revised plan submitted in May. The cash balance held at the end of the month is higher than the plan by £0.4m. Further information is given below.

**Non-Current Assets** -
The 2019/20 capital additions are £16.9m of which £0.8m relates to donated assets. 2019/20 is the fifth year in the current five year cyclical valuation period; a full valuation will be undertaken in March 2020 by the Trust's professional valuers Montagu Evans LLP.

**Current Assets** -
Inventories of £8.8m is higher that the planned value of £7.8m. The main stock balances are pharmacy £3.3m, TWH theatres £1.4m, Materials Management £1m and Cardiology £1.4m.
NHS Receivables have decreased from the February's position by £6.6m to £23.6m. Of the £23.6m reported balance, £11.8m relates to invoiced debt of which £2.3m is aged debt over 90 days. Invoiced debt over 90 days has decreased since the February's position of £3m to £2.3m. The remaining £11.8m relates to uninvoiced accrued income including quarter 4 PSF of £2.7m, Covid 19 income accrual of £2.8m and Trust SLA accruals of £5.8m and partially completed spells £2.7m. Due to the cash pressures of many neighbouring NHS bodies regular communication is continuing and arrangements are being put in place to help reduce the level of debt.
Non NHS Receivables has increased by £12.9m to £23.9m from the reported February position of £11m . Included within the £12.9m balance is trade invoiced debt of £2.7m and private patient invoiced debt of £0.5m. Also included within the £23.9m are prepayments and accrued income totalling £19m. Included within the accruals are £11.4m pension increase of 6.3% and £0.9m Clinical Pension Tax - both are now accruals for mth 12. Prepayments primarily relate to rates & annual service maintenance contracts, which will reduce throughout the year as they are expensed.
The closing cash balance at the end of March 2020 was £3.36m which is slightly higher than cash plan of £3m. This value includes the agreed £2m carry forward from the asset sale to be used for capital projects and £1m baseline requirement.

**Current Liabilities** -
NHS payables have remained consistent at £7.7m. Non-NHS trade payables have increased slightly to £42.7m from £41.9m giving a combined payables balance of £50.4m .

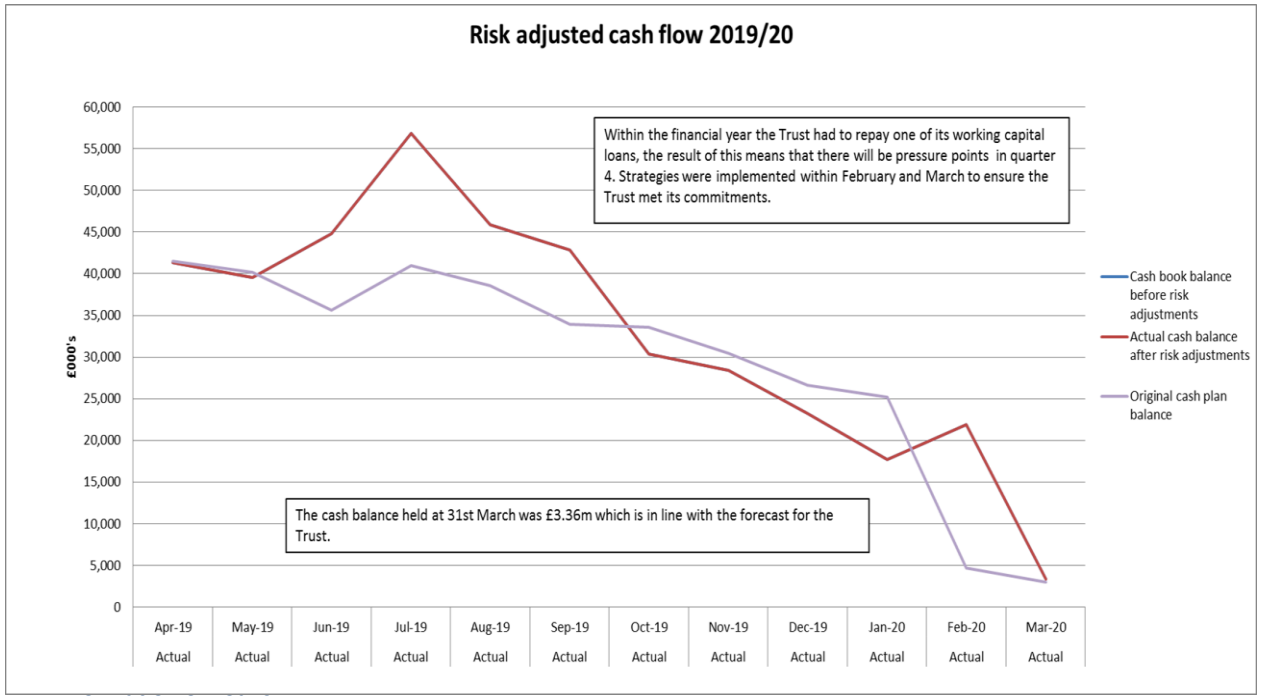
Of the £50.4m combined payables balances, £10.9m relates to actual invoices of which £4m are approved for payment and will be released when they fall due, the remaining balance of payables of £39.5m relates to uninvoiced accruals.
The Balance of £4m approved invoices at the end of March shows 81% are within 0-30 days outstanding.
Deferred income of £3.1m primarily relates to £2.1m for Maternity Pathway
Both the working capital loans totalling c.£26.1m have moved from Non Current Liabilities to Current Liabilities as both are due for repayment during 2020/21.

**Non current liabilities:**
Other loans for both current and non current liabilities relate to the Salix loan which has been taken out to improve the energy efficiency of the Trust.

**Capital and Reserves**
The public dividend capital increases by the end of the financial year by £4.3m. £1.3m is in relation to ICT - EPMA project and £2.1m for Diagnostic funding to purchase an MRI and 2 CT scanners, the funding for both the projects are expected to be received in quarter 4.

There is a slight decrease in the revaluation reserve due to an overall decrease in the valuation exercise at 31st March . The Trust had forecast a 5% increase in the valuation of Build and Land assets, but the actual valuation resulted in a decrease of c£3.8m due a reduction in the geographical location.

## 4b. | Cash Flow




| | Rate | Value £m's | 19/20 Annual Repayment £m's | 19/20 Annual Interest Paid £m's | Repayment Date |
|---|---|---|---|---|---|
| **Revenue loans:** | | | | | |
| Interim Revolving Working Capital Facility (IRWCF) | 3.50% | 12.132 | 0.00 | 0.43 | 19/10/2020 |
| interim working capital loans | 3.50% | 13.990 | 0.00 | 0.49 | 18/03/2021 |
| **Capital loans:** | | | | | |
| Capital investment loan | 2.02% | 12.000 | 1.20 | 0.06 | 15/09/2020 |
| Capital investment loan | 3.91% | 11.000 | 0.73 | 0.19 | 15/09/2025 |
| Capital investment loan | 4.73% | 6.000 | 0.24 | 0.16 | 15/09/2035 |
| **Other loans:** | | | | | |
| Salix loan (interest free) | 0.00% | 1.743 | 0.44 | 0.00 | 2024/25 |

**Commentary:**

**2019/20**

The red line shows the Trust's actual cash position after risk adjustments for 2019/20 and the purple line shows the original plan values.

The cash balance of £3.36m is in line with the FOT plan value of £3m. This includes £2m agreed carry forward of the remaining asset sale receipts from 2018/19 on top of the £1m that the Trust is required to hold as a minimum level of liquidity.

**2020/21**

The cash flow for 2020/21 is based on the I&E plan submitted in early March. However, due to the current Covid-19 crisis - for the periods between April and July 2020 all clinical activity will be paid via block payments to ensure that NHS providers have sufficient cash to see it through the next four months.

The cash flow is updated daily to ensure that the Trust can meet all its commitments as well as working towards ensuring prompt payment is made to suppliers as per the Cabinet Offices procurement policy of paying suppliers within 7 days.

The two interim working capital loans which are due to be repaid within 2020/21 (total £26.1m) are going to be replaced by the Trust being issued Public Dividend Capital (PDC) to effect the repayment of outstanding balances at 31st March 2020. The effective date of the transactions to repay the loans will be 30th September 2020 at the same time the Trust will receive the PDC to enable this repayment to be made. All loans will be frozen at 31st March 2020 and interest payments will cease from that date. The existing normal business capital loans remain in place.

This support will be provided as PDC which does not require principal repayment but carries a dividend payable at the current PDC rate (3.5%).

## 4c. Capital Programme

### Capital Projects/Schemes

| | Year to Date | | | Forecast | | |
|---|---|---|---|---|---|---|
| | *Plan* | *Actual* | *Variance* | *Plan* | *Actual* | *Variance* |
| | £000 | £000 | £000 | £000 | £000 | £000 |
| Estates | 6,588 | 2,198 | 4,390 | 6,588 | 2,198 | -4,390 |
| ICT | 4,103 | 7,522 | -3,419 | 4,103 | 7,522 | 3,419 |
| Equipment | 3,163 | 5,847 | -2,684 | 3,163 | 5,847 | 2,684 |
| PFI Lifecycle (IFRIC 12) | 594 | 434 | 160 | 594 | 434 | -160 |
| Donated Assets | 400 | 890 | -490 | 400 | 890 | 490 |
| **Total Including Donated Assets** | **14,848** | **16,891** | **-2,043** | **14,848** | **16,891** | **2,043** |
| Less donated assets | -400 | -890 | 490 | -400 | -890 | -490 |
| **Total Excluding Donated Assets** | **14,448** | **16,001** | **-1,553** | **14,448** | **16,001** | **1,553** |

The Trust's original plan has been varied during the year by a number of additional national funds: Equipment for Diagnostics = MRI, 2 x CT scanners & Mammography (£2.11m); ICT for EPMA, HSLI, Cyber & LHCRE (£2.45m); Estates for Covid-19 Pods (£50k) Total = £4.6m.

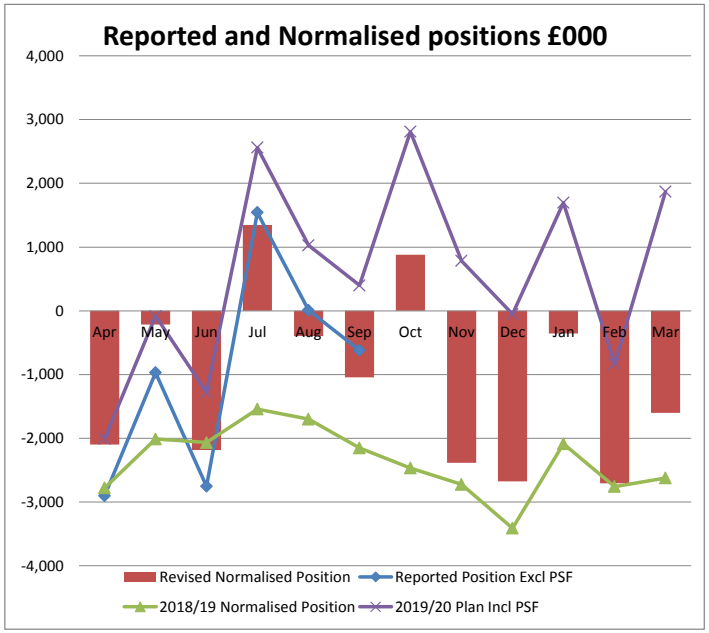
The overall capital programme spend is £16m, excluding donated assets. This includes internally generated capital of £4.85m and £6.4m asset sales carried forward from 2018/19. The internally generated capital of £4.85m has reduced in year by c.£0.4m as a result of an underspend on depreciation resulting from the reduction in the overall programme value (removal of a external financing items) and slippage in the timing of schemes due to the planning issues around the national capital position.

The major spends in-year relate to ICT; £5.3m on EPR/EPMA (EPMA funded from PDC), £0.4m on cyber security (PDC funded) and £0.6m on PCs/Laptops - Equipment; £2.6m (£2.1m PDC funded) for CTs x 2, MRI & Mammography, £0.8m on surgical reconfiguration and endoscopy, and Estates; £2.1m for backlog maintenance and Linac enabling work. The Trust has also spent £462k relating to Covid-19 including assessment pods, anaesthetic machines, video layrngoscopes and laptops for working from home. The Trust has been funded £50k in March for the Covid 19 pods and there is an expectation that PDC will be paid in 2020/21 relating to the remaining spend in 2019/20.

## 5a. Normalisation (Pre PSF)

Analysis of Trusts Normalised Financial Position

| | | Current Month | | | Year to Date | | |
|---|---|---|---|---|---|---|---|
| | | *Actual* | *Plan* | *Variance* | *Actual* | *Plan* | *Variance* |
| | | £m | £m | £m | £m | £m | £m |
| **Reported position Excl STF** | Income Excl PSF | 55.6 | 52.7 | 3.0 | 499.0 | 498.6 | 0.4 |
| | Pay | -36.9 | -35.7 | -1.2 | -299.9 | -302.0 | 2.0 |
| | Non Pay | -16.7 | -13.9 | -2.8 | -176.2 | -172.7 | -3.5 |
| | Other Finance Costs | -4.2 | -3.0 | -1.2 | -32.1 | -32.0 | -0.1 |
| | Technical Adjustments | 2.6 | 0.4 | 2.1 | 2.3 | 1.1 | 1.2 |
| | **Total Position Excl PSF** | **0.4** | **0.5** | **-0.1** | **-6.8** | **-7.0** | **0.1** |
| **Income Excl STF** | | | | | | | |
| | Old Year Adjustment | 0.0 | 0.0 | 0.0 | -0.7 | 0.0 | -0.7 |
| | Medical Pay Award funding | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | Sussex Risk Reserve | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | Fines | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | QIPP Adjustment | 0.0 | 0.0 | 0.0 | -1.3 | 0.0 | -1.3 |
| | RTT Income support | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | Employers Pension 6.3% | -10.4 | 0.0 | -10.4 | 0.0 | 0.0 | 0.0 |
| | COVID 19 | -1.9 | 0.0 | -1.9 | -1.9 | 0.0 | -1.9 |
| | Sexual Health Contract review | -0.6 | 0.0 | -0.6 | 0.0 | 0.0 | 0.0 |
| | Medical Education defered income | -0.3 | 0.0 | -0.3 | 0.0 | 0.0 | 0.0 |
| | **Total Income** | **-13.2** | **0.0** | **-13.2** | **-3.8** | **0.0** | **-3.8** |
| **Normalisation Adjustments** | | | | | | | |
| **Pay** | Old Year Adjustment | -0.2 | 0.0 | -0.2 | -2.0 | 0.0 | -2.0 |
| | Medical Pay award assessment | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | Release of Reserves | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | COVID 19 | 1.1 | 0.0 | 1.1 | 1.1 | 0.0 | 1.1 |
| | Employers Pension 6.3% | 10.4 | 0.0 | 10.4 | 0.0 | 0.0 | 0.0 |
| | **Total Pay** | **11.3** | **0.0** | **11.3** | **-0.9** | **0.0** | **-0.9** |
| **Non Pay** | Old Year Adjustment | 0.0 | 0.0 | 0.0 | -1.0 | 0.0 | -1.0 |
| | Release of Reserves | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | EPR Project costs | 0.0 | 0.0 | 0.0 | -1.0 | 0.0 | -1.0 |
| | Review of Overseas Visitor charges | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | COVID 19 | 0.8 | 0.0 | 0.8 | 0.8 | 0.0 | 0.8 |
| | **Total Non Pay** | **0.8** | **0.0** | **0.8** | **-1.2** | **0.0** | **-1.2** |
| | PDC | -0.9 | 0.0 | -0.9 | 0.0 | 0.0 | 0.0 |
| | **Total Other Finance Costs** | **-0.9** | **0.0** | **-0.9** | **0.0** | **0.0** | **0.0** |
| | **Total Normalisation Adjustments** | **-2.0** | **0.0** | **-2.0** | **-6.0** | **0.0** | **-6.0** |




| | | Current Month | | | Year to Date | | |
|---|---|---|---|---|---|---|---|
| | | *Actual* | *Plan* | *Variance* | *Actual* | *Plan* | *Variance* |
| | | £m | £m | £m | £m | £m | £m |
| **Revised Normalised Position Excl STF** | Income Excl PSF | 42.4 | 52.7 | -10.3 | 495.1 | 498.6 | -3.5 |
| | Pay | -25.6 | -35.7 | 10.1 | -300.9 | -302.0 | 1.1 |
| | Non Pay | -15.9 | -13.9 | -2.0 | -176.2 | -172.7 | -3.5 |
| | Other Finance Costs | -5.1 | -3.0 | -2.1 | -32.1 | -32.0 | -0.1 |
| | Technical Adjustments | 2.6 | 0.4 | 2.1 | 2.3 | 1.1 | 1.2 |
| | **Total Position Excl PSF** | **-1.6** | **0.5** | **-2.1** | **-11.6** | **-7.0** | **-4.7** |

## 5b. Run Rate Analysis

**Analysis of 13 Monthly Performance (£m's)**

| | | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Change between Months |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Revenue** | Clinical Income | 34.5 | 35.2 | 36.4 | 34.3 | 37.9 | 36.3 | 35.9 | 38.2 | 35.2 | 37.1 | 38.1 | 35.0 | 50.8 | 15.8 |
| | STF / PSF | 12.8 | 0.9 | 0.9 | 1.5 | 1.0 | 1.0 | 1.0 | 0.5 | 0.5 | 2.8 | 1.4 | 1.4 | 1.4 | (0.0) |
| | High Cost Drugs | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | Other Operating Income | 5.3 | 4.1 | 4.1 | 4.6 | 4.5 | 3.9 | 4.1 | 4.2 | 4.0 | 4.4 | 3.9 | 2.1 | 4.8 | 2.7 |
| | **Total Revenue** | **52.6** | **40.2** | **41.4** | **40.4** | **43.4** | **41.2** | **41.0** | **42.9** | **39.7** | **44.3** | **43.3** | **38.6** | **57.0** | **18.5** |
| **Expenditure** | Substantive | (19.9) | (20.1) | (19.5) | (19.3) | (19.7) | (19.9) | (19.6) | (20.2) | (20.4) | (20.8) | (20.5) | (20.7) | (31.9) | (11.2) |
| | Bank | (1.4) | (1.3) | (1.1) | (1.1) | (1.2) | (1.3) | (1.2) | (1.2) | (1.3) | (1.3) | (1.2) | (1.4) | (1.7) | (0.3) |
| | Locum | (1.1) | (0.8) | (0.9) | (0.9) | (0.9) | (1.0) | (1.1) | (0.8) | (1.2) | (1.1) | (1.1) | (0.9) | (1.3) | (0.4) |
| | Agency | (1.4) | (1.6) | (1.7) | (1.5) | (1.9) | (1.8) | (1.8) | (1.7) | (1.1) | (1.5) | (1.6) | (1.4) | (1.9) | (0.4) |
| | Pay Reserves | (0.2) | (0.3) | (0.3) | (0.3) | (0.3) | 0.7 | (0.1) | (0.1) | 0.6 | (0.1) | (0.1) | (0.1) | (0.1) | (0.0) |
| | Total Pay | (23.9) | (24.2) | (23.5) | (23.1) | (23.9) | (23.3) | (23.9) | (24.1) | (23.3) | (24.8) | (24.5) | (24.5) | (36.9) | (12.4) |
| **Non-Pay** | Drugs & Medical Gases | (4.5) | (4.6) | (4.6) | (4.2) | (4.7) | (4.5) | (4.4) | (4.8) | (4.7) | (4.6) | (4.8) | (4.5) | (4.7) | (0.2) |
| | Blood | (0.2) | (0.2) | (0.2) | (0.2) | (0.2) | (0.2) | (0.2) | (0.2) | (0.2) | (0.2) | (0.2) | (0.2) | (0.1) | 0.1 |
| | Supplies & Services - Clinical | (2.7) | (2.7) | (2.7) | (2.8) | (3.0) | (2.6) | (2.8) | (2.9) | (2.9) | (3.0) | (2.6) | (2.7) | (4.0) | (1.3) |
| | Supplies & Services - General | (0.5) | (0.4) | (0.4) | (0.4) | (0.4) | (0.4) | (0.4) | (0.4) | (0.5) | (0.5) | (0.5) | (0.4) | (0.7) | (0.4) |
| | Services from Other NHS Bodies | (3.2) | (1.0) | (0.8) | (0.7) | (0.6) | (0.6) | (0.8) | (0.5) | (0.6) | (0.5) | (0.5) | (0.5) | (0.1) | 0.4 |
| | Purchase of Healthcare from Non-NHS | (0.5) | (1.5) | (1.7) | (1.6) | (1.2) | (1.2) | (1.1) | (1.1) | (1.1) | (1.2) | (1.3) | (1.3) | (1.4) | (0.1) |
| | Clinical Negligence | (1.5) | (1.5) | (1.5) | (1.5) | (1.5) | (1.5) | (1.5) | (1.5) | (1.5) | (1.4) | (1.5) | (1.5) | (1.5) | (0.0) |
| | Establishment | (0.2) | (0.2) | (0.3) | (0.3) | (0.3) | (0.3) | (0.4) | (0.3) | (0.4) | (0.4) | (0.3) | (0.2) | (0.1) | 0.1 |
| | Premises | (2.3) | (2.3) | (2.2) | (2.4) | (1.9) | (2.1) | (1.9) | (2.2) | (1.9) | (1.8) | (2.3) | (2.6) | (2.8) | (0.2) |
| | Transport | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.2) | (0.2) | (0.2) | 0.1 |
| | Other Non-Pay Costs | 1.8 | (0.5) | (0.5) | (0.7) | (1.2) | (1.0) | (1.0) | (0.7) | (0.6) | (0.6) | (0.7) | 1.6 | (1.1) | (2.7) |
| | Non-Pay Reserves | 0.0 | (0.5) | (0.4) | (0.4) | 0.7 | 0.1 | 0.4 | 0.0 | 0.5 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | Total Non Pay | (14.0) | (15.4) | (15.4) | (15.4) | (14.3) | (14.4) | (14.3) | (14.8) | (13.9) | (14.4) | (14.7) | (12.5) | (16.7) | (4.2) |
| | Total Expenditure | (38.0) | (39.6) | (38.9) | (38.5) | (38.3) | (37.7) | (38.1) | (38.8) | (37.2) | (39.3) | (39.2) | (36.9) | (53.5) | (16.6) |
| **EBITDA** | EBITDA | 14.7 | 0.5 | 2.5 | 1.9 | 5.1 | 3.6 | 2.8 | 4.1 | 2.5 | 5.1 | 4.2 | 1.6 | 3.5 | 1.9 |
| | | *28%* | *1%* | *6%* | *5%* | *12%* | *9%* | *7%* | *9%* | *6%* | *11%* | *10%* | *4%* | *6%* | |
| **Other Finance Costs** | Depreciation | (1.1) | (1.1) | (1.1) | (1.1) | (1.1) | (1.1) | (1.0) | (1.1) | (1.0) | (1.1) | (1.1) | (1.1) | (1.1) | (0.0) |
| | Interest | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | 0.0 |
| | Dividend | 0.5 | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | 0.8 | 1.0 |
| | PFI and Impairments | 7.9 | (1.2) | (1.2) | (1.2) | (1.2) | (1.2) | (1.2) | (1.3) | (1.2) | (1.2) | (1.2) | (1.2) | (3.9) | (2.7) |
| | **Total Other Finance Costs** | **7.2** | **(2.6)** | **(2.6)** | **(2.5)** | **(2.6)** | **(2.6)** | **(2.4)** | **(2.6)** | **(2.5)** | **(2.5)** | **(2.5)** | **(2.5)** | **(4.2)** | **(1.8)** |
| **Net Surplus / Deficit (-)** | Net Surplus / Deficit (-) | 21.9 | (2.0) | (0.1) | (0.7) | 2.5 | 1.0 | 0.5 | 1.4 | (0.0) | 2.6 | 1.7 | (0.8) | (0.7) | 0.1 |
| **Technical Adjustments** | Technical Adjustments | (0.2) | 0.0 | 0.0 | (0.6) | 0.0 | 0.0 | (0.0) | 0.1 | 0.0 | (0.5) | 0.0 | 0.0 | 2.6 | 2.5 |
| **Surplus/ Deficit (-) to B/E Duty Incl pSF** | Surplus/ Deficit (-) to B/E Duty | 21.7 | (2.0) | (0.1) | (1.3) | 2.6 | 1.0 | 0.4 | 1.5 | 0.0 | 2.0 | 1.7 | (0.8) | 1.8 | 2.6 |
| **Surplus/ Deficit (-) to B/E Duty Excl STF** | Surplus/ Deficit (-) to B/E Duty | 8.9 | (2.9) | (1.0) | (2.8) | 1.5 | 0.0 | (0.6) | 1.0 | (0.5) | (0.8) | 0.3 | (2.2) | 0.4 | 2.6 |

| Mar-20 | | DAY | | | | NIGHT | | | | TEMPORARY STAFFING | | | | | | | | | | 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) | Bank / Agency Demand: RN/M (number of shifts)comparison of previous month | WTE Temporary demand RN/M | Temporary Demand Unfilled -RM/N (number of shifts) | Temporary Demand Unfilled - RM/M comparison of previous month | Overall Care Hours per pt day | Falls | PU ward acquired | Comments | Budget £ | Actual £ | Variance £ (overspend) |
| MAIDSTONE | Stroke Unit (M) - NK551 | 96.1% | 74.3% | - | 100.0% | 100.0% | 98.2% | - | - | 16.8% | 14.6% | 68 | ↓ | 4.54 | 13 | ↗ | 9.6 | 2 | 0 | | 129,839 | 129,422 | 417 |
| MAIDSTONE | Cornwallis (M) - NS959 | 111.3% | 93.4% | - | 100.0% | 93.6% | 93.5% | - | - | 38.3% | 4.4% | 49 | ↑ | 3.07 | 4 | → | 6.4 | 2 | 0 | | 124,053 | 97,907 | 26,146 |
| MAIDSTONE | Culpepper Ward (M) - NS551 | 84.5% | 90.3% | - | - | 92.8% | 93.3% | - | - | 17.9% | 25.9% | 65 | ↗ | 4.65 | 10 | ↑ | 8.2 | 0 | 0 | Reduced RN fill rate reflective of an increase in temporary demand. 10 shifts remained uncovered. | 113,018 | 111,784 | 1,234 |
| MAIDSTONE | John Day Respiratory Ward (M) - NT151 | 111.5% | 82.6% | - | - | 108.4% | 91.8% | - | - | 32.4% | 17.8% | 94 | ↑ | 6.64 | 14 | ↗ | 7.1 | 4 | 2 | Increased RN fill rate due to increased patient acuity during COVID- 19 pandemic | 132,265 | 163,551 | (31,286) |
| MAIDSTONE | Intensive Care (M) - NA251 | 96.0% | 99.0% | - | - | 89.5% | - | - | - | 10.4% | 5.5% | 104 | ↑ | 7.06 | 44 | ↑ | 37.5 | 0 | 0 | Staffing in line with bed occupancy requirements and increase in capacity. Increase in both temporary staffing demand and unfilled shifts due to COVID-19 | 163,371 | 161,715 | 1,656 |
| MAIDSTONE | Pye Oliver (Medical) - NK259 | 87.5% | 100.2% | - | - | 101.1% | 101.1% | - | - | 22.6% | 67.8% | 112 | ↑ | 7.38 | 17 | → | 6.3 | 4 | 0 | Reduced RN fill rate reflective of escort requirements during the first part of March and an increase in the requirements for temporary staff. Bed occupancy redcued due to COVID-19 toward end of the month and staffing in line with requirements. | 119,314 | 113,038 | 6,276 |
| MAIDSTONE | Chaucer Ward (M) - NS951 | 130.0% | 90.0% | - | - | 129.3% | 92.7% | - | - | 47.4% | 30.7% | 178 | ↑ | 11.78 | 26 | → | 8.2 | 7 | 1 | 1 fall above threshold. Increased fill rate and temporary staffing requests to support RMN requirements throughout the month | 165,185 | 172,094 | (6,909) |
| MAIDSTONE | Whatman Ward - NK959 | 90.5% | 79.7% | - | 100.0% | 157.6% | 148.4% | - | - | 41.7% | 22.9% | 124 | ↓ | 8.68 | 23 | ↗ | 8.4 | 2 | 0 | Increased fill rate at night due to frailty escalation for the first part of the month. Area now de escalted and staffed according to bed occupancy requirements | 92,372 | 119,966 | (27,594) |
| MAIDSTONE | Lord North Ward (M) - NF651 | 105.6% | 136.4% | - | 100.0% | 97.8% | 93.5% | - | - | 16.4% | 9.5% | 46 | ↑ | 3.22 | 2 | ↗ | 8.5 | 4 | 1 | 2 falls above threshold. Increased CSW fill rate a considered action to support increased dependency levels on ward. | 88,181 | 111,211 | (23,030) |
| MAIDSTONE | Mercer Ward (M) - NJ251 | 106.2% | 95.7% | - | 100.0% | 97.8% | 109.0% | - | - | 23.4% | 57.4% | 76 | ↓ | 5.16 | 6 | ↘ | 7.0 | 2 | 2 | Bed occupancy reduced during the last week in March. Reports of staff self isolating due to COVID-19 | 119,487 | 126,189 | (6,702) |
| MAIDSTONE | Edith Cavell (M) - NE959 | 117.2% | 101.8% | - | 100.0% | 94.5% | 168.2% | - | - | 15.0% | 27.0% | 40 | ↑ | 2.57 | 7 | ↑ | 25.1 | 0 | 0 | Ward speciality changed during the month to support COVID positive patient pathway during pandemic | 81,233 | 71,133 | 10,100 |
| MAIDSTONE | Acute Medical Unit (M) - NG551 | 92.2% | 84.9% | - | - | 123.4% | 157.5% | - | - | 31.9% | 32.9% | 135 | ↓ | 8.94 | 36 | ↑ | 22.3 | 2 | 1 | Reduction in temporary demand requested in line with de escaltion during the month with bed occupancy reducing. Some staff redeployment to support organisation safe staffing levels | 117,548 | 140,615 | (23,067) |
| TWH | Ward 22 (TW) - NG332 | 139.4% | 101.2% | - | 100.0% | 114.3% | 90.1% | - | - | 39.3% | 30.5% | 158 | ↑ | 10.92 | 36 | ↑ | 7.3 | 9 | 0 | 2 falls above threshold | 129,106 | 143,522 | (14,416) |
| TWH | Coronary Care Unit (TW) - NP301 | 116.7% | 82.1% | - | - | 96.4% | - | - | - | 19.1% | 25.4% | 51 | ↓ | 2.95 | 12 | ↗ | 15.9 | 1 | 0 | 1 fall above threshold. Staff sickness recorded during the month and episodes of staff redeployed to support organisational staff levels | 69,979 | 71,643 | (1,664) |
| TWH | Ward 33 (Gynae) (TW) - ND302 | 92.5% | 88.8% | - | - | 97.8% | 96.8% | - | - | 19.6% | 11.8% | 68 | ↑ | 4.16 | 11 | ↗ | 14.2 | 0 | 0 | Increased in demand for temporary staffing. Staff sickness reported latter part of month | 97,878 | 105,931 | (8,053) |
| TWH | Intensive Care (TW) - NA201 | 108.6% | 119.8% | - | - | 94.9% | 93.5% | - | - | 12.4% | 0.0% | 89 | ↑ | 5.88 | 9 | ↗ | 37.8 | 0 | 0 | Temporary staffing requirements increased due to COVID-19 pandemic and supporting increased capacity. | 190,571 | 208,196 | (17,625) |
| TWH | Acute Medical Unit (TW) - NA901 | 87.8% | 72.9% | - | 100.0% | 92.7% | 98.9% | - | 100.0% | 27.6% | 25.8% | 179 | ↓ | 12.70 | 41 | ↑ | 10.6 | 6 | 0 | Reduction in temporary demand requested in line with a reduction of bed occupancy during the latter part of March. RN fill rate reduced due to lack of available temporary staff across 41 shifts. | 184,662 | 185,493 | (831) |
| TWH | Surgical Assessment Unit (TW) - NE701 | 103.4% | 100.5% | - | - | 101.6% | 100.0% | - | - | 20.4% | 8.8% | 25 | ↑ | 1.75 | 4 | ↗ | 21.3 | 1 | 0 | 1 fall above threshold. Escalated during ealry part of March followed by reduction in bed occupancy due to COVID -19 | 61,157 | 64,482 | (3,325) |
| TWH | Ward 32 (TW) - NG130 | 77.7% | 67.8% | - | - | 102.2% | 65.6% | - | - | 15.7% | 12.8% | 57 | ↑ | 3.42 | 6 | ↘ | 7.8 | 1 | 0 | Bed occupancy between 10 - 20 during the month. Staffing supported by internal redeployment in particular from SSSU due to COVID | 115,442 | 113,501 | 1,941 |
| TWH | Ward 10 (TW) - NG131 | 110.3% | 88.1% | - | 100.0% | 119.1% | 121.3% | - | 100.0% | 42.0% | 34.0% | 176 | ↑ | 12.08 | 26 | ↑ | 7.6 | 2 | 0 | | 119,152 | 80,028 | 39,124 |
| TWH | Ward 11 (TW) Winter Escalation 2019 - NG144 | 98.2% | 72.5% | - | - | 105.4% | 91.1% | - | - | 67.7% | 34.5% | 183 | ↑ | 12.86 | 18 | ↘ | 7.6 | 1 | 0 | | 0 | 172,557 | (172,557) |
| TWH | Ward 12 (TW) - NG132 | 108.5% | 86.0% | - | 100.0% | 110.8% | 92.6% | - | - | 25.1% | 31.1% | 98 | ↑ | 6.46 | 18 | ↗ | 7.3 | 11 | 1 | 5 falls above threshold. Increased temporary staffing requests in line with some staff sickness reported during the month. | 124,066 | 135,772 | (11,706) |
| TWH | Ward 20 (TW) - NG230 | 127.6% | 77.8% | - | - | 113.0% | 95.2% | - | - | 34.8% | 19.3% | 82 | ↑ | 5.65 | 18 | ↑ | 5.9 | 8 | 0 | 1 fall above threshold. Increased temporary staff requests with 18 unfilled shifts. Staff sickness reported during the month. | 112,116 | 124,232 | (12,116) |
| MAIDSTONE | Foster Winter Escalation 2019 (M) - NR359 | 69.5% | 45.0% | - | 100.0% | 129.0% | 57.3% | - | - | 49.5% | 43.9% | 139 | ↓ | 9.87 | 12 | ↑ | 7.4 | 1 | 0 | Reduced fill rate in line with bed occupancy requirements. Decrease in temporary staffing request and | 148,543 | 75,511 | 73,032 |
| TWH | Ward 21 (TW) - NG231 | 94.9% | 83.3% | - | 100.0% | 96.8% | 101.6% | - | - | 23.5% | 36.4% | 112 | ↓ | 7.33 | 25 | ↘ | 7.9 | 5 | 1 | Staff sickness reported during the month. | 144,590 | 147,318 | (2,728) |
| TWH | Ward 2 (TW) - NG442 | 117.4% | 85.8% | - | 100.0% | 101.3% | 105.4% | - | - | 30.3% | 27.4% | 119 | ↑ | 7.48 | 15 | ↘ | 9.1 | 12 | 1 | 5 falls above threshold. Increased fill rate supporting escalation at the beginning of March. Bed occupancy subsequently reduced at the end of the month due to COVID pandemic. | 116,959 | 129,808 | (12,849) |
| TWH | Ward 30 (TW) - NG330 | 130.5% | 97.4% | - | - | 103.3% | 96.5% | - | - | 39.9% | 13.5% | 116 | ↑ | 7.25 | 16 | ↗ | 7.8 | 2 | 3 | Increased fill rate and temporary staffing requirements to support enhanced care needs and supporting new staff to ward. | 118,756 | 149,676 | (30,920) |
| TWH | Ward 31 (TW) - NG331 | 102.1% | 93.8% | - | 100.0% | 98.5% | 94.6% | - | - | 33.1% | 13.0% | 122 | ↗ | 7.48 | 21 | → | 7.1 | 9 | 0 | 3 falls above threshold | 130,352 | 146,850 | (16,498) |
| Crowborough | Crowborough Birth Centre (CBC) - NP775 | 68.0% | 132.8% | - | - | 98.8% | 96.8% | - | - | 8.5% | 0.0% | 22 | ↑ | 1.19 | 2 | ↗ | | | 0 | | 67,938 | 81,531 | (13,593) |
| TWH | Midwifery (multiple rosters) | 86.2% | 46.1% | - | - | 94.3% | 49.5% | - | - | 16.1% | 9.3% | a | ↑ | 35.19 | 75 | ↑ | 23.4 | 0 | 0 | Reduced fill rate due to lack of available temporary staff. Increased in temporary demand this month and increase in unfilled shifts. Delivery suite prioritised to ensure safe staffing levels. MSW | 671,782 | 672,269 | (487) |
| TWH | Hedgehog Ward (TW) - ND702 | 101.0% | 50.1% | - | - | 95.3% | - | - | - | 30.9% | 34.2% | 161 | ↓ | 10.63 | 12 | ↘ | 11.3 | 0 | 0 | RMN requirements across 7 episodes. Bed occupancy between 7-24 | 161,550 | 157,826 | 3,724 |
| MAIDSTONE | Maidstone Birth Centre - NP751 | 102.6% | - | - | - | 98.6% | 90.3% | - | - | 25.1% | 0.0% | 38 | ↗ | 2.28 | 1 | → | | 0 | 0 | | 72,406 | 78,210 | (5,804) |
| TWH | SCBU (TW) - NA102 | 72.5% | 423.6% | - | - | 92.6% | - | - | - | 17.6% | 0.9% | 121 | ↑ | 6.70 | 4 | ↗ | 17.7 | | 0 | RN fill rate aligned to bed occupancy between 7-12 throughout the month. Amber escalation reported once only and unit remained green across all other episodes. Increased CSW fill rate as these numbers are inclusive of 84 Nursery Nurses which increase the fill rate of unregistered hours against a plan of 172.5. Roster to be realigned to reflect unregistered demand. | 179,170 | 177,055 | 2,115 |
| MAIDSTONE | Short Stay Surgery Unit (M) - NE751 | 94.7% | 84.0% | - | - | 112.7% | - | - | - | 16.9% | 23.8% | 36 | ↓ | 2.43 | 11 | ↗ | 16.2 | 0 | 0 | Planned ward closure late in m onth reporting period due to COVID -19 pathway. Staff redeployed to support COVID areas. | 43,595 | 51,962 | (8,367) |
| TWH | Short Stay Surgical Unit (TW) - NE901 | 152.6% | 47.8% | - | - | 66.7% | 136.4% | - | - | 37.5% | 14.8% | 70 | ↓ | 4.10 | 5 | ↘ | 15.5 | 0 | 0 | Increased fill rate reflective of escalation during early part of march. Occupancy levels changed due to COVID pandemic during the month. | 162,043 | 80,904 | 81,139 |
| MAIDSTONE | Accident & Emergency (M) - NA351 | 100.5% | 82.3% | - | - | 113.1% | 94.8% | - | - | 35.6% | 30.0% | 342 | ↑ | 22.93 | 97 | ↑ | | 0 | 0 | MH - Increase in both temporary staffing demand and unfilled shifts due to COVID-19 | 193,850 | 247,713 | (53,863) |
| TWH | Accident & Emergency (TW) - NA301 | 87.8% | 81.6% | - | 100.0% | 92.1% | 90.5% | - | - | 41.3% | 40.0% | 453 | ↑ | 31.39 | 68 | ↑ | | 1 | 0 | TWH- Reduced fill rate due to staff sickness alongside an increase in temporary demand and an increase of 68 unfilled shifts. | 347,656 | 449,703 | (102,047) |
| MAIDSTONE | Maidstone Orthopaedic Unit (M) - NP951 | 72.4% | 75.0% | - | - | 72.5% | - | - | - | 31.3% | 19.2% | 45 | ↓ | 3.07 | 1 | ↘ | 19.4 | 1 | 0 | 1 fall above threshold. Planned ward closure during mid March and staff redeployed due to COVID-19 | 43,805 | 53,092 | (9,287) |
| MAIDSTONE | Peale COVID - ND451 | 76.5% | 38.7% | - | - | 66.7% | 100.0% | - | - | 45.2% | 59.7% | 45 | ↓ | 3.31 | 19 | ↑ | 2.2 | 1 | 0 | Ward speciality changed during the month to support COVID positive patient pathway during pandemic | 0 | 20,724 | (20,724) |
| | | | | | | | | | | | | | | | | | | | | Total Established Wards | 5,252,990 | 5,644,135 | (391,145) |
| | | | | | | | | | | | | | | | | | | | | Additional Capacity beds Cath Labs | 40,411 | 38,972 | 1,439 |
| | | | | | | | | | | | | | | | | | | | | Whatman | 0 | 0 | 0 |
| | | | | | | | | | | | | | | | | | | | | | -6,836 | 1,351 | (8,187) |
| | | | | | | | | | | | | | | | | | | | | | -7,739 | 0 | (7,739) |
| | | | | | | | | | | | | | | | | | | | | | 7,050,940 | 7,027,188 | 23,752 |
| | | | | | | | | | | | | | | | | | | | | | 12,329,766 | 12,711,646 | (381,880) |

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 120%

RAG Key

↓ Reduction of greater than 5

↑ Increase of greater than 5

↗→ Remains equal to Or less than a difference of 5

| Only complete sites your organisation is accountable for | | | Day | | | | | | | | Night | | | | | | | | Day | | | | Night | | | | Care Hours Per Patient Day (CHPPD) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward name | Main 2 Specialties on each ward | | Registered Nurses/Midwives | | Non-registered Nurses/Midwives (Care Staff) | | Registered Nursing Associates | | Non-registered Nursing Associates | | Registered Nurses/Midwives | | Non-registered Nurses/Midwives (Care Staff) | | Registered Nursing Associates | | Non-registered Nursing Associates | | Average fill rate - registered nurses/ midwives (%) | Average fill rate - non-registered nurses/midwives staff (%) | Average fill rate - Registered nursing associates (%) | Average fill rate - trainee nursing associates (%) | Average fill rate - registered nurses/ midwives (%) | Average fill rate - care staff (%) | Average fill rate - nursing associates (%) | Average fill rate - trainee nursing associates (%) | Cumulative count over the month of patients at 23:59 each day | Registered midwives/ nurses | Care Staff | Overall |
| | Specialty 1 | Specialty 2 | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | | | | | | | | | | | | |
| Acute Stroke | 300 - GENERAL MEDICINE | 430 - GERIATRIC MEDICINE | 2,048 | 1,968 | 1,367 | 1,016 | 0 | 0 | 265 | 265 | 1,364 | 1,364 | 682 | 670 | 0 | 0 | 0 | 0 | 96.1% | 74.3% | No data | 100.0% | 100.0% | 98.2% | No data | No data | | | | |
| Cornwallis | 100 - GENERAL SURGERY | 101 - UROLOGY | 1,094 | 1,229 | 653 | 611 | 0 | 0 | 108 | 108 | 682 | 639 | 341 | 319 | 0 | 0 | 0 | 0 | 112.3% | 93.4% | No data | 100.0% | 93.6% | 93.5% | No data | No data | | | | |
| Culpepper (incl CCU) | 320 - CARDIOLOGY | 300 - GENERAL MEDICINE | 1,764 | 1,491 | 1,116 | 1,008 | 0 | 0 | 0 | 0 | 1,364 | 1,266 | 330 | 308 | 0 | 0 | 0 | 0 | 84.5% | 90.3% | No data | No data | 92.8% | 93.3% | No data | No data | | | | |
| John Day | 340 - RESPIRATORY MEDICINE | 300 - GENERAL MEDICINE | 1,959 | 2,224 | 1,518 | 1,254 | 0 | 0 | 0 | 0 | 1,683 | 1,825 | 671 | 616 | 0 | 0 | 0 | 0 | 113.5% | 82.6% | No data | No data | 108.4% | 91.8% | No data | No data | | | | |
| Intensive Treatment Unit (ITU) | 192 - CRITICAL CARE MEDICINE | | 2,915 | 2,799 | 253 | 251 | 0 | 0 | 0 | 0 | 2,507 | 2,243 | 345 | 0 | 0 | 0 | 0 | 0 | 96.0% | 99.0% | No data | No data | 89.5% | 0.0% | No data | No data | | | | |
| Pye Oliver | 301 - GASTROENTEROLOGY | 300 - GENERAL MEDICINE | 1,699 | 1,487 | 1,506 | 1,509 | 0 | 0 | 0 | 0 | 1,023 | 1,034 | 1,023 | 1,034 | 0 | 0 | 0 | 0 | 87.5% | 100.2% | No data | No data | 101.1% | 101.1% | No data | No data | | | | |
| Chaucer | 430 - GERIATRIC MEDICINE | 300 - GENERAL MEDICINE | 2,014 | 2,618 | 1,877 | 1,690 | 0 | 0 | 0 | 0 | 1,353 | 1,749 | 1,353 | 1,254 | 0 | 0 | 0 | 0 | 130.0% | 90.0% | No data | No data | 129.3% | 92.7% | No data | No data | | | | |
| Lord North | 370 - MEDICAL ONCOLOGY | 800 - CLINICAL ONCOLOGY | 1,766 | 1,865 | 524 | 714 | 0 | 0 | 113 | 113 | 1,116 | 1,092 | 372 | 348 | 0 | 0 | 0 | 0 | 105.6% | 136.4% | No data | 100.0% | 97.8% | 93.5% | No data | No data | | | | |
| Mercer | 430 - GERIATRIC MEDICINE | 300 - GENERAL MEDICINE | 1,637 | 1,738 | 1,459 | 1,396 | 0 | 0 | 75 | 75 | 1,023 | 1,001 | 682 | 744 | 0 | 0 | 0 | 0 | 106.2% | 95.7% | No data | 100.0% | 97.8% | 109.0% | No data | No data | | | | |
| Edith Cavel | 300 - GENERAL MEDICINE | | 1,311 | 1,484 | 1,002 | 1,020 | 0 | 0 | 120 | 120 | 1,012 | 957 | 242 | 407 | 0 | 0 | 0 | 0 | 113.2% | 101.8% | No data | 100.0% | 94.5% | 168.2% | No data | No data | | | | |
| Urgent Medical Ambulatory Unit (UMAU) | 180 - ACCIDENT & EMERGENCY | 300 - GENERAL MEDICINE | 2,565 | 2,365 | 1,496 | 1,270 | 0 | 0 | 0 | 0 | 1,023 | 1,263 | 352 | 555 | 0 | 0 | 0 | 0 | 92.2% | 84.9% | No data | No data | 123.4% | 157.5% | No data | No data | | | | |
| Ward 22 | 300 - GENERAL MEDICINE | 430 - GERIATRIC MEDICINE | 1,648 | 2,148 | 1,512 | 1,531 | 0 | 0 | 80 | 80 | 1,023 | 1,169 | 1,364 | 1,229 | 0 | 0 | 0 | 0 | 130.4% | 101.2% | No data | 100.0% | 114.3% | 90.1% | No data | No data | | | | |
| Cornary Care Unit (CCU) | 320 - CARDIOLOGY | 300 - GENERAL MEDICINE | 1,202 | 1,404 | 372 | 306 | 0 | 0 | 0 | 0 | 1,023 | 986 | 0 | 0 | 0 | 0 | 0 | 0 | 116.7% | 82.1% | No data | No data | 96.4% | No data | No data | No data | | | | |
| Gynaecology/Ward 33 | 502 - GYNAECOLOGY | 100 - GENERAL SURGERY | 1,522 | 1,408 | 711 | 632 | 0 | 0 | 0 | 0 | 1,023 | 1,001 | 341 | 330 | 0 | 0 | 0 | 0 | 92.5% | 88.8% | No data | No data | 97.8% | 96.8% | No data | No data | | | | |
| Intensive Treatment Unit (ITU) | 192 - CRITICAL CARE MEDICINE | | 3,727 | 4,048 | 372 | 446 | 0 | 0 | 0 | 0 | 3,058 | 2,901 | 339 | 317 | 0 | 0 | 0 | 0 | 108.6% | 119.8% | No data | No data | 94.9% | 93.5% | No data | No data | | | | |
| Medical Assesment Unit | 180 - ACCIDENT & EMERGENCY | 300 - GENERAL MEDICINE | 3,326 | 2,921 | 1,473 | 1,074 | 0 | 0 | 89 | 89 | 2,128 | 1,972 | 1,058 | 1,047 | 0 | 0 | 12 | 12 | 87.8% | 72.9% | No data | 100.0% | 92.7% | 98.9% | No data | 100.0% | | | | |
| SAU | 180 - ACCIDENT & EMERGENCY | 100 - GENERAL SURGERY | 1,115 | 1,152 | 372 | 374 | 0 | 0 | 0 | 0 | 682 | 693 | 341 | 341 | 0 | 0 | 0 | 0 | 103.4% | 100.5% | No data | No data | 101.6% | 100.0% | No data | No data | | | | |
| Ward 32 | 300 - GENERAL MEDICINE | | 2,129 | 1,654 | 1,532 | 1,038 | 0 | 0 | 0 | 0 | 1,023 | 1,045 | 1,023 | 671 | 0 | 0 | 0 | 0 | 77.7% | 67.8% | No data | No data | 102.2% | 65.6% | No data | No data | | | | |
| Ward 10 | 100 - GENERAL SURGERY | | 2,273 | 2,507 | 1,298 | 1,144 | 0 | 0 | 71 | 71 | 1,364 | 1,625 | 660 | 803 | 0 | 0 | 22 | 22 | 110.3% | 88.1% | No data | 100.0% | 119.1% | 121.7% | No data | 100.0% | | | | |
| Ward 11 (TW) Winter Escalation 2019 - NG144 | 100 - GENERAL SURGERY | | 1,476 | 1,450 | 1,485 | 1,077 | 0 | 0 | 0 | 0 | 1,023 | 1,078 | 1,364 | 1,243 | 0 | 0 | 0 | 0 | 98.2% | 72.5% | No data | No data | 105.4% | 91.1% | No data | No data | | | | |
| Ward 11 (TW) - NG131 | 100 - GENERAL SURGERY | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | No data | No data | No data | No data | No data | No data | No data | No data | | | | |
| Ward 12 | 320 - CARDIOLOGY | 301 - GASTROENTEROLOGY | 2,053 | 2,228 | 1,522 | 1,310 | 0 | 0 | 62 | 62 | 1,023 | 1,133 | 1,364 | 1,264 | 0 | 0 | 0 | 0 | 108.5% | 86.0% | No data | 100.0% | 110.8% | 92.6% | No data | No data | | | | |
| Ward 20 | 430 - GERIATRIC MEDICINE | 300 - GENERAL MEDICINE | 909 | 1,160 | 1,281 | 996 | 0 | 0 | 0 | 0 | 1,012 | 1,144 | 1,364 | 1,298 | 0 | 0 | 0 | 0 | 127.6% | 77.8% | No data | No data | 113.0% | 95.2% | No data | No data | | | | |
| Foster Winter Escalation 2019 (M) - NR359 | | | 1,650 | 1,147 | 1,543 | 695 | 0 | 0 | 7 | 7 | 682 | 880 | 1,023 | 586 | 0 | 0 | 0 | 0 | 69.5% | 45.0% | No data | 100.0% | 129.0% | 57.3% | No data | No data | | | | |
| Ward 21 | 340 - RESPIRATORY MEDICINE | 302 - ENDOCRINOLOGY | 2,277 | 2,160 | 969 | 807 | 0 | 0 | 180 | 180 | 1,705 | 1,650 | 682 | 693 | 0 | 0 | 0 | 0 | 94.9% | 83.3% | No data | 100.0% | 96.8% | 101.6% | No data | No data | | | | |
| Ward 2 | 430 - GERIATRIC MEDICINE | 300 - GENERAL MEDICINE | 1,982 | 2,327 | 1,699 | 1,457 | 0 | 0 | 93 | 93 | 990 | 1,003 | 1,023 | 1,078 | 0 | 0 | 0 | 0 | 117.4% | 85.8% | No data | 100.0% | 101.3% | 105.4% | No data | No data | | | | |
| Ward 30 | 110 - TRAUMA & ORTHOPAEDICS | | 1,933 | 2,523 | 1,472 | 1,434 | 0 | 0 | 0 | 0 | 990 | 1,023 | 1,254 | 1,210 | 0 | 0 | 0 | 0 | 130.5% | 97.4% | No data | No data | 103.3% | 96.5% | No data | No data | | | | |
| Ward 31 | 110 - TRAUMA & ORTHOPAEDICS | | 2,023 | 2,067 | 1,592 | 1,493 | 0 | 0 | 156 | 156 | 1,364 | 1,343 | 1,023 | 968 | 0 | 0 | 0 | 0 | 102.1% | 93.8% | No data | 100.0% | 98.5% | 94.6% | No data | No data | | | | |
| Birth Centre (Crowborough). | 501 - OBSTETRICS | | 1,276 | 867 | 402 | 533 | 0 | 0 | 0 | 0 | 733 | 724 | 357 | 345 | 0 | 0 | 0 | 0 | 68.0% | 132.8% | No data | No data | 98.8% | 96.8% | No data | No data | | | | |
| Midwifery Services (ante/post natal & Delivery Suite) | 501 - OBSTETRICS | | 23,429 | 20,185 | 8,463 | 3,902 | 0 | 0 | 0 | 0 | 5,332 | 5,026 | 3,655 | 1,809 | 0 | 0 | 0 | 0 | 86.2% | 46.1% | No data | No data | 94.3% | 49.5% | No data | No data | | | | |
| Hedgehog | 420 - PAEDIATRICS | | 2,645 | 2,672 | 390 | 196 | 0 | 0 | 0 | 0 | 2,139 | 2,038 | 0 | 201 | 0 | 0 | 0 | 0 | 101.0% | 50.1% | No data | No data | 95.3% | No data | No data | No data | | | | |
| Birth Centre | 501 - OBSTETRICS | | 842 | 865 | 0 | 36 | 0 | 0 | 0 | 0 | 679 | 669 | 333 | 301 | 0 | 0 | 0 | 0 | 102.6% | No data | No data | No data | 98.6% | 90.3% | No data | No data | | | | |
| Neonatal Unit | 420 - PAEDIATRICS | | 4,144 | 3,006 | 165 | 699 | 0 | 0 | 0 | 0 | 2,378 | 2,202 | 0 | 297 | 0 | 0 | 0 | 0 | 72.5% | 423.6% | No data | No data | 92.6% | No data | No data | No data | | | | |
| MSSU | 100 - GENERAL SURGERY | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | No data | No data | No data | No data | No data | No data | No data | No data | | | | |
| Peale | 100 - GENERAL SURGERY | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | No data | No data | No data | No data | No data | No data | No data | No data | | | | |
| SSSU | 100 - GENERAL SURGERY | | 1,367 | 2,155 | 540 | 258 | 0 | 0 | 0 | 0 | 495 | 330 | 242 | 330 | 0 | 0 | 0 | 0 | 157.6% | 47.8% | No data | No data | 66.7% | 136.4% | No data | No data | | | | |
| Whatman | 300 - GENERAL MEDICINE | | 2,087 | 1,888 | 1,440 | 1,148 | 0 | 0 | 80 | 80 | 682 | 1,034 | 341 | 506 | 0 | 0 | 0 | 0 | 90.5% | 79.7% | No data | 100.0% | 151.6% | 148.4% | No data | No data | | | | |
| MOU | | | 963 | 697 | 780 | 585 | 0 | 0 | 0 | 0 | 682 | 495 | 0 | 88 | 0 | 0 | 0 | 0 | 72.4% | 75.0% | No data | No data | 72.5% | No data | No data | No data | | | | |

## Year-end review of the Board Assurance Framework (BAF), 2019/20 — Trust Secretary

**The management of the Board Assurance Framework (BAF) and link with the Risk Register**

The BAF is the document through which the Trust Board identifies the main risks to the Trust meeting its objectives, and to ensure adequate controls are in place to manage those risks. The BAF model applied at the Trust is based on the most accepted model of best practice[1]. The ultimate aim of the BAF is to help ensure that the objectives are met. The BAF is managed by the Trust Secretary, who liaises with the persons responsible for empowering our staff to update it through the year. The BAF differs from the Risk Register as the BAF only includes risks that pose a threat to the achievement of the Trust's objectives (and the risks listed on the BAF are not required to be subject to a detailed risk assessment/risk-rating). There are therefore some red-rated risks on the Risk Register that are not referenced in the BAF. These are however managed via the Risk Register. However, the selection of objectives took into account the risks faced by the Trust.

**Key objectives for 2019/20, and year-end position**

The objectives in the BAF were approved by the Trust Board on 23/05/19. This report describes the year-end status for each objective, in terms of whether they were "Fully achieved", "Partially achieved" or "Not achieved"[2]. The ratings were all agreed by the Executive Team Meeting on 21/04/20. A summary is shown below.

| Objective (measure of success) | Achieved?[2] |
|---|---|
| 1. Reduce our falls rate while in hospital to 6 per 1'000 bed days | Not achieved |
| 2. Reduce E. coli blood stream infections to 21.5 per 100'000 bed days by March 2020 | Not achieved |
| 3. Improve complaints performance to 75% across all divisions and directorates by March 2020 | Fully achieved |
| 4. Improve our vacancy rate to 9% by March 2020 | Fully achieved |
| 5. Achieve staff engagement score of ≥ 7.2 within 2019/20 | Not achieved |
| 6. Implement the planned surgical reconfiguration by the end of 2019/20 | No rating applied[3] |
| 7. Build new AMU to enable a new Hyper Acute Stroke Unit (HASU) by winter 2019 | Fully achieved |
| 8. Ensure that 85% or more of cancer patients are treated within 62 days | Fully achieved |
| 9. Ensure that 86.7% or more of patients wait no longer than 18 weeks from referral to treatment | Fully achieved |
| 10. Ensure that 91.67% or more of people presenting to our Accident and Emergency Departments wait no longer than 4 hours | Fully achieved |
| 11. Deliver a surplus of £6.9m in 2019/20 so that we can invest back into patient care | Fully achieved |
| 12. Ensure that our Hospital Standardised Mortality Ratio (HSMR) is <100 | Fully achieved |

The content of the year-end review will feature in the Trust's Annual Report for 2019/20 (albeit in a different format). The Trust Board is therefore asked to review the content of the report and either confirm the year-end ratings as valid or agree an alternative rating for each objective.

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

- The Executive Team Meeting, 21/04/20

**Reason for receipt at the Board (decision, discussion, information, assurance etc.) [4]**

To review the content of the report and either confirm the year-end ratings as valid or agree an alternative rating for each objective..

[1] HM Treasury: Assurance frameworks

[2] "Fully achieved" and "Not achieved" ratings are relevant when there is absolute clarity as to whether (or not) an objective has been achieved, and usually relate to the objectives with the most 'SMART' qualities. A "Partially achieved" rating may be applicable when an element of subjectivity is involved, or a more nuanced assessment of performance is required

[3] It was agreed at the Executive Team Meeting on 21/04/20 that objective 6 should not be allocated a year-end rating, as the Trust had made a deliberate decision to stop the reconfiguration because of the COVID-19 period.

[4] 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

**Objective**

1 Reduce our falls rate while in hospital to 6 per 1,000 bed days

**Person responsible for empowering our staff:** Chief Nurse

**Trust Board sub-committee responsible for oversight:** Quality Committee

**Throughout the year, how confident was the person responsible for empowering our staff that the objective would be achieved by the end of 2019/10?**[5]

June 2019 | August 2019 | January 2020 | February 2020 | March 2020

**Year-end position: Was the objective achieved by the end of 2019/20?**

☐ Fully achieved ☐ Partially achieved ☒ Not achieved

**Explanation of year-end rating / detailed status of year-end position:**

The falls rate for the year was 6.09 per 1,000 bed days

**Objective**

2 Reduce E. coli bloodstream infections to 21.5 per 100,000 bed days by March 2020

**Person responsible for empowering our staff:** Director of Infection Prevention and Control (DIPC)

**Trust Board sub-committee responsible for oversight:** Quality Committee

**Throughout the year, how confident was the person responsible for empowering our staff that the objective would be achieved by the end of 2019/10?**

June 2019 | August 2019 | January 2020 | February 2020 | March 2020

**Year-end position: Was the objective achieved by the end of 2019/20?**

☐ Fully achieved ☐ Partially achieved ☒ Not achieved

**Explanation of year-end rating / detailed status of year-end position:**

The full year rate was 30.9 per 100,000 bed days (the actual number of cases was 75, which compared to 69 in 2018/19).

**Objective**

3 Improve complaints performance to 75% across all divisions and directorates by March 2020

**Person responsible for empowering our staff:** Chief Nurse

**Trust Board sub-committee responsible for oversight:** Quality Committee

**Throughout the year, how confident was the person responsible for empowering our staff that the objective would be achieved by the end of 2019/10?**

June 2019 | August 2019 | January 2020 | February 2020 | March 2020

**Year-end position: Was the objective achieved by the end of 2019/20?**

☒ Fully achieved ☐ Partially achieved ☐ Not achieved

**Explanation of year-end rating / detailed status of year-end position:**

Although overall performance across the year was 67.8%, 75% was achieved for March 2020.

**Objective**

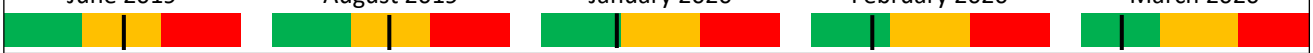
4 Improve our vacancy rate to 9% by March 2020

**Person responsible for empowering our staff:** Director of Workforce

**Trust Board sub-committee responsible for oversight:** Workforce Committee

**Throughout the year, how confident was the person responsible for empowering our staff that the objective would be achieved by the end of 2019/10?**

June 2019 | August 2019 | January 2020 | February 2020 | March 2020



**Year-end position: Was the objective achieved by the end of 2019/20?**

☒ Fully achieved ☐ Partially achieved ☐ Not achieved

**Explanation of year-end rating / detailed status of year-end position:**

The vacancy rate at the end of March 2020 was 8.11%.

[5] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

**Objective**

5 Achieve staff engagement score of ≥ 7.2 within 2019/20

**Person responsible for empowering our staff:** Director of Workforce

**Trust Board sub-committee responsible for oversight:** Quality Committee

**Throughout the year, how confident was the person responsible for empowering our staff that the objective would be achieved by the end of 2019/10?**[6]

June 2019 | August 2019 | January 2020 | February 2020 | March 2020

**Year-end position: Was the objective achieved by the end of 2019/20?**

☐ Fully achieved ☐ Partially achieved ☒ Not achieved

**Explanation of year-end rating / detailed status of year-end position:**

The staff engagement score in the 2019 national NHS staff survey (which was published in February 2019) was 7.1. This was a statistically significant improvement on the score from the 2018 survey (7.0), but is still below the score in the objective.

**Objective**

6 Implement the planned surgical reconfiguration by the end of 2019/20[7]

**Person responsible for empowering our staff:** Director of Strategy, Planning and Partnerships

**Trust Board sub-committee responsible for oversight:** Finance and Performance Committee

**Throughout the year, how confident was the person responsible for empowering our staff that the objective would be achieved by the end of 2019/10?**

June 2019 | August 2019 | January 2020 | February 2020 | March 2020

**Year-end position: Was the objective achieved by the end of 2019/20?**

No rating has been applied

**Explanation of year-end rating / detailed status of year-end position:**

It was agreed at the Executive Team Meeting on 21/04/20 that the objective should not be allocated a year-end rating, as the Trust had made a deliberate decision in March 2020 to stop the reconfiguration because of the COVID-19 period (although progress with the reconfiguration was in accordance with the objective until that point).

**Objective**

7 Build new AMU to enable a new Hyper Acute Stroke Unit (HASU) by winter 2019

**Person responsible for empowering our staff:** Chief Operating Officer

**Trust Board sub-committee responsible for oversight:** Finance and Performance Committee

**Throughout the year, how confident was the person responsible for empowering our staff that the objective would be achieved by the end of 2019/10?**

June 2019 | August 2019 | January 2020 | February 2020 | March 2020

**Year-end position: Was the objective achieved by the end of 2019/20?**

☒ Fully achieved ☐ Partially achieved ☐ Not achieved

**Explanation of year-end rating / detailed status of year-end position:**

The Acute Medical Unit (AMU) at Maidstone Hospital relocated to the new Acute Assessment Unit (AAU) (which is located next to the hospital's Emergency Department) on 11/03/20.

[6] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

[7] On 27/02/20, the Trust Board approved a request to amend the title of the objective from "Establish functioning Digestive Diseases Unit by October 2019"

**Objective**

8 Ensure that 85% or more of cancer patients are treated within 62 days

**Person responsible for empowering our staff:** Chief Operating Officer

**Trust Board sub-committee responsible for oversight:** Finance and Performance Committee

**Throughout the year, how confident was the person responsible for empowering our staff that the objective would be achieved by the end of 2019/10?**[8]

June 2019 | August 2019 | January 2020 | February 2020 | March 2020

**Year-end position: Was the objective achieved by the end of 2019/20?**

☒ Fully achieved ☐ Partially achieved ☐ Not achieved

**Explanation of year-end rating / detailed status of year-end position:**

The full year position to the end of February 2020 is 79.9%, but the Trust has achieved the 85% target every month for the past several months, and the Chief Operating Officer confirmed to the Executive Team Meeting on 21/04/20 that he expected the target to be achieved again for March 2020.

**Objective**

9 Ensure that 86.7% or more of patients wait no longer than 18 weeks from referral to treatment

**Person responsible for empowering our staff:** Chief Operating Officer

**Trust Board sub-committee responsible for oversight:** Finance and Performance Committee

**Throughout the year, how confident was the person responsible for empowering our staff that the objective would be achieved by the end of 2019/10?**

June 2019 | August 2019 | January 2020 | February 2020 | March 2020

**Year-end position: Was the objective achieved by the end of 2019/20?**

☒ Fully achieved ☐ Partially achieved ☐ Not achieved

**Explanation of year-end rating / detailed status of year-end position:**

At the end of February 2020 the Trust's performance was at 87.3%, and the Executive Team Meeting on 21/04/20 agreed that it was not appropriate to take account of the performance for March 2020, as that had been significantly affected by the Trust's management of the COVID-19 period.

**Objective**

10 Ensure that 91.67% or more of people presenting to our Accident and Emergency Departments wait no longer than 4 hours

**Person responsible for empowering our staff:** Chief Operating Officer

**Trust Board sub-committee responsible for oversight:** Quality Committee / Finance and Performance Committee

**Throughout the year, how confident was the person responsible for empowering our staff that the objective would be achieved by the end of 2019/10?**

June 2019 | August 2019 | January 2020 | February 2020 | March 2020

**Year-end position: Was the objective achieved by the end of 2019/20?**

☒ Fully achieved ☐ Partially achieved ☐ Not achieved

**Explanation of year-end rating / detailed status of year-end position:**

Performance for 2019/20 was 90.64%, but performance for March 2020 was 93.12%.

[8] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

**Objective**

11 Deliver a surplus of £6.9m in 2019/20 so that we can invest back into patient care

**Person responsible for empowering our staff:** Chief Finance Officer

**Trust Board sub-committee responsible for oversight:** Finance and Performance Committee

**Throughout the year, how confident was the person responsible for empowering our staff that the objective would be achieved by the end of 2019/10?**[9]

June 2019 | August 2019 | January 2020 | February 2020 | March 2020

**Year-end position: Was the objective achieved by the end of 2019/20?**

☒ Fully achieved ☐ Partially achieved ☐ Not achieved

**Explanation of year-end rating / detailed status of year-end position:**

The surplus at the end of 2019/20 (subject to external audit) was £7.0m.

**Objective**

12 Ensure that our Hospital Standardised Mortality Ratio (HSMR) is <100

**Person responsible for empowering our staff:** Medical Director

**Trust Board sub-committee responsible for oversight:** Quality Committee

**Throughout the year, how confident was the person responsible for empowering our staff that the objective would be achieved by the end of 2019/10?**

June 2019 | August 2019 | January 2020 | February 2020 | March 2020

**Year-end position: Was the objective achieved by the end of 2019/20?**

☒ Fully achieved ☐ Partially achieved ☐ Not achieved

**Explanation of year-end rating / detailed status of year-end position:**

The HSMR for March 2020 was 91.8, and the ratio has been below 100 throughout 2019/20.

[9] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

| **Update on the 2020/21 Operating Plan** | **Chief Finance Officer / Director of Strategy, Planning and Partnerships** |
|---|---|

The enclosed report provides an update on the 2020/21 Operating Plan including:

- Financial Control process during this period
- Budget Setting for months 1 to 4
- Capture and Reporting of COVID-19 cost
- Cash Management
- Capital Management

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

- Finance and Performance Committee 28/04/20

**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

## 1. Introduction

The business planning process was paused in March 2020, a new contractual process has been put in place for April to July 2020 and budgets should be set to reflect this process. This paper outlines the steps to be taken in the next few months.

## 2. Financial Control process during this period

The Trust needs to maintain good financial governance and control during this period. Existing controls remain but additional expenditure related to COVID-19 should also be approved by the Incident Command Centre (ICC). There are principles agreed with the ICC and revenue expenditure is then approved by the Deputy Director of Finance – Performance. Capital expenditure is agreed by Chief Finance Officer. The principles are attached in appendix 1.

## 3. Capture and Reporting of COVID-19

3.1. The Finance Team have set up a dedicated cost centre for additional revenue expenditure such as additional orders for kit and PPE and escalation wards. Other expenditure will be coded to existing cost centres, for example additional shifts to cover sickness, extended working hours and days. Budget holders are responsible for identifying additional COVID-19 costs and reporting these additional costs to their Divisional Finance Manager who will coordinate with John Coffey, Senior Finance Manager to insure this is captured on the national return for COVID-19 revenue costs. .

### 3.2. 19/20 Reporting

3.3. The Trust submitted a revenue return on Thursday 9th April, this was for expenditure up to 31st March. The return includes specific categories, not all of which are applicable to the Trust. The return showed the additional expenditure was £1.8m and in additional there is an income loss estimated at £0.3m. It was confirmed on 17th April that the Trust will receive income for all additional costs and revenue losses submitted. This indicates the costs met the reasonable definition and gives some assurance for planning in 2020/21. All costs and income are included in the 19/20 financial position. A summary of the return is in appendix 2

3.4. The Trust submitted a capital return on Wednesday 8th April for expenditure up to 31st March over and above the £50k funded in March for the initial COVID-19 pods. The additional expenditure was £412k principally relating to the first tranche of additional anaesthetic ventilation machines and IT equipment for home working and cyber security. This expenditure is not yet confirmed as funded, but the Trust has followed the guidance and itemised this spend separately on its year end accounts – if it is funded then the Trust will receive additional cash PDC in 2020/21. The Trust has covered the costs from within its existing Capital Resource Limit for 2019/20. A summary of the return is included in appendix 3.

### 3.5. 2020/21 Reporting

3.6. The reporting process continues for 2020/21 expenditure and income, and monthly (or more frequent) returns are expected. This will be known as a retrospective top up. If the expenditure incurred to support COVID-19 isn't fully funded by the retrospective top up then the Executive Team will consider how this cost pressure is managed.

3.7. Budget Holders and Finance will need to continue to analyse the financial position to identify unexpected variations which may indicate additional COVID-19 costs that have not been captured effectively.

3.8. The reporting process for 2020/21 Capital spend now includes the requirement to gain prior approval for any spend of £250k or over from the national team. The Trust reported committed and forecast spending of £2.8m in its early April return. If this capital is not fully funded in 2020/21 the Executive Team will need to consider how this spend is managed in the context of the Trust's internally generated capital resource.

## 4. Financial Planning for 2020/21 months 1 to 4

4.1. In light of the current situation alternative contracting and finance arrangements have been put in place. NHS Trusts will be given a guaranteed minimum level of funding on the following basis;

4.1.1. All NHS Trusts and Foundation Trusts ('providers') will move to block contract payments 'on account' for an initial period of 1 April to 31 July 2020, with suspension of the usual PBR national tariff payment architecture and associated administrative/ transactional processes

4.1.2. A national top-up payment ('projected top-up') will be issued to providers to reflect the difference between the expected baseline net costs and block contract and other income, where modelling of the expected cost base is higher.

4.1.3. A national true-up ('retrospective true-up') will be provided to adjust provider positions for additional costs and/or loss of revenue where the block and top-up payments do not equal the actual costs of genuine and reasonable additional marginal costs due to COVID-19.

4.1.4. Providers should continue with provider to provider invoicing in line with normal billing arrangements to reflect services actually provided, but should proceed in the spirit of the interim financial framework, simplifying where possible and paying invoices promptly.

4.1.5. These funding streams should provide sufficient funds for providers to deliver a break-even position through the period and will provide the basis against which we will monitor financial performance.

4.2. The winter period of months 8 to 10 in 19/20 has been used as a baseline for costs and expenditure to reflect the likely escalated level providers will be working at.

4.3. The plan for the Trust based on this methodology is shown in table 1;

**Table 1**

| | Nationally calculated plan based on months 8 to 10 | | | |
|---|---|---|---|---|
| From revised plan | Apr-20 | May-20 | Jun-20 | Jul-20 |
| | £ 000 | £ 000 | £ 000 | £ 000 |
| Commissioner Block payments | 36,791 | 36,791 | 36,791 | 36,791 |
| Top up funding | 1,437 | 1,437 | 1,437 | 1,437 |
| Other patient income | 942 | 942 | 942 | 942 |
| Other income | 2,651 | 2,651 | 2,651 | 2,651 |
| Total Income | 41,820 | 41,820 | 41,820 | 41,820 |
| | | | | |
| Employee expenses | (24,783) | (24,783) | (24,783) | (24,783) |
| Operating expenses excluding employee expenses | (15,638) | (15,638) | (15,638) | (15,638) |
| Finance expense | (1,400) | (1,400) | (1,400) | (1,400) |
| | | | | |
| Planned Expenditure | (41,820) | (41,820) | (41,820) | (41,820) |
| | | | | |
| Deficit | 0 | 0 | 0 | 0 |

The Top Up payment of £1.4m is shown in table 2;

**Table 2**

| Top up funding calculation | | £ 000 |
|---|---|---|
| Underlying surplus based on months 8 to 10 I&E | | 1,406 |
| 2019/20 Non recurrent items | PSF | (1,062) |
| | Other items | (183) |
| Items to be funded through Top Up | PFI support Income | (668) |
| | MRET | (517) |
| 2020/21 Changes | Inflationary Uplift | (654) |
| | CNST Increase | (133) |
| | SLA Income change | 375 |
| **Total Top Up** | | **(1,436)** |

## 5. Budget Setting for Months 1 to 4

The proposal is to set the budget for months 1 to 4 on the following principles;

5.1. It is aligned to the existing business planning work that has taken place so that budget holders recognise their budget.

5.2. The Clinical income is set as per the new block arrangements

5.3. The Expenditure and non clinical income is aligned to the same principles as the revised contract;

- No growth or waiting list steady state expenditure or income
- IFRS 16 delayed until April 2021
- Delays to developments such as Organisational Development and the Ive Project
- Some Cancer recovery investment will be delayed
- Non Pay reduction on elective prosthesis and outsourcing
- CIP plan removed except Divisional ones that have already been implemented.

5.4. In addition we have made the following changes

- Revisions to baseline where significant movement between FOT and outturn 19/20. For example energy funded at outturn not at 20/21 forecast. More work will be done to understand the pressures on energy in particular the unit costs and usage as a result of the new AMU.
- Pay award – fund at 2.9% pay increase less 0.5% reduction in workforce plan.
- Contingency Reserves - Added a contingency reserve of £125k per month.

5.5. The budgets will only be uploaded for months 1 to 4. Budget setting for month 5 onwards will be developed as part of business planning recommencement. The reason for this is so budget holders are still aware that there needs to be a further process to reach a balanced plan for 20/21. There is still work to do on the underlying recurrent financial position, CIP delivery and service developments.

5.6. The budgets and expectations for budget management and reporting will be discussed in more detail with finance managers and divisions.

5.7. Monthly reporting to the Executive Team, Finance and Performance Committee and Trust Board will continue, however the format will be different for April to July under these revised arrangements.

## 6. Cash Management

6.1. The financial arrangements for the NHS have been amended to ensure that NHS providers have certainty regarding cash inflows over the next four months. To facilitate this Commissioners and NHSE/I central will make payments to NHS Providers as follows via Block Payments, Top Up Payments and additional COVID-19 payments.

6.2. The timetable for the new arrangements is as follows:

| Payment Date | From commissioners | From NHSE/I central |
|---|---|---|
| 1 April 2020 | • Block Payment for April 2020; or<br>• April 2020 NHS Provider invoice if already received | • On-account central Top Up Payment for April |
| 15 April 2020 | • Block Payment for May 2020; and<br>• where applicable, adjustment to April 2020 payment made to true up to Block Payment Amount;<br><br>i.e. at this date NHS Provider should have received cash to the equivalent of 2 months of Block Payment | • Central Top Up Payment for May; and<br>• any adjustment to the April on-account payment |
| 15 May 2020 | • Block Payment for June 2020 | • Central Top Up Payment for June; and<br>• final payment for additional Covid-19 costs for 19/20 |
| 1 June 2020 | | • Additional Covid-19 costs for April |
| 15 June 2020 | • Block Payment for July 2020 | • Central Top Up Payment for July |

6.3. The original cash plan submitted in early March had forecast contract activity income to be received in April of £59.6m. The Trust has actually received £75.9m under the temporary arrangements, giving the Trust an extra £16.3m. It is not yet clear how this advanced funding will unwind during the period after the end of July and interact with the resumption of normal contracting, or if the temporary arrangements will be extended. Therefore the Trust will need to be mindful that there is likely to be a reduced trajectory of cash receipts in the later part of the financial year.

6.4. The advance cash is helpful to ensure that the Trust is able to meet its obligations for the back ended 2019/20 capital programme with c£5m of invoices to settle early in the financial year, together with the additional 2020/21 revenue and capital COVID-19 expenditure prior to any funding received for this.

6.5. In addition Trusts have been directed to ensure that pharmacy invoices are settled as rapidly as possible to ensure national continuity of supply. The Trust is not restricting any suppliers and is paying all invoices when they are approved and fall due for payment.

6.6. The two interim working capital loans which are due to be repaid within 2020/21 (total £26.1m) will be replaced by Public Dividend Capital (PDC) issued to repay the outstanding balances. The effective date of this transaction will be 30th September 2020 when the Trust will receive the PDC to make the repayment. All loans will be frozen at 31st March 2020 and interest payments will cease from that date.

6.7. The financial regime means the Trust has sufficient cash for first four months of the year. The cash flow is updated daily to ensure that the Trust can meet all its commitments and will be reviewed in the light of further guidance in regard to the future contracting process.

## 7. Capital Management

7.1. The financial regime changes to respond to the COVID-19 pandemic included the suspension of planning. The Trust's submitted draft capital programme for 2020/21 (and its five year plan) was therefore not approved by NHSE/I. In addition the national guidance was that Trusts should not at present engage in developing services beyond what was necessary to respond to the COVID-19 requirements. Therefore the interim arrangements for capital over at least the next four months are:

- Existing commitments that cross the financial years continue e.g. RAP, enabling works for the Diagnostic Fund equipment

- COVID-19 related capital purchases – this is subject to an additional governance process agreed with the ICC that requires any proposals to be agreed by them as COVID-19 essential, and then approved by the Chief Finance Officer. If any spend is £250k or over, it will also require prior approval from the national COVID-19 team via the Regional NHSE/I teams, before any purchase order is placed. All Capital COVID-19 spend is reported on a monthly basis to NHSE/I for consideration for funding.

- Any other emergency capital requirements will need to be considered and approved through the existing process (business case/Executive approval including the Chief Finance Officer.

7.2. In addition revised capital regime guidance was issued for 2020/21 which is intended to enable local ICS/STP organisations to take the lead in prioritising capital financing across their patches working with the Provider organisations including external PDC funding for "emergency" requirements. The precise arrangements for how these arrangements will work locally remain to be confirmed.

7.3. The general framework of capital financing remains in place i.e. Trusts will need to contain spend within their capital resource limits, and this is subject to the level of internally generated resource actually incurred i.e. actual depreciation resource during the year.

## 8. Conclusion and updates

8.1. The Trust has controls in place to manage and monitor expenditure related to the COVID-19 response. The monthly spend will be shared with the Executive Team.

8.2. The contract arrangements in place should ensure the Trust have sufficient income to cover their expenditure if the mitigations suggested are achieved. An update will be provided to the Executive Team and Finance and Performance Committee including any updated guidance.

8.3. The Divisions will receive budgets for Month 1 to Month 4 and monthly reporting to the Executive Team, Finance and Performance Committee and Trust Board will continue.

**Appendix 1**
Financial Governance Approval

**COVID-19 Revenue Expenditure**

| Expense Type | Approval required by | Cost Centre to be charged | Controls in Place | Risks |
|---|---|---|---|---|
| **Pay** | | | | |
| Filling existing staff rosters Temporary staffing booked to cover empty slots on rota due to sickness or vacancies | Usual Budget Holder no additional approval required | Ward or Department Cost Centre | Health Roster | |
| Escalation of wards – the safe staffing levels of wards may change as wards are escalated to COVID-19 wards. | Staffing levels for wards should be agreed on a Trust level basis by Deputy Chief Nurse and appropriate Clinical Lead<br><br>Charlotte Wadey to confirm. | Ward Cost Centre | 1. The level of staffing should be the same on all similar wards, therefore when the next ward is escalated the clinical decision to escalate is the financial approval to increase staffing to the appropriate level.<br>2. This should be documented and the ward manager / temporary staffing team should be made aware of the changes. | |
| Overtime and on call New on calls rotas are being introduced, on call payment arrangements should be clear and consistent | ICC | Staff substantive cost centre | | |
| Staff required to work additional hours. | ICC | Staff Substantive cost centre | | |
| Recruitment of existing roles | Usual approval through TRAC | Staff Substantive cost centre | Usual recruitment continues | |
| Existing Agency Bookings are extended – | Temporary Staffing | | | This could delay substantive recruitment |
| **Non Pay** | | | | |
| PPE | Existing items – no additional approval required<br><br>New items - approval of suitability from Infection Control Team via ICC | COVID-19 Cost Centre | Usual Procurement procedures | This will have to be monitored as demand starts to decrease to avoid over stocking. |
| Other Non Pay | ICC | COVID-19 Cost | | |

| Expense Type | Approval required by | Cost Centre to be charged | Controls in Place | Risks |
|---|---|---|---|---|
| | | Centre | | |
| Estates Expenditure | ICC then sent to Director of Estates | | | |
| Staff Welfare<br>Additional Food and Drinks<br>Changing facilities<br>Rest facilities | ICC | | | |

Notes
All expenditure relating to additional costs should be charged where possible to the COVID -19 Cost Centre.
Where ICC approval is required this should be during a daily meeting where actions are taken.
Expenditure must be agreed by the ICC team not an individual. See flow chart . Divisions cannot order additional items without approval.
Any increases in expenditure not captured through this approval such as increases in staffing should be identified by Budget Holders. Budget Holders are responsible for informing John Coffey, Senior Finance Manager of additional spends. (john.coffey@nhs.net)
The process will be overseen by Hannah Ferris, Deputy Director of Finance

**COVID-19 Capital Expenditure**
All Capital COVID-19 purchases now need to be approved by

1) ICC
2) Chief Finance Officer (who is the delegated capital budget holder)
3) If £250k or over, prior approval has to be obtained from the national NHSE/I COVID-19 team before placing any orders – they promise a 48hr turnaround.

**Appendix 2**

COVID-19 19/20 expenditure

| **Total Revenue (£s):** | **1,855,226** |
|---|---|

| **Breakdown by Allowable Cost Type** | **£s** |
|---|---|
| 111 | 0 |
| Decontamination | 105,005 |
| Diagnostic Sampling (in Community) | 0 |
| Diagnostic Sampling (in Hospital) | 234,036 |
| Direct Provision of Isolation Pod | 2,000 |
| Field Hospital related | 0 |
| HCID centres: Backfill and additional staffing capacity as requested Specialised services | 0 |
| Hospital discharge programme (£1.3bn) | 0 |
| Hotel accommodation | 5,705 |
| Increase administrative capacity | 18,432 |
| Increase hospital assisted respiratory support capacity, particularly mechanical ventilation | 25,199 |
| OOH capacity increase | 0 |
| Other action (provide commentary) | 202,847 |
| Other action on instruction of national incident response team (provide commentary) | 0 |
| Plans to release bed capacity | 0 |
| PPE | 132,820 |
| Preparation for ITU capacity | 157,906 |
| Remote management of patients | 0 |
| Segregation of patient pathways | 418,859 |
| Sickness / isolation cover | 552,416 |
| Support stay at home model | 0 |
| Swabbing services | 0 |
| Transportation of patients | 0 |

Loss of Income and Annual Leave impact

**Summary: Loss of income**

| **Total (£s):** | **287,342** |
|---|---|

| **Breakdown by income type** | **Value of cost pressure** |
|---|---|
| Car parking income | 88,732 |
| Catering | 6,780 |
| Education and training | 0 |
| Non-NHS: overseas patients (non-reciprocal, chargeable to patient) | 0 |
| Non-NHS: private patients | 77,876 |
| Property rental (not lease income) | 0 |
| Research and development (both IFRS 15 and non-IFRS 15 income) | 0 |
| Staff accommodation rental | 0 |
| Other - please provide details | 55,664 |

| | **Value of COVID-19 cost pressure** |
|---|---|
| **Annual leave accrual Total (£s):** | **58,290** |

| | | | 19/20 | 20/21 | | | | TOTAL |
|---|---|---|---|---|---|---|---|---|
| Scheme description | Spend type - short Description | Short rationale | March £ | April £ | May £ | June £ | Sub Total 20/21 £ | 19/20 & 20/21 £ |
| Additional Anaesthetic/Ventilator machines | 44 Maquet Sevoflurane Vaporiser Anaesthetic machines including CPAP Non invasive ventilation. Procured through Tower 7 framework. | 44 machines to provide additional ventilated capacity for Covid 19 patients in line with Trust response to NHSE/I national modelling forecast regional requirements. 8 delivered 30/03/2020; 10 delivered 5/4/20; 19 due for delivery 27/4/20; 7 due 11/5/20 | 185,040 | 798,930 | 197,400 | | 996,330 | 1,181,370 |
| Video Laryngoscope systems | 4 Karl Storz laryngoscope systems | 4 additional machines for the safe intubation of Covid 19 patients in additional ICU capacity - delivered 31/03/20 | 50,653 | | | | 0 | 50,653 |
| Additional Laptops to support staff working from home | 100 additional staff Dell laptops | Additional devices to enable staff to work from home in self-isolation or to minimise infection risk - delivered by 31/03/20 | 93,240 | | | | 0 | 93,240 |
| Additional firewall security | Firewall Hardware from CAE technology | Additional IT "barrier" between Trust and external world to provide cyber resilience given the large increase in issuing additional VPNs to enable home working for staff in self-isolation or to minimse infection risk | 82,824 | | | | 0 | 82,824 |
| CPAP Ventilators | 40 Philips V60 CPAP ventilators | To provide the recently clinically recommended CPAP capacity for first line non invasive ventilation of Covid 19 patients. Existing Trust Optiflow machines are not suitable for Covid patients. 5 week lead time, so due 7/5/20. | | | 680,342 | | 680,342 | 680,342 |
| GE VSCAN Hand held ultrasound | GE hand held ultrasound | Handheld scanner enables on duty consultant to scan cardio patients at point of referral to assess if full scan is required. It reduces risk to staff by not having to visit query or positive patients; & reduces risk of spread in cardio-respiratory | | 5,904 | | | 5,904 | 5,904 |
| Additional Laptops to support staff working from home | 200 additional staff Dell laptops | Additional devices to enable staff to work from home in self-isolation or to minimise infection risk - delivery expected by 23/4/20 | | 186,480 | | | 186,480 | 186,480 |
| Additional Patient Monitoring devices | Intellivue MX750 Philips monitoring devices to use with the additional anaesthetic machines | 44 monitors necessary to fully support ICU level of obs on the anaesthetic machines. Delivery 30/04/20. | | | 400,078 | | 400,078 | 400,078 |
| Point of care blood gas analysers | 5 Werfen GEM Premier 5000 Point of Care blood gas analysers | 5 machines for dedicated Covid 19 patient testing on ICU escalation wards - ventilated and CPAP monitoring. Immediate testing, avoids footfalls in A&E and ICU with static blood gas analysers. 3 delivered 6/4/20 and 2 expected 14/4/20 | | 84,000 | | | 84,000 | 84,000 |
| Ultrasound machines | 2 GE Venue Ultrasound machines | 2 machines for lung and heart testing on Covid 19 patients in escalated ITU and cohorted wards. Delivered 7/04/20 | | 83,868 | | | 83,868 | 83,868 |
| Additional Defibrillators and Trolleys | 8 Philips Heartstart Defibrillators + Trolleys | To provide appropriate resuscitation capacity in Covid escalation areas (ITU escalation wards). Delivery anticipated at end of April. | | 132,449 | | | 132,449 | 132,449 |
| Clinical area touchscreens for use with PAS system | 37 Parity Touchscreens | Touchscreens are connected to our PAS ADT Whiteboard software to provide real time information on the status of the Covid 19 patients to assist teams in mgmt & monitoring patient treatment. Delivery of 6 screens 7/4/20 - remaining screens by end of May | | | | 143,615 | 143,615 | 143,615 |
| Installation of access controls and maglocks in clinical areas | Installation by Brook Security of access controls | Clinical areas at Maidstone Hospital installed with door entry access controls, and some maglocks, to resrtict entry for reducing infection risk with escalated Covid 19 patient areas; completed 7.4.20 | | 66,231 | | | 66,231 | 66,231 |
| IPADs plus infection control cases | 80 XMA IPADs | IPADs for Covid 19 patient communication with families given isolation protocol. Delivered 2.4.20 | | 38,626 | | | 38,626 | 38,626 |
| | | | **411,757** | 1,396,488 | 1,277,820 | 143,615 | **2,817,923** | **3,229,680** |

**Update on the establishment of the Hyper Acute Stroke Unit (HASU) at Maidstone Hospital** **Chief Operating Officer**

The paper aims to update the Board on the following areas related to the Maidstone and Tunbridge Wells (MTW) stroke service:

### 1. Judicial and Independent progress

The outcome of the Judicial Reviews was received on 21st February 2020. The judge handed down her ruling in favour of the JCCCG decision on the configuration of HASU/ASU developments in Kent and Medway on all grounds. On 30th March there were two requests to appeal against the decisions from the Judicial Reviews. It is anticipated there will be an outcome as to whether the appeals can go ahead by the end of April 2020. There is no news at the time of writing regarding the outcome of the Independent Review.

### 2. Estates Phasing, OBC timeline, Capital

The Judicial and Independent processes do not preclude the Trust from getting preparatory work (surveys and detailed plans) started for the estates work.

The phasing of the work for the development of the new HASU/ASU has been reviewed again by the estates team and there are two options for a go live date assuming work can commence in April 2020. The phasing shows that the new go live date would be the beginning of August 2021 if winter capacity could be used for the stroke decant. If this is not possible, or there is no other winter escalation plan or capacity available, the go live date would move to November 2021.

As part of the Trust's COVID 19 plan stroke rehabilitation has moved to KIMS independent hospital in Maidstone and consideration is being given to whether this could be a longer-term plan. If this were possible the relief of pressure on the MH beds may allow for site development to continue over the winter months and deliver the build at the earlier date.

However the OBC and FBC are yet to be fully completed by the STP although they are working to get this done as soon as possible. Having missed their April deadline there is no clear date for when the OCB and then FBC will be submitted and this may impact on the progression of the build.

Capital will not be released by NHSE until agreement of the OBC and FBC, however the STP have confirmed that money can be spent on preparatory work and will be reimbursed by the NHSE when capital is released. On this basis it seems sensible to progress with this work over the summer months and hope for completion of the process by the early autumn.

### 3. Recruitment

Staffing plans have been completed and the establishment for the new HASU/ASU confirmed. We do not yet have a network recruitment strategy. However there is a potential opportunity to recruit to a substantive stroke consultant which would be part of the future establishment and would also bolster the current service that will be continuing in its current guise longer than had originally been anticipated.

**Which Committees have reviewed the information prior to Board submission?**
Executive Directors Meeting

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

1. Note the current legal position
2. Note the OBC/FBC position
3. Note the potential impact on the delivery timeline
4. Confirm expenditure of the £280k capital on estates preparatory work (surveys and detailed plans)
5. Support exploring options for stroke rehabilitation to remain off site to support winter plan and possible continuation of the stroke build
6. Support the recruitment of a consultant outside of current establishment

[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

**Subject:** **The Maidstone and Tunbridge Wells Stroke Service Stroke Service**

**To:** **Trust Board Meeting**

**From:** **Sean Briggs, Chief Operating Officer, Maidstone and Tunbridge Wells NHS Trust**

**Date:** **30th April 2020**

**Purpose:** **To Update the Board on the Stroke HASU/ASU Programme.**
**To request support to completing the £280K estates preparation work**
**To request the Boards support to recruit a substantive stroke consultant**

## 1. Current Legal Position:

In the outcome of the Judicial Reviews announced in February 2020 the judge was emphatic in the decision to support all grounds in favour of the JCCCGs decisions regarding the HASU/ASU configuration in Kent and Medway.

On Monday 30th March 2020 two requests were made to the Supreme Court for permission to appeal against the ruling on the review of acute stroke services in Kent and Medway. In response to this the NHS has requested the appeal is denied on the basis the Judicial Review found in favour on all of the NHS eight grounds brought by the claimants. The system recognises that any delay to the work to implement a new hyper acute and acute model of care in Kent and Medway will lead to further death and disability. For this reason the claimants and the NHS have requested the case be dealt with as quickly as possible and the STP hope to hear the outcome by the end of April.

At the time of writing there is no confirmed outcome from the Independent Review by the Secretary of State for Health, with the current COVID crisis this may be delayed for a period of time as yet unknown.

## 2. OBC and FBC Progress and Decision Making Timeline:

Despite the actual and potential delays the STP are continuing with the finalisation of the Outline Business Case (OBC) and Full Business Case (FBC). The judgement in February allows the process to continue until any change to the decision making as a result of any appeal.

The draft OBC was submitted to NHSE and a subsequent meeting with NHSE in March 2020 outlined a number of updates and changes required. MTW have responded to all requests from the STP to date including, a staffing refresh between the current and HASU/ASU establishment, completion of OB forms (1-4) to confirm the capital requirement, confirmation and submission of 1:200 drawings. There is apparently another information set required by the STP which is being sent to providers and MTW will respond rapidly to these requests.

The STP aimed to submit the final OBC in April 2020 but this has not happened. The Network partners in Darenth Valley and East Kent are not able to provide the OBC information rapidly due to a number of reasons, the main one being the time pressure on

all staff from the COVID crisis. Also MTW still has more information to provide. Without the information from all three providers the OBC cannot be submitted.

Despite the challenges the STP is pushing to complete the OBC and FBC process as quickly as possible and will be submitting a proposed July/August 21 go live for DVH/MTW and July/August 22 go live for EKHUFT although they are clear these dates maybe not be delivered.

## 3. Potential Impact on Estates Programme of Work:

The February 2020 report to the Board assumed two different time lines for delivery of the completed HASU/ASU being either August 2021 (option 1), if the ward moves and construction could carry on over the winter period, or November 2021 (option 2) if one of the ward areas was required for winter escalation.

Table 1 below outlines the phasing of each stage for each option depending on whether a winter break is required and interrupts construction.

This all assumes that the COVID 19 pandemic does not impact on the Trust's ability to carry out the works schedule outlined. Currently all beds and resources are allocated to managing the activity associated with the pandemic. At this stage it is difficult to make a judgement as to how much of the work can go on and in what timescale, however work has started on considering scenarios that enable the effective management of winter pressures, an assumed ongoing challenge of COVID 19 and the continuation of a build programme to allow the HASU/ASU estates work to be completed. This is ongoing.

In the current situation the stroke service have moved the stroke rehabilitation beds (Chaucer) to KIMS independent sector hospital in Maidstone where 18 beds are being provided with MTW providing specialist therapy advice and medical cover by the MTW stroke consultants. Whilst this arrangement has been set up to support MTW in managing the current pandemic it maybe of note that continuation of this arrangement once the crisis has settled may be beneficial in terms of progressing the estates build.

**Table 1 Stroke HASU/ASU/Rehab – Estates Timeline Comparing Continued Construction of a Winter Break**

| Item | Phase | Start date Option 1 | End date Option 1 | Start date Option 2 | End date Option2 |
|---|---|---|---|---|---|
| 1 | Planning and design work<br>Detailed design work and quantum of costs<br>Design review and mobilisation | Apr2020 | Sept 2020 | Apr 2020 | Sept 2020 |
| 2 | Alteration and modification works to vacated AMU | Sept 2020 | Dec 2020 | Sept 2020 | Dec 2020 |
| 3 | Relocation to stroke service from ASU and Chaucer ward to modified AMU and Foster Clark | Dec 2020 | Dec 2020 | Apr 2021 | Apr 2021 |
| 4 | Alteration and modification works to existing ASU and Chaucer ward | Jan 2021 | July 2021 | Apr 2021 | Oct 2021 |
| 5 | Relocation of stroke services to newly developed area | July 2021 | Aug 2021 | Oct 2021 | Nov 2021 |

Concern has been voiced in the past regarding Medway Maritime NHS Trust's ability to continue to sustain a robust stroke service beyond the original implementation date of April 2020. In response to this the STP has been working with Medway and confirms that they recognise their responsibility in maintaining their local stroke service, have recently trained all junior doctors in the administration and management of thrombolysis and have recently replaced a thrombolysis nurse. The situation is still brittle and MTW have requested that the network develops plans to support a phased implementation of the new flows if required before the HASU/ASU's go live. At present, MTW have experienced no impact from Medway. The issue is an agenda item for the stroke programme board of which Medway is a part.

## 4. Capital Spend Position:

The capital requirement for MTW has been confirmed in the OBC process as £6.25m, as agreed with the Executive Directors in February 2020. The breakdown of the costs is detailed in the table 2 below.

In terms of expenditure, until the final OBC and the subsequent FBC are signed off by NHS there is a limit on what capital can be spent. The STP have confirmed that planning and survey expenditure can go ahead prior to the completion and agreement of the OBC and FBC, and that NHSE will reimburse Trusts with this capital once the process is complete. This means for MTW the maximum that can be spent in the near future is £280,000 as detailed in item 1 in table 1 above. Any capital expenditure over and above this amount will constitute a risk as NHSE may not reimburse any spend on building work.

There is the potential the programme of work is further delayed if a) there is excessive time taken to agree the OBC and FBC by NHSE and b) the impact of the COVID 19 pandemic on services and the time taken for the organisation to recover capacity and return to business as usual is compromised longer than anticipated.

The STP is pushing for NHSE decision making as quickly as possible. At this time it is difficult to assess the impact of the COVID 19 situation but as the start dates outlined in table 1 have passed it is clear there will be an impact. In the meantime it seems sensible for MTW to spend the £280k on enabling and survey work in preparation for the build. The proposal is this takes place over the summer months.

**Table 2 - Capital Cost Allocation**

| Item | Phase | Start date | End date | Capital Costs £ |
|---|---|---|---|---|
| 1 | Planning and design work<br>Detailed design work and quantum of costs<br>Design review and mobilisation | April 2020 | September 2020 | **280,000** |
| 2 | Alteration and modification works to vacated AMU | September 2020 | December 2020 | **1,785,000** |
| 3 | Relocation to stroke service from ASU and Chaucer ward to modified AMU and Foster Clark | December 2020 | December 2020 | |
| 4 | Alteration and modification works to existing ASU and Chaucer ward | January 2021 | July 2021 | **4,175,000** |
| 5 | Relocation of stroke services to newly developed area | July 2021 | August 2021 | |
| | | | | **6,240,000** |

## 5. Recruitment:

MTW has now agreed the final establishment for the OBC/FBC. Although there are no specific recruitment plans at this stage as the STP will coordinate a network approach, the Trust recognises opportunities as and when they arise. Revenue to over recruit against the current establishment is not available however the directorate would like the ability to over recruit should a suitable candidate become available particularly in a difficult to recruit to discipline.

Currently an SpR working with us, due to gain his CCT in October, is keen to specialise in stroke and is keen to work at MTW. The Trust has a job description approved by the Royal College of Physicians, although this approval is due to expire in May. Although this may seem a challenging time to put out job advertisements we do need to look forward to business as usual and service development. The aim is to advertise the post in April/May and recruit early in the summer. If the candidate is successful he will start in October once his CCT is complete. The financial pressure (5 months for 2020/21) will be absorbed initially by a consultant vacancy in frailty but keeping this post vacant is not sustainable in the long term.

**Agreement of key objectives for 2020/21** **Director of Strategy, Planning & Partnerships**

Enclosed for consideration and agreement are the Trust's key objectives for 2020/21

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

- Executive Team Meeting, 21/04/20

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

Review and agreement

[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

# MTW 2020/21 Objectives

24th April 2020

MTW
exceptional people, outstanding care

We have focused on a hybrid approach that links our main objectives to PRIDE values and also offers key "progress objectives" that will drive progress during the year and linked back to 4 key programmes of work

Maidstone and Tunbridge Wells NHS Trust

| PRIDE VALUE | OBJECTIVE | PROGRESS OBJECTIVE |
|---|---|---|
| PATIENT FIRST<br>We will embed a culture of safety improvement. We will actively seek out the views of patients, relatives and visitors and use this to improve the care we provide | Improve Friends and Family Score to national standards | Improve end of life communication and decrease Trust EoLC complaints relating to communication |
| DELIVERY<br>We will treat people in a timely consistent manner making the best possible use of our resources to do so | Reduce temporary medical staff spend | Decrease medical vacancies |
| | Achieve a bed occupancy target of 92% | Increase weekend discharges |
| EXCELLENCE<br>We will consistently go above and beyond for our patients to deliver the best care possible | Hospital Standardised Mortality Ratio <100 | Decrease disparity between weekend and weekday mortality rates |
| RESPECT<br>We will make MTW a great place to work and ensure that we value and listen to our staff | Improve Staff engagement score | Improve score of staff feeling able to make improvements to 74% |
| INNOVATION<br>We will continually improve the way we provide our services to ensure that our services meet the needs of the people we serve | Ensure the right patients are seen in the right place by the right people with the right information | Implement the Electronic Patient Record |
| | | Move 50% of our outpatient appointments to virtual |

**HOW WE DELIVER**

**Recruit medical staff** to ensure Implementation of **7 day services** and senior staff availability to:

- Discuss end of life care with patients, relatives and carers
- Ensure that patients are discharged appropriately at weekends
- Ensure patients have senior reviews at weekends and their medical care is fully optimised

**Train all of our staff in QSIR** and ensure that they have the opportunity to deploy those skills

Implement the **EPR**

**Transform outpatient services** through a move to virtual and deploying appropriate triaging and prioritisation systems

**Agreement of key objectives for 2020/21** **Director of Strategy, Planning & Partnerships**

Enclosed for consideration and agreement are the Trust's key objectives for 2020/21

The proposed objectives have been updated following feedback my members of the Executive Team Meeting.

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

- Executive Team Meeting, 21/04/20

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

Review and agreement

[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

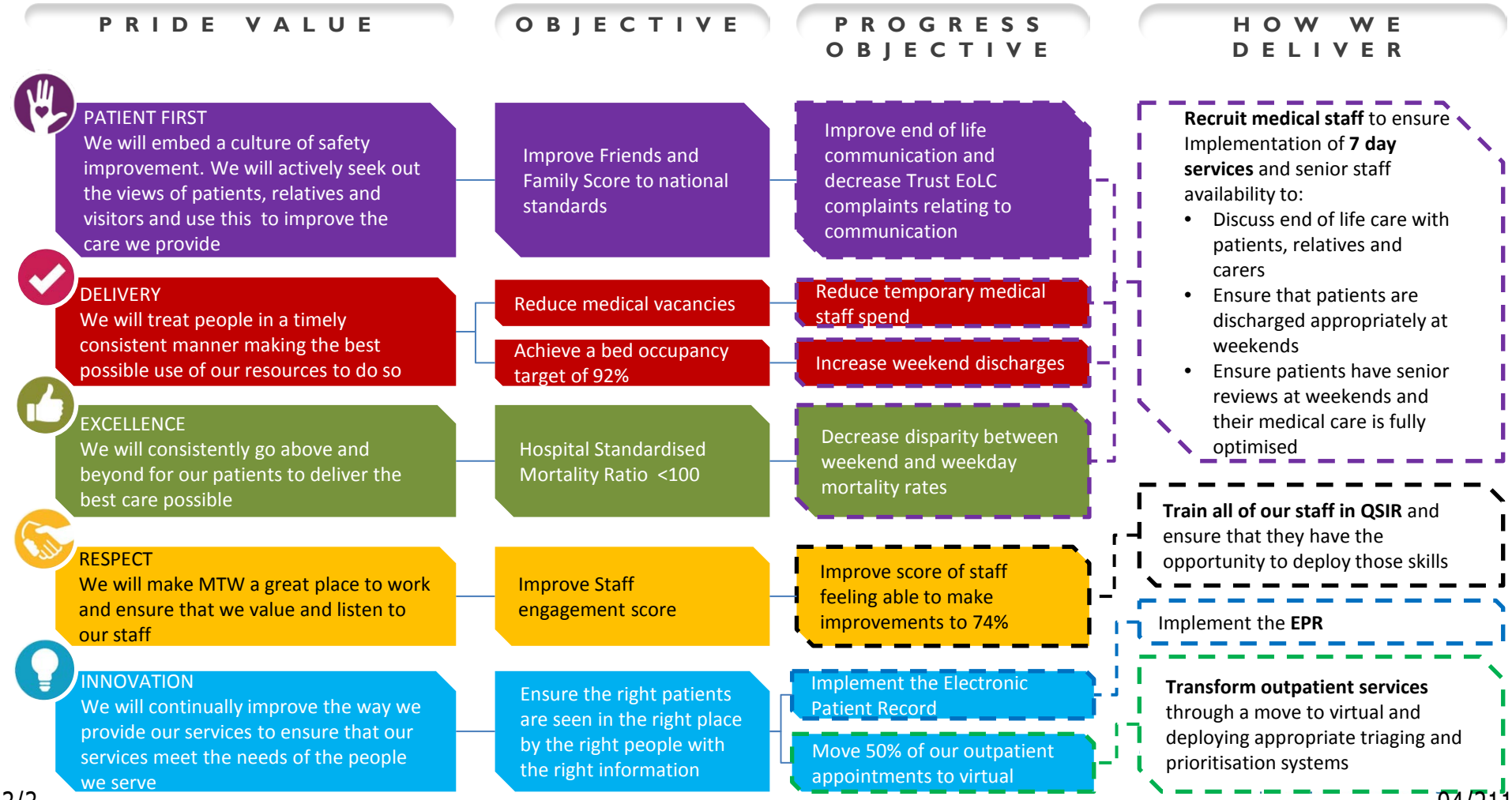
# MTW 2020/21 Objectives

29th April 2020

MTW
exceptional people, outstanding care

We have focused on a hybrid approach that links our main objectives to PRIDE values and also offers key "progress objectives" that will drive progress during the year and linked back to 4 key programmes of work

NHS
Maidstone and Tunbridge Wells
NHS Trust



| **Review of the Workforce Race Equality Scheme (WRES) (including the Trust's Model Employer aspirational targets)** | **Chair of the Cultural & Ethnic Minorities Network** |
|---|---|

The Workforce Race Equality Scheme (WRES) (including The Trust's Model Employer aspirational targets) was considered by the Workforce Committee on 28th March 2020, it was agreed that the WRES should be submitted to the Trust Board, with the Chair of the Cultural and Ethnic Minorities Network in attendance. The Chair of the Trust Board subsequently agreed to the request to schedule the item at the Trust Board meeting on 30th April.

The enclosed report therefore sets out the clear intentions of the Trust to increase diversity and inclusivity enabling us to deliver services for all people within our communities.

The 2018/19 WRES data for the Trust has been reviewed, along with the 2019 report from NHS England, NHS Improvement "A Model Employer: increasing black and minority ethnic representation at senior levels across the NHS". In order to increase the number of black and minority ethnic (BME) staff in senior positions and reduce the number of BME staff experiencing bullying, harassment or abuse at the Trust, there are four pieces of work that aim to:

1. Increase the understanding of why promoting diversity in the workforce influences the care we provide to our patients
2. Increase career progression and promotion of our BME staff, including a focus on senior positions
3. Increase the percentage of BME staff being appointed to a role here
4. Reduce the percentage of BME staff experiencing harassment, bullying or abuse

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

- Workforce Committee, 28/03/20
- Executive Team Meeting, 07/04/20

**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

## 1.0 INTRODUCTION

1.1.1 The Workforce Race Equality Standard (WRES) was introduced in April 2015 and mandated as part of the NHS Standard Contract.

1.1.2 The Trust also sees this as a vital component as we strive to improve and deliver our obligations under the Public Sector Equality Duty to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

1.1.3 The WRES ultimately supports the Trust to increase its diversity and inclusivity enabling us to deliver services for all people within our communities. It is not possible to deliver safe, personalised, accessible and recovery focussed services if we are not diverse and inclusive.

1.1.4 It is widely known that women, staff with disabilities and BME staff have fewer opportunities to access opportunities that allow staff to showcase their ability and develop their potential and this impacts on patient care and safety. CQC ratings and NHS staff survey results shows “a clear pattern between the quality of care and staff experience of discrimination in the NHS, with staff in Trusts with lower ratings more likely to say they have experienced discrimination” (CQC 2017).

1.1.5 We know that in hospital settings, managing staff with respect and compassion correlates with improved patient satisfaction, infection and mortality rates, CQC ratings and financial performance (Dixon-Woods, Me el al 2015) as well as turnover and absenteeism.

1.1.6 The 2019 report from NHS England, NHS Improvement – “A Model Employer: increasing black and minority ethnic representation at senior levels across the NHS” recognises that the WRES data points to progress in some areas of workplace race inequality and also states that further work needs to be done including removing barriers to recruitment and progression along the workforce pipeline for all ethnic groups in the NHS.

1.1.7 The Government has set a national goal that is clear and ambitious: that NHS leadership should be as diverse as the rest of the workforce and, in particular, we should ensure that BME representation at senior management matches that across the rest of the NHS workforce within ten years.

1.1.8 This report contains the Trust’s fourth WRES report which is published on our website, shared with NHS England, our local commissioners as well as being reviewed as part of our CQC inspection.

## 2.0 BACKGROUND

2.1.1 The latest WRES data report for NHS Trusts was published in January 2019 presenting three years’ of WRES data against all nine WRES indicators of workplace experience and opportunity. It shows trends over time regarding the level of progress made by NHS Trusts across the country as well as shining a light on those areas where further concerted support and action is required.

2.1.2 The Key Findings of 2018/2019 Nationally

- Analyses of WRES data between 2016 and 2018 shows *continuous* ***improvement*** across the range of workforce indicators

- Across the 231 NHS Trusts in England, there were just ***8 BME executive directors of nursing***
- BME staff make up ***19.1% of the workforce in NHS Trusts***. Across NHS Trusts, there were 10,407 more BME staff
- ***White applicants were 1.45 times relatively more likely to be appointed*** from shortlisting compared to BME applicants, a reduction from the 1.60 ratio in 2017.
- The proportion of ***BME staff in very senior manager (VSM) positions increased from 5.7% in 2017 to 6.9%*** in 2018. This is still significantly lower than the proportion of BME staff (193.1%) in NHS Trusts.
- BME staff were ***1.24 times relatively more likely to enter the formal disciplinary*** process compared to white staff. There have been year on year improvements on this indicator since 2016.
- The percentage of ***BME staff reporting the experience of discrimination in the last 12 months increased from 13.8% to 15.0%***. In contrast, 6.6% of white staff reported the experience of discrimination at work
- ***Only 71.5% of BME staff believed that their Trust provides equal opportunities*** for career progression or promotion. This is lower than the response in 2016 (75.5%). In contrast 86.6% of white staff believe that their trust provides equal opportunities for career progression or promotion.
- The net numbers of BME Board members increased. There were ***11 more executive BME board members across the NHS Trusts*** in 2018 compared to 2017. Overall there was one extra non-executive board member across NHS Trusts.
- A ***sustained increase in BME nurses, health visitors and midwives*** in AfC bands 6 and above. There has been an increase of 2,224 from 2017.

2.1.3 MTW WRES data 2018/19

| | 2019 | 2018 | NHS 2018 |
|---|---|---|---|
| Proportion of BME Staff in Trust | 24% (21-26%) | 23% (21-26%) | 18.94% |
| Proportion of BME Staff Bands 8A and Above | 12% (10-14%) | 12% (10-13%) | 11.2% |
| Gap | 12% (11 - 12%) | 11% | 7.74% |
| Proportion of BME Staff Band 5 Clinical | 34% (31-37%) | 31% (31-33%) | 26% |
| Proportion of BME Staff Band 6 Clinical | 17% (15-18%) | 16% (14-17%) | 19% |
| Proportion of BME Staff Band 1-5 Non-Clinical | 20% (18-23%) | 20% (18-22%) | |
| Proportion of BME Staff Band 6 and above Non- Clinical | 11% (8-13%) | 10% (8-12%) | |
| Proportion of Consultant Staff BME | 33% (31-35%) | 34% | |
| Proportion of Staff Senior Medical BME *Defined as Chiefs of Service* | 0% | 0% | |
| Proportion of VSM | 20%* (12-29%) | 0% | 6.9% |
| | | | |
| *Data taken from ESR April 2018 – March 2019* | | | |
| Relative likelihood of white staff being appointed from shortlisting compared to BME staff | 1.20 | 1.31 | |
| Relative likelihood of BME staff entering the formal disciplinary process compared to white staff | 1.04 | 0.93 | |
| Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff | 1.58 | 1.06 | |
| | | | |
| *Data taken from 2018 national NHS Staff Survey* | | | |
| | **BME** | **White** | |
| Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months | 26% | 27% | |
| Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion | 78% | 97% | |
| Percentage of staff personally experienced discrimination at work from manager/team leader or other colleague | 13% | 7% | |

2.1.4 Whilst the Trust have made improvements in all indicators since the first WRES report published in 2016, there are areas which require continued focus.

2.1.5 It is encouraging to note that the relative likelihood of white staff being appointed from shortlisting compared to BME staff has reduced since 2018. We can, however, see an increase in the relative likelihood of BME staff entering the formal disciplinary process compared to white staff in 2018 with a noticeable difference in the relative likelihood of white staff accessing non mandatory training compared to BME staff.

2.1.6 The 2018 National NHS Staff Survey shows that BME and white staff experience similar harassment, bullying or abuse from staff. There has been a significant reduction in the number of BME staff who believe that the Trust provides equal career development opportunities and the number of BME people experiencing discrimination at work from managers and colleagues is nearly double that of white staff.

2.1.7 Data aside, members of the CEMN are receiving an increasing number of concerns from staff regarding discrimination and bullying and harassment. The staff have not felt inclined to report the issues through the formal channels for a number of reasons; concerns about repercussions of reporting, worries that the allegations will be dismissed without appropriate investigation and a feeling that nothing will change as evidenced with previous complaints either by themselves or by colleagues. These concerns are not confined to substantive staff; the network have recently been approached by nursing students on placement with similar concerns. Clearly, this cannot continue.

2.1.8 We can congratulate ourselves on the areas that we have made progress in. However, we also need to plan and deliver Trust wide initiatives that will influence the way that we demonstrate an inclusive and developmental working environment for our BME staff, thereby leading to improved staff engagement across the board and ultimately improving the care that we are giving to our patients.

## 3.0 ACTIVITY OVER THE LAST YEAR

3.1.1 Since submission of the 2018 WRES data, the most noticeable improvement at MTW has been the re-invigoration of the Cultural & Ethnic Minorities Network (CEMN). Chaired by Ms Rantimi Ayodele, Consultant Paediatric Orthopaedic Surgeon, the network has been driven by the ambitions of Rantimi to support ethnic minority staff; encourage and work towards a culture of inclusion; spearhead and develop the Trust's diversity and inclusion work; advise staff and managers across the Trust in development and maintaining diverse teams and leading the Trust in celebrating our diversity.

3.1.2 Activities undertaken under the leadership of Ms Ayodele:

- Created a Committee within the network to lead on communications and marketing, advocate for pastoral care of international staff and developing diversity events
- Updated the name and associated logo of the network
- Produced posters and postcards to promote the network
- Increased the network membership by 100% with committee going out and talking to staff about the support offered
- Updated the equality statement that accompanies all job adverts
- Delivered "The Power of Me" – a half day development programme aimed at supporting staff with their career development and breaking down barriers
- Worked with staff side, HR and other diversity networks to review disciplinary and Bullying and Harassment cases asking the question – was the investigation appropriate given the nature of the allegation and was the outcome appropriate?
- Provided support to our international staff by attending Meet & Greet sessions for cohorts of international nurses and taking part in International Staff Drop In sessions providing advice, guidance and faith support
- Secured a small budget for the promotion of the network and diversity events

- Arranged diversity events including meet & greet sessions and steel bands playing at main sites to celebrate Black History Month; Diwali meet and greet activities
- Attended “Addressing the Barriers for BAME representation in the workplace” conference
- Secured funds to pilot “Recruiting for Difference” in Q4 of 2019/20

3.1.3 The CEMN has increased its visibility throughout the organisation and with that has come reports from BME staff and students about a lack of career progression, an inability to attend network related activities and concerns around discrimination.

3.1.4 In order to address those issues, a WRES action plan has been carefully constructed to enable our Trust Board to demonstrate leadership, accountability and deliver support interventions to help MTW continuously improve on workforce race equality.

## 4.0 WRES ACTION PLAN

4.1.1 The 2019/20 WRES action plan aims to deliver the priorities of improving BME representation across the workforce pipeline of the Trust as identified in the Model Employer paper as well as creating more inclusive cultures that value the contributions of all staff as highlighted in the NHS Long Term Plan.

| Action | Lead | Due Date | Activity |
|---|---|---|---|
| Increase the Understanding of why promoting Diversity in the Workforce is a Business and Asset argument to help the Trust develop the Culture of Inclusion that will promote the actual aims and objectives for Patient Care (and not a separate removed activity) | CEMN Committee | July 2020 | • Lead executives in a workshop/ review of its goals around diversity to be able to articulate how this work will lead to a better achievement of the Trusts Aims and objectives.<br>o Executives to lead the embedding of understanding the benefits of the importance of diversity in the workplace<br>o Executives to lead on publicising the work of the CEMN to the Trust and validating the importance of staff being allowed to have time to be involved in all Network activities |
| **Indicator 1**<br>Increase the % of BME staff in each of the AfC Bands 1 – 9 and VSM (compared with the % of staff in the overall workforce)<br><br>**Indicator 7**<br>Increase % of BME staff believing the Trust provides equal opportunities for career progression or promotion | Head of Equality<br>Head of L&D<br>CEMN Committee<br><br>Head of Learning & Development | July 2020 | • Deliver "The Power of Me", actively targeting BME staff to attend<br>• Provide job interview skills workshops for BME staff<br>• CEMN Chair to mentor a member of the CEMN to lead to wider Mentorship programme being established<br>• Pilot a reverse mentoring programme for Executive Board Members<br>• Develop Talent Boards within each Division working in collaboration with HR Business Partners to set up to identify and support talent management and succession planning ensuring that assessment of BME staff is identified and supported<br>• Create a central respository of BME talent within the Trust |
| **Indicator 2**<br>Increase the relative likelihood of BME staff being appointed from shortlisting compared to white staff | Recruitment<br>Head of Equality<br>CEMN Committee | July 2020 | • Pilot "Recruiting for Difference" with Chief Operating Officer in Q4 of 2019. |
| **Indicator 6**<br>Reduce % of BME staff experiencing harassment, bullying or abuse from staff | | | *Whilst the data does not suggest a decline in staff experiencing harassment, bullying or abuse, the CEMN and others are being approached by staff with issues who are not reporting through formal channels or within the staff survey. These actions are intended to further reduce the negative response to Indicator 6.*<br>• Implement 'Safe Space Champions' to support the FTSU Guardian in the provision of first port of call service to staff –to listen and signpost to relevant support.<br>• Develop and implement a robust communications plan to ensure that staff are aware of the role of the SSC |

| Action | Lead | Due Date | Activity |
|---|---|---|---|
| | | | • Continue to review B&H and disciplinary cases on an annual basis with other diversity network reps, HR and staff side<br>• Undertake quarterly reviews of B&H and discrimination recorded on Datix<br>• Hold engagement/drop in sessions allowing staff to discuss B&H/harassment issues<br>• Develop a trust wide, cross diversitynetwork campaign to combat B&H more generally which centres around behaviours and expectations which will be linked to culture and leadership work |

# Workforce Race Equality Report

CULTURAL & ETHNIC MINORITIES NETWORK

MTW
exceptional people, outstanding care

**Jo Garrity**

Head of Staff Engagement and Equality

**Ms Rantimi Ayodele**

Consultant Trauma and Orthopaedic Surgeon

Chair of the Cultural & Ethnic Minorities Network

# WRES - Importance

studies shows that a motivated, included and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety

# WRES – phase one

first phase of the WRES focused on supporting the system to understand the nature of the challenge of workforce race equality

and

for leaders to recognise that it was their responsibility to help make the necessary changes.

# WRES – phase two

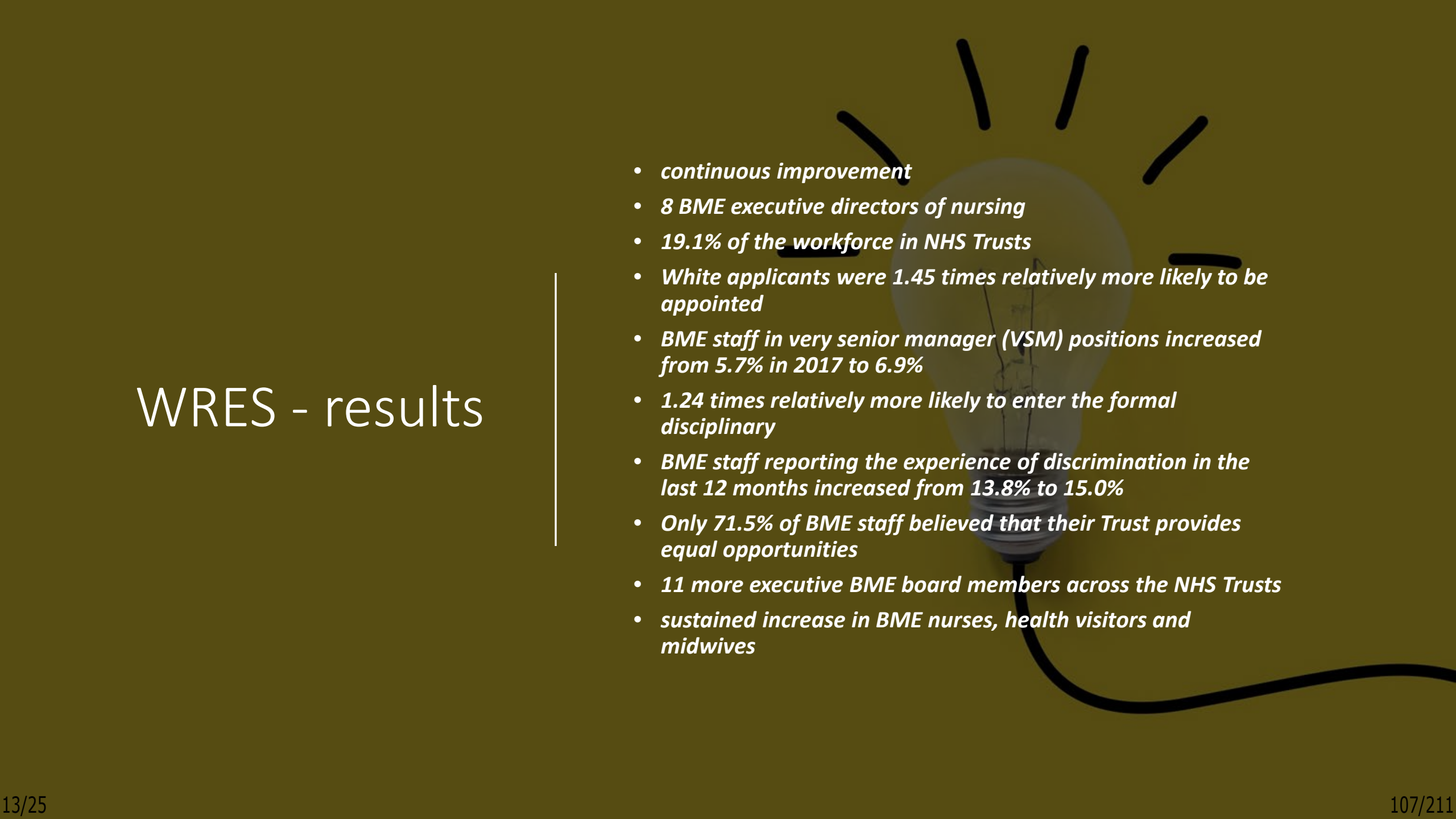
enabling people to work comfortably with race equality.

Through communications and engagement, we will work to change the deep-rooted cultures of race inequality in the system, learn more about the importance of equity, to build capacity and capability to work with race

# WRES - Progress

WRES data points to progress in some areas of workplace race inequality but further work needs to be done including removing barriers to recruitment and progression along the workforce pipeline for all ethnic groups in the NHS.

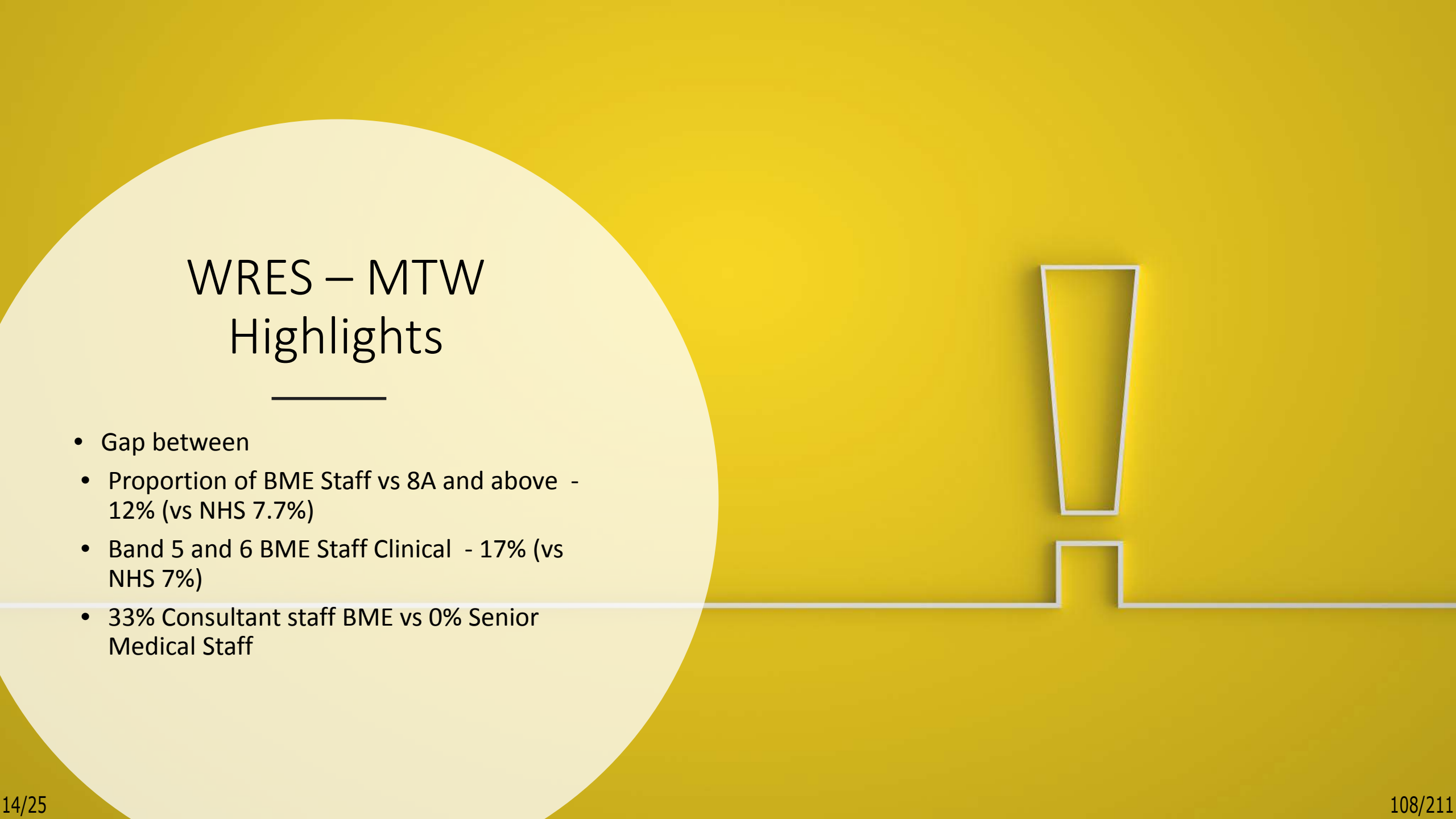
# WRES - results



- *continuous improvement*
- *8 BME executive directors of nursing*
- *19.1% of the workforce in NHS Trusts*
- *White applicants were 1.45 times relatively more likely to be appointed*
- *BME staff in very senior manager (VSM) positions increased from 5.7% in 2017 to 6.9%*
- *1.24 times relatively more likely to enter the formal disciplinary*
- *BME staff reporting the experience of discrimination in the last 12 months increased from 13.8% to 15.0%*
- *Only 71.5% of BME staff believed that their Trust provides equal opportunities*
- *11 more executive BME board members across the NHS Trusts*
- *sustained increase in BME nurses, health visitors and midwives*

# WRES – MTW Highlights

- Gap between
- Proportion of BME Staff vs 8A and above - 12% (vs NHS 7.7%)
- Band 5 and 6 BME Staff Clinical - 17% (vs NHS 7%)
- 33% Consultant staff BME vs 0% Senior Medical Staff



# WRES - MTW

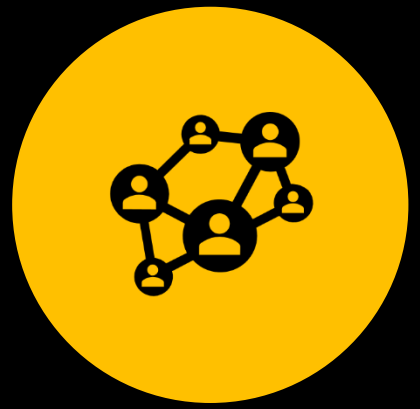
- It is encouraging to note that the relative likelihood of white staff being appointed from shortlisting compared to BME staff has reduced since 2018. We can, however, see an increase in the relative likelihood of BME staff entering the formal disciplinary process compared to white staff in 2018 with a noticeable difference in the relative likelihood of white staff accessing non mandatory training compared to BME staff.

- There is a danger of a quick review year on year when further review of the data highlights disparities that we cannot ignore

# Racial Diversity and Inclusion @ MTW

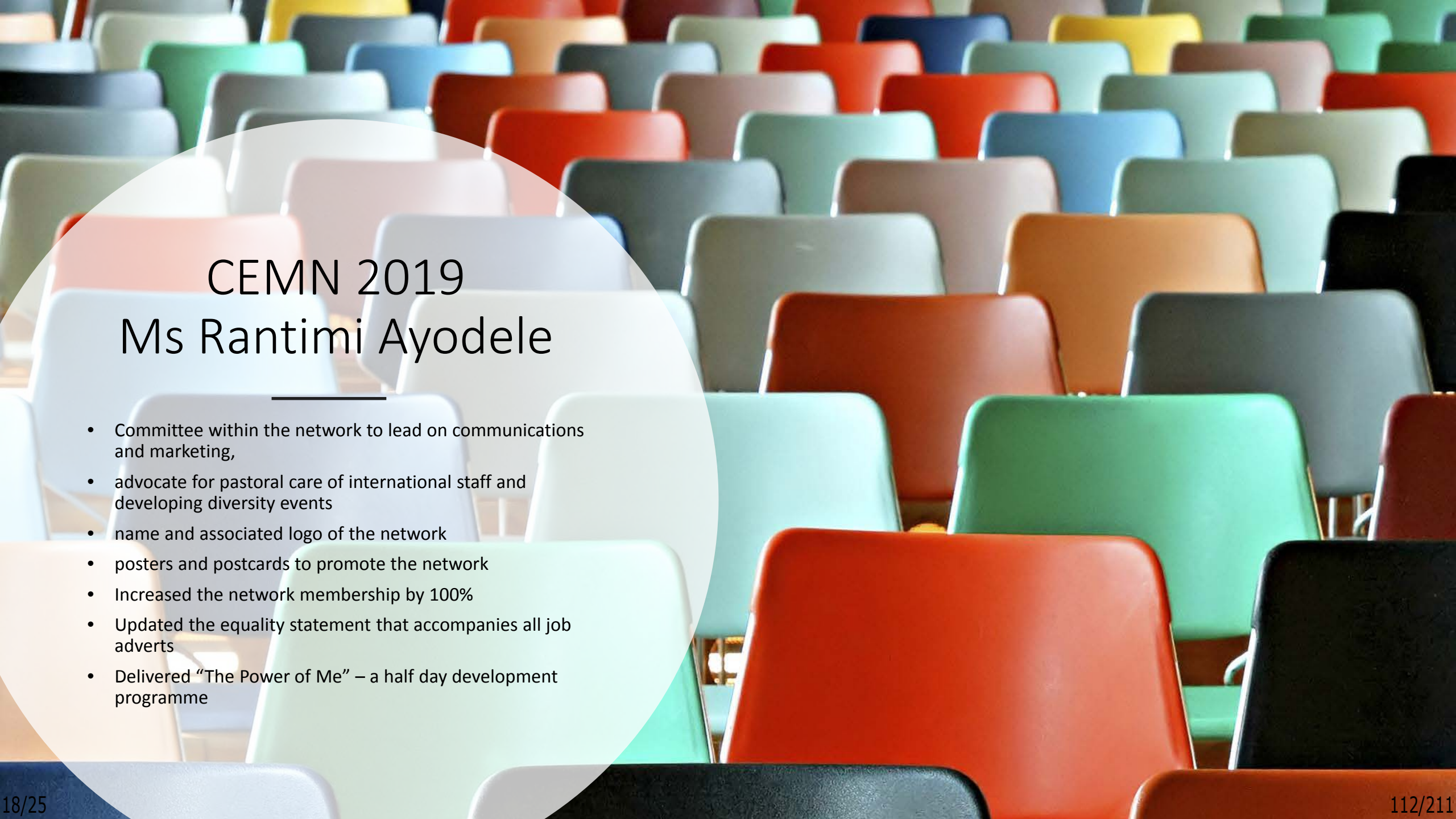
PERSONAL AND REPORTED NEGATIVE EXPERIENCES

MICRO AND MACRO RACIAL AGGRESSION TO STAFF MEMBERS OF ALL BANDS



RACIAL DIVERSITY AND EXPERIENCE SEEN AS NOT A PRIORITY OF THE TRUST


# Racial Diversity and Inclusion @ MTW



# CEMN 2019
# Ms Rantimi Ayodele

- Committee within the network to lead on communications and marketing,
- advocate for pastoral care of international staff and developing diversity events
- name and associated logo of the network
- posters and postcards to promote the network
- Increased the network membership by 100%
- Updated the equality statement that accompanies all job adverts
- Delivered “The Power of Me” – a half day development programme

# CEMN 2019 – Ms Rantimi Ayodele

- Worked with staff side, HR and other diversity networks to review disciplinary and Bullying and Harassment Provided support to our international staff by attending Meet & Greet sessions for cohorts of international nurses and taking part in International Staff Drop-In sessions providing advice, guidance and faith support
- Secured a small budget for the promotion of the network and diversity events
- Arranged diversity events including meet & greet sessions and steel bands playing at main sites to celebrate Black History Month; Diwali meet and greet activities
- Attended “Addressing the Barriers for BAME representation in the workplace” conferenceSecured funds to pilot “Recruiting for Difference” in Q4 of 2019/20
- Secured funds to pilot “Recruiting for Difference” in Q4 of 2019/20

# Racial Diversity&Inclusion @ MTW Going Forward

@ MTW we cannot rely on the Cultural and Ethnic Minorities Network to spearhead the actions needed

The network can help to raise awareness and support staff but the Trust board need to understand and articulate the situation

The Board needs to postitively lead on the changes needed.

Decisive and urgent action is needed to implement the bold vision for the NHS to achieve equality across the workforce in 10 years

Increase the Understanding of why promoting Diversity in the Workforce is a Business and Asset argument to help the Trust develop the Culture of Inclusion that will promote the actual aims and objectives for Patient Care (and not a separate removed activity)

- Lead exec in a workshop/ review of its goals around diversity to be able to articulate how this work will lead to a better achievement of the Trusts Aims and objectives.

Executives to lead the embedding of understanding the benefits of the importance of diversity in the workplace

· **Executives to lead on publicising the work of the CEMN to the Trust and validating the importance of staff being allowed to have time to be involved in all Network activities**

**Indicator 1**
Increase the % of BME staff in each of the AfC Bands 1 – 9 and VSM (compared with the % of staff in the overall workforce)

**Indicator 7**
Increase % of BME staff believing the Trust provides equal opportunities for career progression or promotion

- Deliver “The Power of Me”, actively targeting BME staff to attend
- Provide job interview skills workshops for BME staff
- CEMN Chair to mentor a member of the CEMN to lead to wider Mentorship programme being established

· Pilot a reverse mentoring programme for Executive Board Members

· Develop Talent Boards within each Division working in collaboration with HR Business Partners to set up to identify and support talent management and succession planning ensuring that assessment of BME staff is identified and supported

· Create a central respository of BME talent within the Trust

## Indicator 2
Increase the relative likelihood of BME staff being appointed from shortlisting compared to white staff

- Pilot “Recruiting for Difference” with Chief Operating Officer in Q4 of 2019.

# Indicator 6 Reduce % of BME staff experiencing harassment, bullying or abuse from staff

- *Whilst the data does not suggest a decline in staff experiencing harassment, bullying or abuse, the CEMN and others are being approached by staff with issues who are not reporting through formal channels or within the staff survey. These actions are intended to further reduce the negative response to Indicator 6.*
- · Implement 'Safe Space Champions' to support the FTSU Guardian in the provision of first port of call service to staff –to listen and signpost to relevant support.
- · Develop and implement a robust communications plan to ensure that staff are aware of the role of the SSC
- · Continue to review B&H and disciplinary cases on an annual basis with other diversity network reps, HR and staff side
- · Undertake quarterly reviews of B&H and discrimination recorded on Datix
- · Hold engagement/drop in sessions allowing staff to discuss B&H/harassment issues
- · Develop a trust wide, cross diversitynetwork campaign to combat B&H more generally which centres around behaviours and expectations which will be linked to culture and leadership work

# Summary

We have reviewed the 2018/19 WRES data for MTW along with the 2019 report from NHS England, NHS Improvement – a Model Employer: increasing black and minority ethnic representation at senior levels across the NHS.

In order to increase the number of BME staff in senior positions and reduce the number of BME staff experiencing bullying, harassment or abuse at MTW, there are four pieces of work that aim to:

We need the commitment of the Trust Board through the Workforce Committee to help us pursue these goals which will see a more inclusive Trust with improved patient outcomes

- 1. Increase the understanding of why promoting diversity in the workforce influences the care we provide to our patients
- 2. Increase career progression and promotion of our BME staff, including a focus on senior positions
- 3. Increase the percentage of BME staff being appointed to a role here
- 4. Reduce the percentage of BME staff experiencing harassment, bullying or abuse

**Trust Board meeting – 30th April 2020**

NHS
Maidstone and Tunbridge Wells NHS Trust

| **Report from the Freedom to Speak Up Guardian** | **Non-Executive Director Freedom to Speak Up Sponsor (on behalf of the Freedom to Speak Up Guardian)** |
|---|---|

Enclosed is the latest report to the Board by the Freedom To Speak Up Guardian (FTSUG).

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

- N/A

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

The Trust Board is asked to read the report and discuss the content and recommendations

[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

# Board of Directors (Public)

## *Freedom To Speak Up Guardian Report*

**Action Requested / Recommendation**

The Trust Board is asked to read the report and discuss the content and recommendations.

**Summary**

This is the 4th quarter and year-end report to the Board by the Freedom To Speak Up Guardian (FTSUG) which now outlines and identifies trends, issues and the resource requirement to move the FTSU agenda forward.

**Author;** Christian Lippiatt, Freedom To Speak Up (FTSU) Guardian

**Date;** 27th April 2020

| | |
|---|---|
| **Freedom To Speak Up Non-Executive Director** | Maureen Choong |
| **Freedom To Speak Up Executive Lead** | Simon Hart |
| **Freedom To Speak Up Guardian** | Christian Lippiatt |

**Introduction**

The FTSU Agenda is to;

- Protect patient safety and the quality of care
- Improve the experience of workers
- Promote learning and improvement

By ensuring that;

- Workers are supported in speaking up
- Barriers to speaking up are addressed
- A positive culture of speaking up is fostered
- Issues raised are used as opportunities for learning and improvement

**National Guardians Office (NGO)_Case Reviews**

The last case review was published in September 2019 regarding the handling of two cases referred to it by workers from Northwest Ambulance Service NHS Trust. This was reported on in January 2020. There has been no further review or recommendations to comment on at this time.

**Themes / Issues**

There have been six concerns raised in the last quarter. Five were on the Maidstone site, of which four were bullying /harassment and one patient safety. The one Tunbridge Wells Hospital concern was bullying and harassment. This has been an increase on a previously quiet quarter.

The one patient safety issue was a concern relating to safe staffing levels and more specifically safe skill mix. The Trust has undertaken a significant recruitment drive of overseas nurses. Some areas have experienced a relatively large intake of nurses into their team, all of whom have needed support, training and supervision. This has caused additional pressure on staff who were already struggling to cope due to previously low numbers of staff. Whilst this was only one formal concern that was raised through the FTSU route, it appears to be a concern that has been discussed and mentioned by staff in general. These concerns should now be resolved through recruitment within the Practice Development Nurse team to support them and the newly appointed nurses having settled into their new roles on the wards and clinical areas.

The main theme remains the same around bullying and harassment. Those cases have a commonality as to why they came to the FTSU Guardian. Staff explain that they avoid the HR route for a number of reasons; due to previous poor experience; being told by colleagues of their poor experience and to avoid it; or having raised the concern with HR first, then feeling disillusioned with the experience.

**Growing the Speaking Up Agenda**

It was reported previously that there would be further investment in the FTSU role. The Business Case for this has been drafted. Due to an early and rapid rise of COVID-19 related demands, the Occupational Health needs have been prioritised over the FTSU Guardian role. However, it is anticipated that the business case will be progressed over the coming weeks.

**Networking**

The FTSU Guardian continues to attend regional and local network meetings as well as Trust staff network meeting, inductions and events. There was a national and regional meeting due to take place earlier this year but due to COVID-19 these were either cancelled or not attended.

**Year End Review**

It has been a difficult role to fulfil due to time constraints as has been reported and it is anticipated that resources will be increased by the Trust. It is due to this resourcing issue that advertising / promotion of the FTSU role has not been pushed as much as is desired. Once resourcing is resolved, promotion can be undertaken in the knowledge that concerns will be dealt with in a timely manner.

The common theme has been of bullying and harassment and the reason for this concern being raised with the FTSU Guardian has been discussed above.

Concerns have largely been received from A&C and Clinical support staff, suggesting there is a level of staff who feel unable to raise their concern through their management route, or have tried but been unable to progress it or feel that their concern has not been listened to and taken seriously.

**Data Collection; Concerns Raised**

| '19/'20 Month | No. of contacts | Anonymous | All Open Cases |
|---|---|---|---|
| April | 4 | 1 | 0 |
| May | 6 | 2 | 0 |
| June | 5 | 2 | 0 |
| July | 5 | 4 | 0 |
| August | 6 | 2 | 0 |
| September | 5 | 0 | 0 |
| October | 1 | 0 | 0 |
| November | 0 | 0 | 0 |
| December | 0 | 0 | 0 |
| January | 1 | 0 | 0 |
| February | 1 | 1 | 1 |
| March | 4 | 2 | 2 |
| **Total** | **38** | **14** | **3** |

| Quarter | Month/Year | No. of Contacts |
|---|---|---|
| Q1 | April-June '18 | 0 |
| Q2 | July-September '18 | 0 |
| Q3 | October-December '18 | 2 |
| Q4 | January-March '18 | 8 |
| **Total** | **2018/19** | **10** |

| Quarter | Month/Year | No. of Contacts |
|---|---|---|
| Q1 | April-June '19 | 15 |
| Q2 | July-September '19 | 16 |
| Q3 | October-December '19 | 1 |
| Q4 | January-March '20 | 6 |
| **Total** | **2019/20** | **38** |

**2019/2020 Details**

| Staff Group | Number |
|---|---|
| Estates & Facilities | 3 |
| Nursing | 4 |
| Midwifery | 0 |
| Medical | 1 |
| AHP's | 1 |
| Clinical Support | 10 |
| A&C | 9 |
| Unknown | 10 |
| **Total** | **38** |

| Theme | Number |
|---|---|
| Patient Safety | 5 |
| Bullying/ Harassment | 18 |
| Fraud | 1 |
| Health & Safety | 5 |
| Other | 9 |
| **Total** | **38** |

**Ratification of the Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ('Policy for Policies')** — **Trust Secretary**

The Reservation of Powers and Scheme of Delegation reserves the ratification (i.e. final authorisation for use within the Trust) of a small number of policy documents to the Trust Board. One such document is the "Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures" ("Policy for Policies")", which outlines the governance framework for all Trust-wide policies.

The "policy for policies" (including its appendices) needed to be updated to reflect the revised corporate management / Divisional structure, so the opportunity has been taken to propose a number of other beneficial changes. These changes are summarised below:

- Amendments to clarify the required process when a policy is ratified with content that directly affects the content of another policy.
- Updated section to reflect current Trust committee structure with respect to approval authority.
- Addition of a new appendix (Appendix 6: Style guide for Trust-wide policies and procedures).
- Amended definition of 'Trust-wide policy' to be a policy that covers the method of working across more than one Division (rather than one Directorate).
- Amended definition of a 'Local policy (and procedure)' to be a policy (and procedure) that covers the method of working within a single Division (and the staff therein) (rather than a single Directorate).
- Inclusion of the definition of a Division.
- Formalisation of the Policy Ratification Committee's determination on the use of gender specific language (which is described within the new style guide in Appendix 6).
- Replacement of 'Executive Lead' for a policy with 'Owner' (to enable 'Owners' to include persons other than members of the Executive Team).
- Inclusion of the definition of Standard Operating Procedure (SOP).
- Confirmation that policy documents and any appendices that are primarily linked to that policy must be reviewed in full by the approving committee (and thereby removing the option of the approving committee only receiving a synopsis of a policy)
- Further precision being described for the steps required when documents no longer wish to be regarded as Trust-wide policies (please note that although these amendments were made after the document was reviewed by the Policy Ratification Committee (PRC), they are not considered material enough to warrant the ratification process being delayed to allow the PRC to review, or the Executive Team Meeting to re-approve)

The revised documents have been approved at the Executive Team Meeting and then reviewed at the PRC. The Trust Board is now asked to ratify the revised policy and its appendices.

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

- Executive Team Meeting, 18th February 2020
- Policy Ratification Committee, 13th March 2020

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

Ratification (i.e. final authorisation for use within the Trust).of the revised Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ('Policy for Policies')

[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

# Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ('Policy for Policies')

| | |
|---|---|
| **Target audience:** | All Trust staff involved in the production or review of Trust-wide policies and procedures |
| **Author:** | Kevin Rowan, Trust Secretary<br>**Contact details:** Ext. 28698 |
| **Other contributors:** | Corporate Governance Assistant<br>Assistant Trust Secretary<br>Members of the Policy Ratification Committee (PRC) |
| **Owner:** | Chief Executive |
| **Directorate:** | Corporate |
| **Specialty:** | Corporate |
| **Supersedes:** | Principles of Production, Approval and Implementation of Trust Wide Policies and Procedures [Version 6.0: October 2017]<br><br>Principles of Production, Approval and Implementation of Trust Wide Policies and Procedures [Version 6.1: January 2018]<br><br>Principles of Production, Approval and Implementation of Trust Wide Policies and Procedures [Version 6.2: September 2018] |
| **Approved by:** | Executive Team Meeting, 18th February 2020 |
| **Recommended for ratification by:** | Policy Ratification Committee, 13th March 2020 |
| **Ratified by:** | The Trust Board, 30th April 2020 |
| **Review date:** | April 2024 |

**Document history**

| | |
|---|---|
| **Requirement for document:** | • To comply with national recommendation for good practice.<br>• To ensure a clear and robust approach and system is in place for the production, approval and ratification of Trust-wide policies and procedures. |
| **Cross references (external):** | 1. The Freedom of Information Act 2000.<br>2. NICE Style Guide Corporate document [ECD1]. National Institute for Health and Care Excellence (NICE), 2016.<br>3. Inclusive language: words to use and avoid when writing about disability. The Department for Work & Pensions and the Office for Disability Issues, 2018<br>4. Care and Support Jargon Buster. Think Local Act Personal?, 2020<br>5. Writing for NICE: a guide to help you write more clearly. National Institute for Health and Care Excellence, 2016<br>6. Scientific Nomenclature. The Centers for Disease Control and Prevention, 2020.<br>7. Bureau International des Poids et Mesures (BIPM). International System of Units, 2020. |
| **Associated documents (internal):** | • Standing Orders [RWF-OPPCS-NC-TM23].<br>• Publication Scheme available at www.mtw.nhs.uk/freedom-of-information/publication-scheme/.<br>• Terms of Reference of the Policy Ratification Committee (PRC) [available from the Trust Secretary's office].<br>• Policy Ratification Committee (PRC) pre-submission checklist [available from the Assistant Trust Secretary].<br>• Trust Committee Structure [RWF-OPPCS-NC-TM23]. |

| | | | |
|---|---|---|---|
| **Keywords:** | Ratification | Consultation | PRC |
| | Approval | Trust-wide | Procedure |
| | Policy for Policies | Policy Policy | Author |
| | Policy Ratification Committee | Owner | SOP |

| **Version control:** | | |
|---|---|---|
| **Issue:** | **Description of changes:** | **Date:** |
| 6.0 | Complete revision of policy, to reflect the revised ratification process approved by the Trust Board in May 2014 including:<br>• Clearer definitions (of "Policy", "Trust-wide" etc.).<br>• The exclusion of clinical guidance documents from the policy.<br>• Clarity regarding the various steps in the process (including "approval" and "ratification").<br>• The existence and functioning of the Policy Ratification Committee (PRC).<br>• Clarification that a Review date is not an expiry date | October 2017 |

| Version control: | | |
|---|---|---|
| **Issue:** | **Description of changes:** | **Date:** |
| | (and that a policy and procedure does not become automatically unfit for purpose solely because its Review date has passed).<br>• The processes for considering amendments or withdrawals.<br>• All Trust-wide policies and procedures being ratified for 4 years (unless a shorter period is required). | |
| 6.1 | Clarification added on the requirement for an approving committee to be Trust-wide. | January 2018 |
| 6.2 | Amended consultation sections 5.3.2 and 5.3.4 to clarify that Corporate Governance Assistant must complete the post-consultation check after all other consultation feedback has been addressed. | September 2018 |
| 7.0 | • Amendments to clarify the required process when a policy is ratified with content that directly affects the content of another policy (section 5.3.3 and 5.9.3, and Policy template in Appendix 5).<br>• Updated section 5.5.1 to reflect current Trust committee structure with respect to approval authority.<br>• Addition of new appendix (Appendix 6: Style guide for Trust-wide policies and procedures).<br>• Amended definition of 'Trust-wide policy' to be a policy that covers the method of working across more than one Division (rather than one Directorate).<br>• Amended definition of a 'Local policy (and procedure)' to be a policy (and procedure) that covers the method of working within a single Division (and the staff therein) (rather than a single Directorate).<br>• Inclusion of the definition of a Division.<br>• Formalisation of the Policy Ratification Committee's determination on the use of gender specific language (described within the new style guide in Appendix 6).<br>• Replacement of 'Executive Lead' for a policy with 'Owner' (to enable 'Owners' to include persons other than members of the Executive Team).<br>• Inclusion of the definition of Standard Operating Procedure (SOP).<br>• Confirmation that policy documents and any appendices that are primarily linked to that policy must be reviewed in full by the approving committee (and thereby removing the option of the approving committee only receiving a synopsis of a policy)<br>• Further precision being described for the steps required when documents no longer wish to be regarded as Trust-wide policies | April 2020 |

**Summary for**

# The production, approval and ratification of Trust-wide policies and procedures

Policies are statements of corporate intent that explicitly state responsibilities and accountabilities, and contain details which relevant Trust employees are expected to adhere to, as part of their terms of employment. Trust-wide policies are those that cover the method of working across more than one Division.

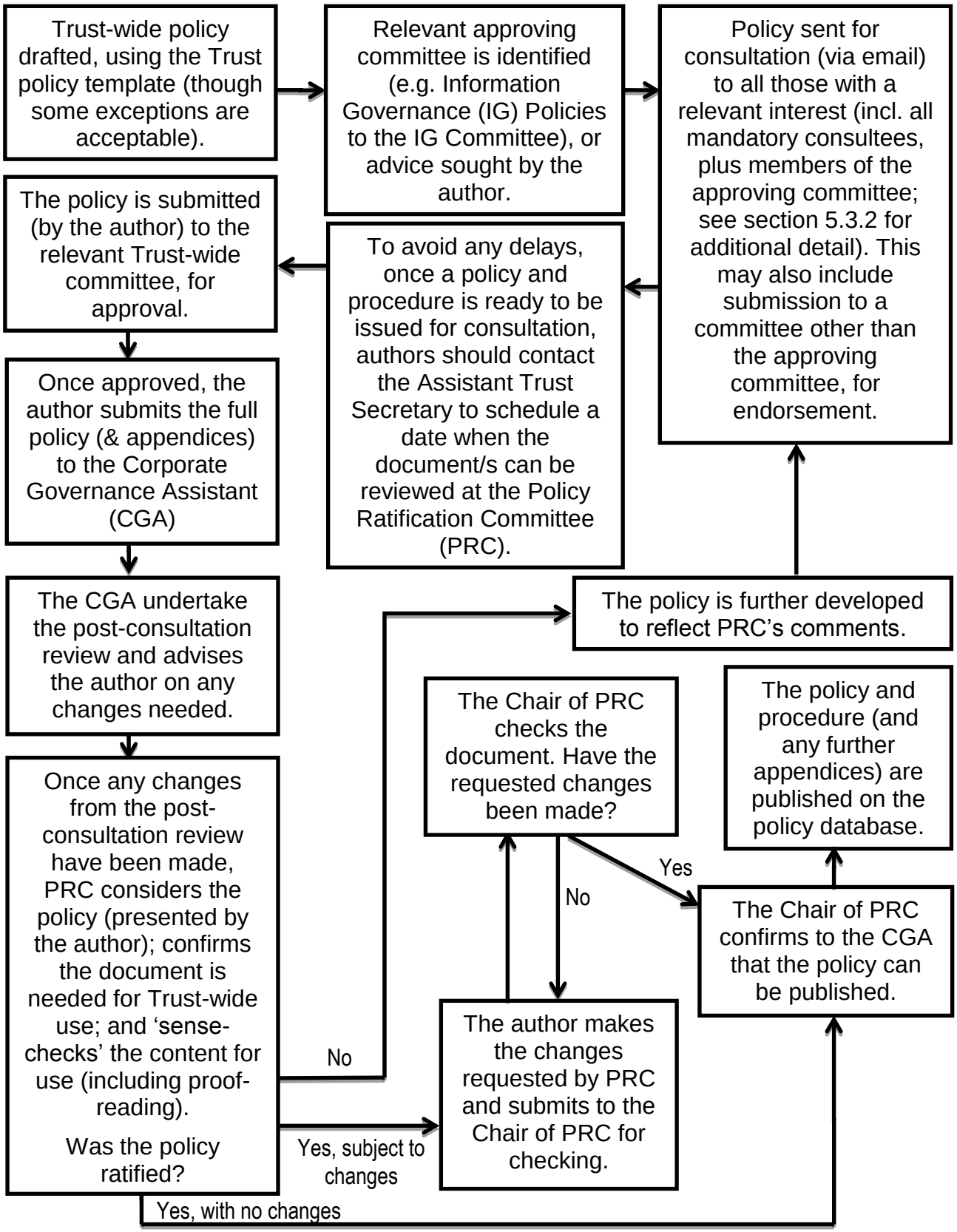
All NHS organisations need a robust process to ensure the policies and procedures they expect their staff to follow:

- are developed with due rigour
- take account of appropriate external guidance and internal opinion
- are well-written
- meet the needs of staff and the organisation
- meet expected equality standards.

This policy describes the Trust's approach to ensuring that Trust-wide policies and procedures are produced to the required standard, and properly approved and ratified, to enable the documents to be issued for use.

# Content

**Overview of procedure to be followed**
(Refer to the policy and procedure for the full details and requirements of each step)



## 1.0 Introduction, purpose and scope

Policies are statements of corporate intent that explicitly state responsibilities and accountabilities, and contain details which relevant Trust employees are expected to adhere to, as part of their terms of employment. Trust-wide policies are those that cover the method of working across more than one Division.

All NHS organisations need a robust process to ensure the policies and procedures they expect their staff to follow:

- are developed with due rigour
- take account of appropriate external guidance and internal opinion
- are well-written
- meet the needs of staff and the organisation
- meet expected equality standards.

This policy describes the Trust's approach to ensuring that Trust-wide policies and procedures are produced to the required standard, and properly approved and ratified, to enable the documents to be issued for use.

This policy and procedure applies to all Divisions, Directorates and locations within the Trust. However, this policy does not apply to the following documents:

- Local policies (i.e. those that are not "Trust-wide"). These should be produced and approved or ratified in accordance with local procedures.
- Corporate strategy documents. These will differ in format, according to their content, but any strategy affecting the whole Trust should be approved or ratified by the Trust Board (having been subject to appropriate consultation beforehand).
- Clinical guidance documents. A separate process is in place. For advice refer to the Trust Intranet or Governance Team/Deputy Director of Quality Governance.
- Trust-wide plans. These can take many forms, but they are usually a description of a series of time-limited steps that will be taken to achieve a particular aim. Plans may or may not be required to be formally approved but this should be considered by the person with overall responsibility for implementing the plan.

Documents may have different titles, which may be influenced by convention, external requirements, local considerations or previous precedent. It is therefore the intent, and not the title, that should determine whether this policy and procedure applies to a particular document, taking into account the definitions in section 2.0. In this context, documents that 'look and feel' like Trust-wide policies and procedures should not be labelled as 'plans' or 'strategies' to avoid having to comply with this policy and procedure.

### 1.1. Principles

This policy and procedure has been developed in accordance with the following principles:

- The Trust will only produce, approve, ratify and apply the Trust-wide policies and procedures that are genuinely regarded as being required to enable the Trust to effectively fulfil its functions and duties.
- Trust-wide policies and procedures are matters for the Trust 'Executive'. Therefore, although it may be appropriate to include Non-Executive Directors (and the committees on which they sit) as part of the consultation on a particular policy, the default position is that policies and procedures will be approved by Executive-led committees (unless expressly agreed otherwise by the Trust Board or one of its sub-committees).
- All Trust-wide policies and procedures are to be ratified for four years unless a shorter period is required. Regardless of this, all policies and procedures should be revised within that four year period to reflect changes as and when they arise.
- Policies should be reviewed and revised (as required) before their review date is exceeded.
- Policies should be reviewed and revised before the next review date if significant changes are made to the regulation, guidance or best practice on which the policy is based.
- Once ratified, non-material changes to a Trust-wide policy and procedure can be made without seeking re-approval and re-ratification.
- All Trust-wide policies and procedures should have a target audience identified in recognition that not all Trust-wide policies are of relevance to all Trust staff.
- All Trust-wide policies and procedures should be written in the current policy and procedure template (Appendix 5) and follow Trust guidance for style and formatting (Appendix 6).
- All Trust-wide policies and procedures should be well-written (including ensuring appropriate grammar, format and style, see Appendix 6), be clear to follow, and contain as much information as is required to provide the appropriate support to its target audience.
- All Trust-wide policies will be available to the public, on request (in accordance with the requirements of the Freedom of Information Act 2000 and the Trust's associated publication scheme).

## 2.0 Definitions / glossary

| Term | Definition |
|---|---|
| **Appendix** | An additional document, with subsidiary information relating to the main body of a policy and procedure that is required or expected to be read by the target audience, but which is not optimally located within the main body of a policy and procedure. Examples include forms, flowcharts, posters, standard operating procedures (SOPs), and registers |
| **Approval** | Official agreement by an appropriate committee that any resource implications associated with implementation of the policy have been properly considered, and that the content of a policy and procedure:<br>• meets applicable national and regional standards<br>• meets the standards of this policy<br>• is suitable to be submitted for ratification.<br>Approval is the penultimate step before a policy and procedure is issued for use. Approval can only be given by the appropriate formal Trust-wide committee. |
| **Author** | The employee who drafts the policy, procedure and appendices (and subsequent updates or revisions) in accordance with the requirements of this policy and procedure. Staff will be designated as the author of a policy and procedure according to the role they are employed to perform. |
| **Clinical guidance** | Any document designed to guide clinical practice. This includes clinical guidelines, integrated care pathways, clinical protocols, resource manuals etc. Such documents are recommendations of good practice, which are expected to be applied, but which permit exceptions, based on the judgement of the practitioner. Clinical guidance documents allow individuals to use their professional judgement and decision making skills. Such documents are excluded from this policy and procedure. |
| **Consultee** | A person or group who has been sent a policy and procedure, prior to it being submitted for approval, to enable that person or group to comment or propose amendments. |
| **Division** | A grouping of two or more ‘Clinical Directorates’ into a single operating unit, for the purposes of oversight. However, for the purposes of this policy (and the definitions of Trust-wide and local policies in particular), corporate areas (i.e. Finance, IT, Human Resources, Corporate Nursing) should also be considered as Divisions |
| **Endorsement** | The provision of formal support to a policy and procedure (and thereby acknowledgement that the content is fit for purpose and ready for approval), by a group/committee, prior to its approval. Endorsement can be provided by more than one group/committee, if relevant. Endorsement is not compulsory, but authors or approving committees may wish to seek endorsement to support the process of approval. |

| Term | Definition |
|---|---|
| **Hyperlink** | A link from text in one document to another internet location, usually activated by clicking on a highlighted word or image. |
| **Local policy (and procedure)** | A policy (and procedure) that does not meet the definition of being 'Trust-wide' i.e. which covers the method of working within a single Division (and the staff therein). |
| **Mandatory consultee** | A person identified by the PRC as needing to be included in the consultation of all Trust-wide policies (or all Trust-wide policies covering a particular subject). The list of mandatory consultees is contained within the policy template. |
| **Material change** | A change to an existing Trust-wide policy and procedure that fundamentally affects what staff are expected to do under that policy. Examples of material changes include:<br>• changes that have resource implications that cannot be applied in a straightforward manner<br>• changes that may be contentious or require debate<br>• changes that would result in the 'target audience' considering the changed policy as being different to the existing policy. |
| **Non-material change** | A change to an existing Trust-wide policy and procedure that does not fundamentally affect what staff are expected to do under that policy. Non-material changes should not be contentious or require debate. Examples of non-material changes include:<br>• changes to the names of jobs, roles, contact details, committees, clinical areas, locations<br>• corrections to typographical errors, formatting etc.<br>• minor changes to policy-related documentation (such as requests for small amounts of additional information on forms). |
| **Other contributors** | Individuals who are closely involved in the production or review of a policy and procedure but who are not the author. Such persons will be listed on the front cover of each Trust-wide policy and procedure. |
| **Owner** | The most senior employee responsible for the content of a policy and procedure (and for ensuring the policies under their specific areas of responsibility have been developed in accordance with this policy and procedure). Owners must be a member of the Executive Team Meeting. Owners will be allocated policies and procedures according to the areas/subjects within their area of responsibility/portfolio. Advice and clarification can be obtained from the Trust Secretary. |
| **Plan** | Plans can take many forms, but they are usually a description of a series of time-limited steps that will be taken to achieve a particular aim. Such documents are excluded from this policy and procedure. |
| **Policy** | A statement of corporate intent explicitly stating responsibility and accountability, and containing details which relevant Trust employees are expected to adhere to, as part of their terms of employment. Some documents may involve a mixture of 'policy' and 'guidance'. The determination of whether a document should |

| Term | Definition |
|---|---|
| | be considered a 'policy' therefore depends on the extent of that mix i.e. if the substance of the document is mostly concerned with content that employees are expected to adhere to, the document should be regarded as a policy. If the substance of the document is mostly concerned with recommendations of good practice, the document should be regarded as guidance. |
| **Policy database** | The database that holds the master versions of all ratified policies and appendices. The current system used for the database is called "Q-Pulse". |
| **Policy template** | A Word document that describes the format, style and layout that Trust-wide policies and procedures should use. The 'Policy template' is set by the Policy Ratification Committee (PRC) - see Appendix 5. A style guide is provided in Appendix 6. |
| **Policy Ratification Committee (PRC)** | The committee authorised to ratify policies for use in the Trust. PRC members are a pool of committed staff from clinical and non-clinical departments who have responded to invitations to be involved in PRC. PRC members are deliberately not representing their department or area of work, nor are they experts in the subject matter covered by most policies. |
| **Post-consultation check** | A review undertaken by the Corporate Governance Assistant, prior to documents being submitted to the PRC, to determine whether the documents meet the requirements of this policy and procedure, including the latest policy template (see Appendix 5). |
| **Procedure** | A standardised method of performing a task/s. A procedure related to a policy defines the specific course of action relevant employees are expected to follow. |
| **Process** | A series of interconnected activities that transform an input into an output. |
| **Q-Pulse** | The database used to upload Trust-wide policies and procedures (along with other documents). |
| **Ratification** | Final authorisation for use within the Trust. Ratification can only be given by the final committee that considers the document. In the vast majority of cases this would be the PRC, but some policies would be ratified by the Trust Board. Ratification consists of:<br>• checking that the policy and procedure has been subject to an appropriate consultation and approval process<br>• 'sense-checking' the policy and procedure, to assess whether it makes sense, flows well, is internally consistent etc.<br>• checking the policy and procedure complies with the format, style and layout requirements of the latest 'Policy template' and<br>• proof-reading the policy and procedure for errors. |
| **Review** | The process of examining the content of an existing policy, procedure or appendix, to determine whether it is still required and that the information is current, adequate and comprehensible to ensure consistent application by its target audience. |
| **Review date** | The date by which a Trust-wide policy and procedure is required to |

| Term | Definition |
|---|---|
| | be fully reviewed, and, if appropriate, the revised version uploaded. A review date is not however an expiry date, and a policy and procedure does not become automatically unfit for purpose solely because its review date has passed. |
| **Standard operating procedure (SOP)** | A document that provides accurate and detailed instructions on how to perform a defined process or procedure to ensure consistency and standardisation. The purpose is to eliminate variations in processes which need to be completed the same way every time. Policies and procedures may contain SOPs (even if they are not labelled as SOPs), and the decision as to whether an SOP falls under the scope of this policy and procedure depends on whether the SOP is Trust-wide |
| **Strategy** | A document outlining a long-term goal/s (with details of how the goal is intended to be achieved). Such documents are excluded from this policy and procedure. |
| **Trust-wide policy** | A policy that covers the method of working across more than one Division |
| **Uploading** | Placing a document on the Trust-wide database, to enable it to be accessed by Trust staff. |

## 3.0 Duties

| Person/Group | Duties |
|---|---|
| **Trust Board** | • Responsible for ensuring the Trust has a robust approach to ensuring the policies and procedures staff are expected to follow have been: developed with due rigour; take account of appropriate external guidance and internal opinion; are well-written; and meet the needs of staff and the Trust .This responsibility will be met by ratifying this policy (and seeking assurance on compliance, as required).<br>• Responsible for ratifying certain Trust-wide policies (see 5.6.6). |
| **Chief Executive** | Responsible for ensuring there are sufficient resources in place to implement this policy and procedure. |
| **Policy Ratification Committee (PRC)** | • Responsible for ratifying Trust-wide policies and procedures in accordance with this policy and procedure.<br>• Be the arbiter of any decisions relating to the approval or ratification of Trust-wide policies and procedures.<br>• Agreeing the 'Policy template' applicable to Trust-wide policies and procedures. |
| **Trust Management Executive (TME)** | Overseeing the process described in this policy and procedure, via monitoring the work of its sub-committee, the PRC. |
| **Approving committee** | Responsible for ensuring that the content of policies and procedures they approve have been properly considered, that the |

| Person/Group | Duties |
|---|---|
| | content matches the best practice in relation to the subject matter of the policy, and that the policy and procedure is suitable for ratification. |
| **Owner** | • Ensuring the policies and procedures under their specific areas of responsibility have been developed in accordance with this policy and procedure.<br>• Ensuring that an author is appointed to each policy and procedure under their specific areas of responsibility (and re-appointing if an author leaves or moves role). |
| **Author** | Responsible for ensuring their policies and procedures are produced, consulted, approved and ratified in accordance with this policy and procedure. This includes any subsequent revisions. |
| **Trust Secretary** | • Responsible for implementing this policy and procedure.<br>• Chairing the PRC, and ensuring it complies with its Terms of Reference.<br>• Providing advice on the implementation of this policy and procedure. |
| **Assistant Trust Secretary** | • Scheduling of the policies to be reviewed at the PRC.<br>• Ensuring that authors respond to the post-consultation check |
| **Corporate Governance Assistant (CGA)** | • Administering the Trust-wide policy database (Q-Pulse).<br>• Uploading policy documents to the Trust-wide policy database (Q-Pulse).<br>• Issuing reminders to authors in relation to review dates.<br>• Providing advice on the implementation of this policy and procedure.<br>• Undertaking a post-consultation check of policies and procedures<br>• Providing reports to the PRC, as required. |

## 4.0 Training and competency requirements

There are no training or competency requirements at this time. However, advice and guidance is available from the Trust Secretary, Ext. 28698. 'Frequently Asked Questions' (FAQs) (see Appendix 4) and a style guide (see Appendix 6) are also available.

## 5.0 Procedure

Refer to the flow diagram on page 6 for an overview of the standard process. The specific steps required are as follows:

### 5.1 Identifying and confirming the need for a Trust-wide policy and procedure

#### 5.1.1 New policy content

The Trust should only produce, approve, ratify and apply the Trust-wide policies and procedures that are genuinely regarded as being required to enable the Trust to effectively fulfil its functions and duties.

The need for a new Trust-wide policy and procedure may be identified via a number of different sources, such as a requirement from external agencies, incidents, complaints or other events; internal audit reviews; in-house or external assessment etc.

However, before concluding that a completely new policy is required, a search of existing policies and procedures should be undertaken, via Q-Pulse, and consideration should be given as to whether it is feasible to extend the scope of an existing policy and procedure to incorporate the new content.

If it is considered feasible to extend the scope, liaison should occur with the author of the existing policy and procedure, and agreement should be reached as to who the author of the revised/extended policy and procedure should be. That person will be responsible for ensuring the revised/extended policy and procedure complies with this policy and procedure.

If it is not considered feasible to extend the scope of an existing policy and procedure, a new policy and procedure should be proposed to be produced. However, before that document is drafted, the proposed Owner should be identified and approached (by the intended author of the new policy), to obtain their written confirmation that they believe a completely new policy and procedure is required. Email confirmation will suffice.

#### 5.1.2 Existing policies and procedures

The Trust should only produce, approve, ratify and apply the Trust-wide policies and procedures that are genuinely regarded as being required to enable the Trust to effectively fulfil its functions and duties. There should therefore be a regular assessment of whether existing policies and procedures are still required, as it is possible that the rationale for the policy being produced has changed or ended. This assessment can occur at any time, but will be formally required (by authors) six months before the review date of each existing Trust-wide policy and procedure.

If a policy and procedure is assessed as no longer being required, it should be withdrawn from publication and archived (see section 5.11.1).

If a policy is assessed as still being required, it should be reviewed in accordance with section 5.8.

## 5.2 Drafting a new policy and procedure / reviewing and revising an existing policy and procedure

### 5.2.1 New policies and procedures

The author should firstly download the latest 'Policy template' [RWF-OP-DocTemp-Policy1] from the Q-Pulse database. The author should then draft the policy and procedure using the 'Policy template', and follow the guidance therein (including that for format, style, and layout; also see Appendix 6). The Chair of the PRC may defer policies and procedures not using the latest 'Policy template' from being reviewed at the PRC. There may however be exceptions to using the 'Policy template' (see section 5.2.3).

### 5.2.2 Existing policies and procedures

The author should firstly download the latest 'Policy template' [RWF-OP-DocTemp-Policy1] from the Q-Pulse database. The author should then critically review the content of the existing policy and procedure and amend/update as required. The revised policy and procedure will need to adhere to the latest 'Policy template', and should therefore follow the guidance therein (including that for format, style and layout; also see Appendix 6). The Chair of the PRC may defer policies and procedures not using the latest 'Policy template' from being reviewed at the PRC. There may however be exceptions to using the 'Policy template' (see section 5.2.3).

### 5.2.3 Exceptions to using the 'Policy template'

Some policies and procedures may be exempt from adhering to the 'Policy template'. These may be policies that are required or expected to be produced in a specific format or style, for example because they are national, or local, 'model' policies, or because they have been agreed in conjunction with several external agencies.

In such circumstances, prior to drafting a new policy, or revising an existing policy (that has not already been authorised to be exempt from using the 'Policy template'), the author should email the Chair of the PRC requesting an exemption from using the 'Policy template', and explaining the reasons for the exemption. The request will be assessed and if an exemption is considered to be warranted, the author will be authorised to add a sentence to the cover page of the policy and procedure stating that "This policy and procedure has been confirmed to be exempt from strictly adhering to the Trust's 'Policy template'."

However, the policy will still need to include certain elements of the 'Policy template', to enable it to be recognised as a policy of the Trust. These elements are as follows:

- cover page
- 'document history', 'Keywords' and 'Version control'
- 'summary'
- Table of contents
- Appendices 1 to 3.

If the request for an exemption is rejected, the author will need to draft or revise the policy and procedure using the latest 'Policy template'.

#### 5.2.4 Appendices

The decision as to whether a document should be included as an appendix to a policy and procedure, or just be listed as either a 'Cross reference' (if an external document) or 'Associated document' (if an internal document) depends on the author's expectations regarding that document.

If the document is not required or expected to be read by the target audience, and is listed in case they wish to, for example, find out more about the rationale or background to the policy and procedure, this should be listed as a 'Cross reference' or 'Associated document'.

If the document is expected to be read and understood by the policy and procedure's target audience, the document should be included as an appendix.

If an appendix is in a format that is unable to be included as a separate document (such as a web-based form), consideration should be given to having an appendix that shows the original appendix as a 'screen shot', and signposts readers to the location of the appendix (i.e. a website/URL, with a hyperlink if suitable).

If an appendix is produced externally (i.e. published by a body other than the Trust), it may still meet the above criteria for being included as an appendix, although it is accepted that revisions to the document might not be possible. See section 5.10 for further details.

### 5.3 Consultation

Consulting with the key individuals and groups who have an interest in a policy and procedure is important. It enables the content to be reviewed by those who have detailed knowledge of the subject matter, as well as enabling the document/s to be 'sense checked' by those who have not been directly involved in their production.

#### 5.3.1 Scheduling at the Policy Ratification Committee (PRC)

To avoid any delays, once a policy and procedure is ready to be issued for consultation, authors should contact the Assistant Trust Secretary (Ext. 26411) to schedule a date when the document/s can be reviewed at the PRC. The dates of PRC are listed on the Intranet.

#### 5.3.2 Consultation period

The default period for consultation is four weeks. This recognises that those asked to review and comment on a policy and procedure will likely have to accommodate this whilst performing their own duties. This period also takes account of any potential annual (or other) leave such individuals may have.

There may however be occasions when a reduced consultation period is required. This would usually be expected to apply if a policy was required to be produced or revised by a specified deadline (for example for a forthcoming external assessment or inspection). In addition, it is acceptable to apply a reduced consultation period for policies that are reviewed annually, on the basis that staff will have had an opportunity to comment on the document within the past year.

A consultation period should not however be less than two weeks, and the author should ensure, before submitting the policy and procedure for approval, that the approving committee is content to consider approving in the context of a reduced consultation period.

Consultation periods less than two weeks can only be authorised by the Owner for the relevant policy and procedure, and such authorisation should be confirmed in writing to the author. The author should also ensure, before submitting the policy for approval, that the approving committee is content to consider approving in the context of a further reduced consultation period. The aforementioned authorisation will be sought by the PRC when it reviews the policy and procedure, and absence of such authorisation is likely to result in PRC deferring the policy and procedure, to enable a longer period of consultation to occur.

It may also be beneficial to consult in stages, to allow those with a more direct interest in the policy and procedure (and who are more likely to propose amendments that will be accepted) to be consulted first, before issuing the policy and procedure to a larger number of consultees.

Once all consultation feedback has been addressed the policy and appendices should be emailed to the Corporate Governance Assistant for final consultation. Once the final consultation feedback has been agreed the author can proceed with submitting the documents for endorsement or approval.

### 5.3.3 Consultees

Appendix 2 of the 'Policy template' contains the list of persons who have been identified as mandatory consultees. The PRC may change this list, for example, to reflect changes in the Trust's structure, and therefore authors should consult the latest version of the 'Policy template' prior to any consultation.

In addition to the mandatory consultees, authors should include the following within the consultation:

- All members of the approving committee.
- All persons or groups who, by the nature of their role/duties, could reasonably be expected to have a specific interest in the policy. This involves a judgement by the author, but it is an important consideration, as excluding a person or group who has a specific interest is likely to result in PRC deferring the policy for further development, and the author being required to re-consult.
- Authors of other policies which contain an overlap in content, e.g. where a new system or process is introduced by the Trust and described in the policy under development, and is also referred to or described within another policy or policies. Wherever possible, these other policies should adopt the wording of the policy under development, once it has been ratified.

It may also be appropriate to include external parties in a consultation (for example, other NHS Trusts) if the policy and procedure is likely to have a significant effect on that party's practice.

### 5.3.4 Response to consultation

When issuing a policy and procedure for consultation, authors are providing consultees with the opportunity to review, comment, and propose amendments. Consultees are under no obligation to respond to this offer, but if they choose not to do so, any subsequent critique is likely to be dismissed (unless the content identified as unsafe or not fit for purpose – see section 5.11.2).

Authors are expected to give due consideration to any comments or proposed amendments arising from the consultation. However, they are not obliged to make the proposed amendments if they disagree, unless the issues raised are a matter of ensuring that Trust template requirements have been met. Any contentious issues arising from the consultation are expected to be resolved, by the author, before the policy and procedure is submitted for approval.

A record of the consultation should be kept by the author and this should be documented within the relevant mandated appendix (authors should refer to the latest 'Policy template').

## 5.4 Endorsement

Policies and procedures need only be submitted to one committee for approval, but certain policies and procedures may be of interest to more than one committee. If the author or the Chair of that committee regards the committee's interest as sufficiently important, the policy and procedure may be formally submitted to that committee, to obtain the committee's support. This support will be considered to be 'endorsement', and if obtained, should be recorded on the front cover of the policy and procedure. Endorsement can be provided by more than one group/committee, if relevant, but such endorsement should occur before approval is sought.

The version of the policy and procedure submitted for endorsement should be the post-consultation version i.e. the consultation should have ended, and any comments/proposed amendments should have been considered before the document/s are submitted.

It is up to the endorsing committee to determine whether it wishes to receive the full policy and procedure document (plus all appendices) when considering whether the policy and procedure should be endorsed. Certain committees may, for example, only wish to receive a synopsis of the policy, outlining the key content and perhaps any changes made to the previous version. There is no standard format for this synopsis, and this can therefore be set by the endorsing committee.

## 5.5 Approval

Policies and procedures submitted for approval should be the post-consultation version i.e. the consultation should have ended, and any comments/proposed amendments should have been considered before the document/s are submitted.

### 5.5.1 Approving committee

The approving committee should be a formal Trust-wide committee of the Trust (i.e. where the membership is not limited to staff from one Division), and should be the committee with the most relevant role in relation to the content of the policy and procedure.

For most policies, the approving committee should be obvious, but if authors are uncertain, advice can be sought from the Chair of the PRC. The precedent set by previous, similar, policies may also be useful. The following list should be considered as a guide only, for illustrative purposes.

| Type of policy | Approving Committee |
|---|---|
| Human resources | The Joint Consultative Forum |
| Clinical operational | Clinical Operations and Delivery Committee |
| Information governance | Information Governance Committee |
| Health and safety, fire, Estates and Facilities | Health & Safety Committee |
| Infection prevention and control | Infection Prevention and Control Committee |
| Policies which:<br>• Set the overall framework of major clinical or corporate governance matters (e.g. Risk Management Policy and Procedure, Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures etc.).<br>• Have significant implications in relation to widespread changes of practice among staff.<br>• Have significant resource implications.<br>• Are likely to be contentious. | Executive Team Meeting |
| General clinical policies (for which there is no specific Trust-wide forum) | Clinical Operations and Delivery Committee |
| Medicines-related policies | The Drugs, Therapeutics and Medicines Management Committee |

The list of Trust-wide committees can be obtained from viewing the Trust Committee Structure chart.

#### 5.5.2 Approval by a Trust Board sub-committee

In accordance with the principles listed in section 1.0, policies would not ordinarily be expected to be approved at a Trust Board sub-committee. However, any Trust Board sub-committee may undertake the role of an approving committee if the Trust Board or sub-committee formally confirms that it wishes to undertake this role.

#### 5.5.3 The documents to be considered for approval

The policy document and any appendices that are primarily linked to that policy must be reviewed in full by the approving committee, as part of the formal agenda and reports for the meeting.

This is because in approving a document, the approving committee is officially agreeing that any resource implications associated with implementation of the policy have been properly considered, and that the content of a policy and procedure:

- meets applicable national and regional standards
- meets the standards of this policy
- is suitable to be submitted for ratification.

By not considering the documents in full, the approving committee therefore risks approving documents that are not well-written and contain (for example) consistency errors.

#### 5.5.4 Documenting approval

Approval should be documented in the minutes of the approving committee meeting at which the policy and procedure was considered.

#### 5.5.5 Approval of sub-standard documents

If the PRC considers that an approving committee is repeatedly approving policies and procedures that are sub-standard, i.e. that are poorly-written, not complying with this policy and procedure, or not adhering to the 'Policy template', the Chair of PRC will contact the Chair of the approving committee to make this known, and request that the approving committee consider whether the processes it applies when approving policies and procedures is sufficiently robust to enable the approving committee to fulfil its duties under this policy and procedure.

### 5.6 Ratification

Ratification is the authorisation for the use of a policy and procedure within the Trust. Ratification can only be given by the final committee that considers the document. In the vast majority of cases this would be the PRC, but some policies would be ratified by the Trust Board (see section 5.6.5).

#### 5.6.1 The documents to be considered for ratification

The documents submitted to PRC should include:

- The full version of the main policy and procedure document.
- The full version of any further appendices that have that policy and procedure as their primary policy (see section 5.10).

#### 5.6.2 The ratification process

Before a policy and procedure can be reviewed at PRC, the author should liaise with the Assistant Trust Secretary and complete a PRC pre-submission checklist, to confirm that all necessary steps have been taken.

Policies and procedures are reviewed in detail at the PRC, and therefore someone who is familiar with the content needs to attend PRC when their policy and procedure is being reviewed, to respond to any queries/proposed amendments. This is expected to be the author, but if they are unavailable, they may send a representative who is able to speak on their behalf.

Ratification consists of the following aspects:

- Checking that the policy and procedure has been subject to an appropriate consultation and approval process.
- 'Sense-checking' the policy and procedure, to assess whether it makes sense, flows well, is internally consistent etc.
- Checking the policy and procedure complies with the format, style and layout requirements of the latest 'Policy template' (or that an exemption has been obtained in the correct manner – see section 5.2.3).
- Proof-reading the policy and procedure for errors.

The PRC may propose amendments to the policy and procedure. Authors are expected to consider proposed amendments, but are not obliged to accept them. Any objections should be raised by the author at the PRC meeting and debated, to enable a conclusion to be reached. However, if the PRC believes that the amendment is essential to ensuring that the policy and procedure is fit for purpose, it may insist that such amendments are made before the policy and procedure is ratified. This position should be made clear within the PRC meeting. Any disputes will be considered according to the principles within section 5.6.5.

### 5.6.3 Outcome of the ratification process

At the end of the review by the PRC, the policy and procedure will either be ratified (as submitted, or subject to changes) or deferred for further development. This latter option will be chosen if the PRC believes that the policy and procedure is not fit for purpose or is not substantially compliant with this policy and procedure.

If ratified, the author will be asked to make any changes that have been agreed, and submit the final version of the policy and procedure (including any further appendices) to the Chair of the PRC. All amendments must be made within three months of the date of review by the PRC, or the policy and procedure would require re-submission to PRC. Discretion may however be applied by the Chair of the PRC, to take account of any extenuating circumstances for missing this three month deadline.

If authors have chosen not to make certain changes proposed by PRC, this should be explained. The Chair of the PRC, or the Chair's nominated representatives, will then check that the requested changes have been made, or whether the rationale for not making any changes had been provided (and is credible), and if this is the case, will confirm the documents can be uploaded (at which point the Corporate Governance Assistant will be asked to upload them to the policy database).

If the Chair of the PRC concludes, after checking, that the changes requested by PRC have not been made, and a rationale for this has not been provided, the author will be notified, asked to make the changes requested by PRC, and submit to the Chair of the PRC again, for checking.

The Chair, or the Chair's nominated representatives, will then check that the requested changes have been made, and if this is the case, will confirm the documents can be uploaded (at which point the Corporate Governance Assistant will be asked to upload them to the policy database).

If the policy and procedure is deferred for further development, the author will need to amend the document/s to reflect PRC's comments, and then follow the processes described earlier for consultation, approval and ratification.

Any disputes will be considered according to the principles within section 5.6.5.

**5.6.4 Documenting the ratification decision**

The ratification decision should be documented in the minutes of the PRC meeting at which the policy and procedure was considered.

**5.6.5 Resolution of disputes**

If an author fundamentally disagrees with an amendment proposed by the PRC, PRC will determine, by a majority verdict, whether it regards the amendment as essential to ensuring that the policy and procedure is fit for purpose. If this is confirmed, the author will be invited to reconsider their position. If the author maintains their position, the policy and procedure will be unable to be ratified at that PRC meeting, and should therefore be deferred, pending further discussion.

The author should then discuss the proposed amendment with the Owner for the policy and procedure. The Chair of the PRC should also provide the Owner with the rationale for the PRC's view. The Owner should be asked to confirm whether they support the author's view or the view of the PRC. The Owner's decision will then be followed (and the policy and procedure re-scheduled for a PRC meeting, to enable formal ratification, reflecting the decision made), unless the Chair of the PRC feels that a further discussion, with the Chief Executive, is required. In this case, the Chair of the PRC will arrange for a meeting between the Chief Executive, the Owner and themselves, to consider the matter. The decision of the Chief Executive will be final. The policy and procedure should then be re-scheduled for a PRC meeting, to enable formal ratification, reflecting the Chief Executive's decision.

**5.6.6 Policies ratified by the Trust Board**

Certain policies may be required or desired to be ratified by the Trust Board, because of an external requirement to do so, or because the Owner or approving committee regards the policy as important enough to warrant this.

It would be inappropriate for PRC to consider such policies after the Trust Board (as the most senior forum in the Trust) had ratified them. Such policies and procedures would therefore be expected to be ratified at the Trust Board having first been reviewed and 'Recommended for ratification' by the PRC. Such policies and procedures would still be required to be approved by the appropriate committee.

### 5.7 Publication

Trust-wide policies and procedure will be uploaded to the Trust's policy database, which is accessible via the Trust's Intranet, to ensure that they are available to all relevant staff.

Staff will be notified of any newly-uploaded policies and procedure via the 'Policy & guideline updates' page on the Intranet.

Hard copy versions of Trust-wide policies and procedures should not be circulated, as there can be no guarantee that the hard copy is the latest version to be uploaded.

The Trust does not currently publish its Trust-wide policies and procedures on its public website. However, in the interests of openness and accountability, staff are permitted to share uploaded versions of Trust-wide policies and procedures with any external party, including patients and staff from other Trusts.

### 5.8 Review of policies

#### 5.8.1 Review dates

All Trust-wide policies and procedures will be ratified for four years, unless a shorter period (one, two, or three years) is required by an external agency, the author, or the approving committee.

Policies should be reviewed and revised (as required) before their review date is exceeded. To ensure this, the Corporate Governance Assistant will issue reminder emails to authors at the following points:

a. Six months before the review date. The email will first ask for confirmation as to whether the policy is still needed. If the policy and procedure is still required, the email will remind the author of the steps involved in reviewing, approving and ratifying the document/s, and request that the process commences. If the policy and procedure is no longer required, the process described in section 5.11.1 should be followed.

b. Three months before the review date. This email is only required if the reply to the six month prompt (see step 1. above) confirms the policy and procedure is still required. The email should again remind the author of the steps involved in reviewing, approving and ratifying the document/s, and request that the process commence if this is not already the case. The email will also state that if the author does not believe that the process will be completed by the review date, the approving committee should be asked to request a short extension to the review date. This extension can be for a maximum of six months, to allow the policy and procedure to be reviewed, consulted, approved and ratified.

This request can be made via email, or via formal discussion at one of the committee's meetings. The email or minutes of the relevant meeting will therefore need to be provided to the Corporate Governance Assistant. The email will also state that if there is no clear plan to enable the revised policy to be uploaded by any extended review date, the policy and procedure may be withdrawn from publication when that review date is reached.
The author will therefore be asked to reply to the email, confirming their intended course of action.

c. At the review date. This email is only likely to be required if there has been no clear indication of a plan for reviewing the policy and procedure. The email will state that the policy and procedure will be withdrawn from publication two weeks from the date of the email. The author will therefore be asked to reply to the email as soon as possible confirming their intended course of action. If the author does not want the policy to be withdrawn, the approving committee will need to request a short extension to the review date. This extension can be for a maximum of six months, to allow the policy and procedure to be reviewed, consulted, approved and ratified. This request can be done via email, or via formal discussion at one of the Committee's meetings. The email or minutes of the relevant meeting will therefore need to be provided to the Corporate Governance Assistant. The email will also state that, at the end of the extension, if there is still no clear plan to enable the revised policy and procedure to be uploaded this will be drawn to the attention of the Approving Committee and the Owner, who will also be advised that policy and procedure will be withdrawn from publication when the extended review date is reached. See section 5.11.3.

### 5.8.2 Mandatory detailed reviews

Each Trust-wide policy and procedure should be subject to a detailed review, consultation, approval and ratification at least once every four years. The full process should be applied even if the author believes that the existing policy and procedure requires no or few changes. The application of this periodic detailed review will ensure that the author's view is subject to appropriate challenge (thereby protecting the Trust against over-reliance on an individual's views) and validated.

### 5.8.3 Light-touch reviews

For Trust-wide policies and procedure that have been allocated a review date of one, two or three years, if the author reviews the document and confirms (in writing, to the Chair of the PRC) that no material changes are required, the review date can be extended to the next period (i.e. another one or two years) without the document/s requiring to be re-approved or re-ratified.

For policies with a one-year review date, this process can occur up to three times (i.e. at year one, year two, and year three). At year four, a mandatory detailed review (see section 5.8.2) would be required.

For policies with a two and three year review date, this process can only occur once (i.e. at years two and three respectively). At year four, a mandatory detailed review (see section 5.8.2) would be required.

## 5.9 Changes to existing policies and procedures

### 5.9.1 Non-material changes

Non-material changes to existing policies and procedures can be made any time these are identified as being needed. Ordinarily, the author would be expected to identify the need for such changes, but there may be occasions when others identify this need (in which case this should be brought to attention of the author).

If the need for non-material changes is identified, the author should email the Chair of the PRC giving details of the change/s required. If the Chair of the PRC agrees that the change is non-material, they will email the Corporate Governance Assistant to formally request that the change be made. The author will then be authorised to make the change/s, update the 'Version control' table, and email this to the Corporate Governance Assistant who will then check, and upload the updated document/s.

Requests for amendments from individuals who are not the named author will not be accepted unless the author or the Owner has confirmed the amendment can be made, in writing (via an email to the Corporate Governance Assistant).

### 5.9.2 Material changes

Material changes to policies and procedures can only be made with the approval of the relevant Approving Committee. In such circumstances, the author should arrange for the Approving Committee to consider, and approve, the proposed changes, and if approval is granted, confirmation should be provided, in writing, to the Chair of the PRC.

All material changes to policies and procedures are then required to be re-ratified at PRC (but the PRC will only be required to ratify the sections of the policy and procedure that have changed).

### 5.9.3 Changes as a result of ratified content in a newer policy or appendix

Changes to an existing policy or appendix that result from newer ratified content in another policy or appendix do not require further approval or ratification. The author of the existing policy or appendix should make the required changes, adopting the newer ratified wording wherever possible, and email this to the Corporate Governance Assistant who will then check, and upload the updated document/s.

## 5.10 Policy appendices

All appendices to policies and procedures should be numbered sequentially, and must be referred to within the body of the policy and procedure, including appropriate text. Appendices 1 to 3 are standard and should be incorporated within the main policy document. All subsequent appendices should be listed within the policy document (in accordance with the latest 'Policy template'), but should be uploaded as separate documents.

Whether the relevant content of a policy and procedure should be incorporated within the main policy document or treated as an appendix will depend on the nature of the policy and procedure, and it is therefore acknowledged that a 'one size fits all' approach is not appropriate. The author should however adopt the approach they believe would result in the best understanding by the target audience, and result in the best 'flow' of the main policy document. The PRC may override the views of the author or approving committee if the PRC feels that the understanding of the target audience would be impaired by the submitted approach.

Each separate appendix document can be an appendix to more than one policy and procedure. However, each appendix should be primarily linked to only one policy and procedure. This primary policy and procedure should be identified in the list of "Further appendices" that appears at the end of each main policy document.

Appendices are to be treated in the same way as the primary policy and procedure to which they are linked, i.e. such appendices should be reviewed, revised, consulted on, approved, and ratified at the same time as their primary policy and procedure. The same process for applying changes (as stated in section 5.9) also applies to appendices.

Appendices are not required to conform to specific template requirements, but must be in Arial font and must include the following:

1. The Trust logo in the header
2. The Trust footer (i.e. that used for main policy and procedure documents)
3. The Trust disclaimer (i.e. that used for main policy and procedure documents)

Appendices that are linked to policies and procedures being reviewed and revised, but which are not the appendices' primary policy and procedure, are not required to be included in that review process. Such appendices are therefore not required to be submitted for review by the PRC when the policy and procedure is considered for ratification.

If an appendix is an externally-produced document (i.e. published by a body other than the Trust), its place within the policy and procedure should be approved, and ratified, although it is accepted that revisions to the document might not be possible. In such circumstances, authors would be expected to relay any identified errors to the body who publishes the document, but it is accepted that the Trust may not be able to influence the correction of such errors.

## 5.11 Withdrawing Trust-wide policies and procedures from use

### 5.11.1 Policies no longer required

If an existing policy and procedure is no longer considered to be required, it can be archived. For this to happen, the Chair of the approving committee for the current policy and procedure will need to confirm that the document/s is no longer required. This can be done via email (from the Chair to the author, Chair of the PRC and Corporate Governance Assistant), or via formal discussion at one of the committee's meetings. If the latter route is chosen, the minutes of the

relevant meeting will need to be provided to the Chair of the PRC or Corporate Governance Assistant.

On receipt of the confirmation, the Corporate Governance Assistant will archive the policy and procedure.

If the approving committee no longer exists, the most appropriate alternative committee should be asked to provide the relevant confirmation, via either of the methods listed above. If there is no appropriate alternative committee, the Owner for the current policy should be asked to provide the relevant confirmation, via email (to the Chair of the PRC and Corporate Governance Assistant).

**5.11.2 Policies identified as unsafe or not fit for purpose**

If an existing, uploaded, policy and procedure is identified by any member of Trust staff (including the policy author) as being unsafe or not fit for purpose, that member of staff should email the Chair of the PRC as soon as possible, explaining the rationale. The Chair of the PRC will consider the matter as soon as possible (which may involve liaison with the author) and if there is felt to be any credence to the claim, will ask the Corporate Governance Assistant to withdraw the policy and procedure from the Policy database.

The Chair of the PRC will then ask the author to liaise with the person raising the concerns and change the policy and procedure to address such concerns (or just change the policy if it was the author that made the request). The process described in section 5.9 should then be followed.

When a policy and procedure is withdrawn in such circumstances, it should be replaced (on the Policy database) with a notice explaining that the policy has been withdrawn for a temporary period, and advising staff which staff member or department they can contact for advice until the policy and procedure is amended and re-uploaded.

**5.11.3 Policies with no clear intention to be reviewed**

As noted in section 5.8.1, a policy and procedure may be withdrawn from publication when its review date is reached, and there has been no clear indication of a plan for reviewing the policy and procedure. Such circumstances are exceptional, and the author and Owner for the policy and procedure should do all they could to prevent it being withdrawn. However, if the Chair of the PRC does not receive satisfactory assurances, they will notify the author, Owner and Chair of the Approving Committee of the intention to withdraw the policy and procedure. If the Chair of the PRC still receives no satisfactory response after two weeks they will ask the Corporate Governance Assistant to withdraw and archive the policy and procedure. In such circumstances, the author, Owner and Chair of the Approving Committee will be notified by the Chair of the PRC that the policy has been withdrawn.

**5.11.4 Documents that no longer wish to be regarded as Trust-wide policies**

There may be occasions when a document that has previously been considered to be a Trust-wide policy and procedure is still required, but which is no longer considered appropriate to be regarded as such. This

may be because of changes to the emphasis of the document, or the way the document is perceived. It may also be related to the fact that the document is, or acts like, an operational plan. The key consideration should be whether the content of the document/s is sufficiently different from the definition of a 'Trust-wide policy' to warrant it being excluded from the policy ratification process.

In such circumstances, the Owner for the document should confirm (to the Chair of the approving Committee) that they are content for the document to be removed from being regarded as a Trust-wide policy. The approving committee should then be asked to formally approve the proposal. It should be made clear to both that if the proposal proceeded, the document could, if desired, remain uploaded to the Trust-wide policy database (Q-Pulse), but it would no longer be subject to the monitoring process applied to Trust-wide policies. In this regard, the author would not be reminded of the document review date, or pursued to ensure this review occurs. The document would also not be obliged to adhere to the Trust's 'Policy template'. If the approval is granted, the Chair of the Approving Committee should arrange for the Corporate Governance Assistant to be notified, to enable the document/s to be removed from the Trust-wide policy database.

If the author or Owner wants the document/s to remain uploaded to the Trust-wide policy database, this is possible, but the author should ensure that the documents are not also uploaded to other locations (such as the Intranet or shared folders that can be accessed by the target audience). This will avoid the risk of alternative versions of the document/s being accessed. The format of the document/s must also be amended, so that it could not be reasonably perceived by readers to be a Trust-wide policy. If the author wishes to promote the awareness of the document/s by making reference to these on, for example, a dedicated Intranet page, the page should just contain hyperlinks to the document/s that are uploaded to the Trust-wide policy database.

#### 5.11.4.1 Trust-wide policies that are requested to become guidelines

If the Owner of a Trust-wide policy wants the document to become a guideline, and the Approving Committee approves the proposal for the document to no longer be a Trust-wide policy, the document must either complete the guideline approval and ratification process (which is overseen by the Deputy Director of Quality Governance), or complete the process to become a guideline as an appendix to an appropriate policy (see sections 5.9 and 5.10 of this policy).

### 5.12 Authors leaving the Trust

If an author leaves the Trust, the responsibility for the policies and procedures they authored will be transferred to their successor. A list of policies and procedures under the original author's name can be generated, to share with the new appointee, by the Corporate Governance Assistant, on request. Please note that the Corporate Governance Assistant cannot update the Trust policies database to reflect the new author's name unless they are informed of the new appointment.

Where no successor is appointed, or where there is a gap between an individual leaving and their successor starting in post, responsibility will transfer to the original author's line manager. In the event of a dispute, the Owner will appoint an author.

**5.13 Policies without procedures**

Some Trust-wide documents consist of policy but no accompanying procedures. Such documents should not therefore include "procedures" in their title. The format of the document should also be amended to remove any references to 'procedures'. Although this would technically constitute an exception to the 'Policy template' (see section 5.2.3) (which assumes that there would be 'procedures', and includes a section for this), the front cover of such policies is not required to state that "This policy and procedure has been confirmed to be exempt from strictly adhering to the Trust's 'Policy template'."

**5.14 Exceptions to this policy and procedure**

This policy and procedure aims to cover all circumstances relating to the production, consultation, approval and ratification of Trust-wide policies and procedures. It is however recognised that there may be some circumstances that warrant exceptional arrangements. In the event of such circumstances arising, which necessitate a request to deviate from this policy and procedure, such requests should be made, in writing, to the Chair of the PRC for their consideration, and potential authorisation. The Chair of PRC should take into account the circumstances, and make a judgement in the best interests of the Trust. Any authorised exceptions should be reported to the next available meeting of the PRC, and then reported to the next meeting of the TME.

**APPENDIX 1**

## Process requirements

### 1.0 Implementation and awareness

- Once ratified the Policy Ratification Committee (PRC) Chair will email this policy and procedure to the Corporate Governance Assistant (CGA) who will upload it to the Trust approved document management database on the intranet, under 'Policies & guidelines'.
- A monthly publications table is produced by the CGA which is uploaded on the Trust intranet under 'Policies & guidelines'; notification of the posting is included on the intranet 'News Feed' and in the Chief Executive's newsletter.
- On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.
- This policy and procedure will also be subject to an all-users email, to draw attention to the documents and ensure the expectations are made clear to the target audience.

### 2.0 Monitoring compliance with this document

- A summary report of the output from each Policy Ratification Committee (PRC) will be submitted to the TME at the earliest opportunity.
- The PRC will receive regular reports on the review status of each Trust-wide policy and procedure, and agree any action to be taken (including escalating issues to the relevant Owner or TME).

### 3.0 Review

This policy and procedure and all its appendices will be reviewed at a minimum of once every four years, following the procedure set out in this policy [RWF-OPPPCS-NC-CG25].

If, before the document reaches its review date, changes in legislation or practice occur which require material changes to be made, a full review, approval and ratification must be undertaken. Refer to the content of this policy for further details.

If non-material changes are required to the policy and procedure between reviews these do not require consultation and further approval and ratification. Refer to the content of this policy for further details.

### 4.0 Archiving

The Trust approved document management database on the intranet, under 'Policies & guidelines', retains all superseded files in an archive directory in order to maintain document history.

**APPENDIX 2**

**CONSULTATION ON:** Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ("Policy for Policies")

**Consultation process** – Use this form to ensure your consultation has been adequate for the purpose.

**Please return comments to:** Trust Secretary

**By date:** 17th January 2020

| Job title: | Date sent dd/mm/yy | Date reply received | Modification suggested? Y/N | Modification made? Y/N |
|---|---|---|---|---|
| **The following staff must be included in all consultations:** | | | | |
| Corporate Governance Assistant | 20/12/19 | 28/01/20 | Y | Y |
| Counter Fraud Specialist Manager (tiaa) | 20/12/19 | | | |
| Head of Fire, Safety and Environment | 20/12/19 | | | |
| Chief Pharmacist and Formulary Pharmacist | 20/12/19 | | | |
| Staff-Side Chair | 20/12/19 | | | |
| Complaints & PALS Manager | 20/12/19 | | | |
| Emergency Planning Team | 20/12/19 | | | |
| Head of Staff Engagement and Equality | 20/12/19 | 30/12/19 | Y | Y |
| Health Records Manager | 20/12/19 | | | |
| All individuals listed on the front page | 20/12/19 | | | |
| All members of the approving committee (the Executive Team Meeting). | 20/12/19 | | | |
| **Other individuals the author believes should be consulted** | | | | |
| Divisional Directors of Nursing & Quality | 20/12/19 | | | |
| Divisional Directors of Operations | 20/12/19 | | | |
| Clinical Directors | 20/12/19 | | | |
| Chief Internal Auditor | 20/12/19 | 14/01/20 | Y | Y |
| Chief Finance Officer | 20/12/19 | | | |
| Chair of the Trust Board | 20/12/19 | | | |
| Non-Executive Directors | 20/12/19 | | | |
| Associate Non-Executive Directors | 20/12/19 | | | |
| Risk and Compliance Manager | 20/12/19 | 03/01/20 | Y | Y |
| Head of Information Governance | 20/12/19 | | | |
| Deputy Director of Quality Governance | 20/12/19 | | | |
| Head of R&D | 20/12/19 | | | |
| Clinical Lead for Research | 20/12/19 | | | |
| Deputy Director of Finance | 20/12/19 | | | |

| Job title: | Date sent dd/mm/yy | Date reply received | Modification suggested? Y/N | Modification made? Y/N |
|---|---|---|---|---|
| (Financial Governance) | | | | |
| Deputy Director of Finance (Financial Performance) | 20/12/19 | | | |
| Deputy Medical Director | 20/12/19 | | | |
| Director of IT | 20/12/19 | | | |
| Director of Estates and Facilities | 20/12/19 | | | |
| Head of Employee Relations | 20/12/19 | | | |
| HR Business Partners | 20/12/19 | | | |
| Head of Fire, Safety & Environment | 20/12/19 | | | |
| Head of Financial Services | 20/12/19 | 20/01/20 | Y | Y |
| Assistant Director of Business Intelligence | 20/12/19 | | | |
| Associate Director of Procurement | 20/12/19 | | | |
| Deputy Chief Nurses | 20/12/19 | | | |
| Director of Medical Physics | 20/12/19 | | | |
| Director of Infection Prevention and Control (DIPC) | 20/12/19 | | | |
| Nurse Consultant for Infection Prevention | 20/12/19 | | | |
| Transformation Programme Director | 20/12/19 | | | |
| Director of Medical Education | 20/12/19 | | | |
| E.M.E. & Technical Services Manager | 20/12/19 | | | |
| Head of Delivery Development | 20/12/19 | | | |
| Heads of Performance & Delivery | 20/12/19 | | | |
| Legal Services Manager | 20/12/19 | | | |
| Trust Lawyer | 20/12/19 | | | |
| General Managers | 20/12/19 | | | |
| Chief Clinical Information Officer | 20/12/19 | | | |
| Trust Lead Cancer Clinician | 20/12/19 | | | |
| Freedom to Speak Up Guardian | 20/12/19 | | | |
| The following staff have given consent for their names to be included in this policy and its appendices:<br>Ruth Dickens, David Kenealy, Mark Vince, Mildred Johnson, Amanda LePage, Jo Garrity, Louise Dunkley, Angela Savage, Kevin Rowan, Daryl Judges | | | | |

**APPENDIX 3**

**Equality impact assessment**

This policy includes everyone protected by the Equality Act 2010. People who share protected characteristics will not receive less favourable treatment on the grounds of their age, disability, gender, gender identity, marital or civil partnership status, maternity or pregnancy status, race, religion or sexual orientation. The completion of the following table is therefore mandatory and should be undertaken as part of the policy development and approval process. **Please note that completion is mandatory for all policy and procedure development exercises.**

| | |
|---|---|
| **Title of policy or practice** | Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ("Policy for Policies") |
| **What are the aims of the policy or practice?** | To ensure the policies and procedures Trust staff are expected to follow have been: developed with due rigour; take account of appropriate external guidance and internal opinion; are well-written; and meet the needs of staff and the organisation |
| **Is there any evidence that some groups are affected differently and what is/are the evidence sources?** | No |
| **Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.** | **Is there an adverse impact or potential discrimination (yes/no).** No<br>If yes give details. |
| Gender identity | No |
| People of different ages | No |
| People of different ethnic groups | No |
| People of different religions and beliefs | No |
| People who do not speak English as a first language (but excluding Trust staff) | No |
| People who have a physical or mental disability or care for people with disabilities | No |
| Pregnant women and individuals on maternity leave | No |
| Sexual orientation (LGB) | No |
| Marriage and civil partnership | No |
| Gender reassignment | No |
| **If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?** | N/A |
| **When will you monitor and review your EqIA?** | Alongside this document when it is reviewed. |
| **Where do you plan to publish the results of your Equality Impact Assessment?** | As Appendix 3 of this document. |

## FURTHER APPENDICES

The following appendices are uploaded as related links to the main policy/procedure on the Trust Policy database on the intranet, under 'Policies & guidelines':

| No. | Title | Unique ID | Title and unique id of policy that the appendix is primarily linked to |
|---|---|---|---|
| 4 | Policy ratification - frequently asked questions (FAQs) | RWF-COR-COR-APP-1 | This policy |
| 5 | Policy template | RWF-OP-DocTemp-Policy1 | This policy |
| 6 | Style guide for Trust-wide policies and procedures | To be added after ratification | This policy |

NHS
Maidstone and Tunbridge Wells NHS Trust

## Policy Ratification - Frequently Asked Questions (FAQs)

**Q: What is a policy?**
A: A policy is a statement of corporate intent that contains details which relevant Trust employees are expected to adhere to, as part of their terms of employment.

**Q: What is a procedure?**
A: A procedure is a standardised method of performing a task/s. A procedure related to a policy defines the specific course of action employees are expected to follow.

**Q: What is the Policy Ratification Committee (PRC)?**
A: The Policy Ratification Committee (PRC) is a committee which has been given the authority (by the Trust Board) to ratify all Trust-wide policies ('ratifying' a policy means giving final authorisation for the policy to be used within the Trust)

**Q: What documents are considered at the PRC?**
A: The PRC considers Trust-wide policies and any associated documents. Such associated documents would include the procedure related to the policy (these are usually included within a single 'policy and procedure' document; and any appendices).

**Q: What is a 'Trust-wide' policy?**
A: A policy that covers the method of working across more than one Division. If a policy is solely concerned with the working within a single Division, and does not have implications beyond that Division, it would not be considered to be 'Trust-wide'.

**Q: Are clinical guidance documents considered at the PRC?**
A: No. Clinical guidance documents (i.e. any document designed to guide clinical practice; this includes clinical guidelines, integrated care pathways, clinical protocols, resource manuals etc.) are excluded from the revised process. Details of the process for ratifying clinical guidance documents can be found on the 'Policies & guidelines' page of the Intranet. The Deputy Director for Quality Governance can also be contacted for advice.

**Q: Are all Trust-wide policies required to be submitted to the PRC for ratification?**
A: Yes. Other committees can 'approve' policies, but only the PRC can 'ratify' Trust-wide policies (apart from a few exceptions, which are ratified by the Trust Board). Ratification is required for a policy to be published on the Policy database (Q-Pulse).

**Q: What is the difference between 'approval' and 'ratification'?**
A: Approval is official agreement by an appropriate committee that any resource implications associated with implementation of the policy have been properly considered, and that the content of a policy and procedure meets applicable national and regional standards; meets the standards of the 'Policy for policies' and is suitable to be submitted for ratification. Ratification is final authorisation for use within the Trust.

**Q: Do authors need to attend PRC?**
A: Yes. Policies are reviewed in detail at PRC, and therefore someone who is familiar with the content of the policy needs to attend to respond to any queries / proposed amendments.

**Q: Who are the members of PRC?**
A: PRC members are a pool of committed staff from clinical and non-clinical departments who have responded to invitations to be involved in PRC. PRC members are deliberately not representing their department or area of work, nor are they experts in the subject matter covered by most policies, but they do have an enquiring mind, a keen eye for detail, 'common sense', and a desire to improve the quality of the Trust's processes.

**Q: How often does the PRC meet?**
A: PRC meetings are held monthly, and the dates are publicised via the Intranet (see http://mtwintranet/policies/). If there is a need to ratify a policy in between scheduled meeting dates, extraordinary meetings can be scheduled, at the discretion of the Chair of PRC.

**Q: Where does PRC meet?**
A: All PRC meetings are held at Maidstone Hospital.

**Q: Which committee oversees the work of the PRC?**
A: The PRC is a sub-committee of the Trust Management Executive (TME), which is chaired by the Chief Executive. A summary report of the outcome of each PRC meeting is received at each meeting of the TME.

**Q: What process needs to be followed before a policy is ratified?**
A: Refer to the flowchart within the main body of the policy and procedure for the production, approval and ratification of Trust-wide Policies and procedures.

**Q: What is 'approval'?**
A: Approval is official agreement by an appropriate committee that the content of a policy meets the required standards, is fit for purpose, and is suitable to be submitted for ratification.

**Q: What is 'endorsement'?**
A: Endorsement is provision of support to a policy (and thereby acknowledgement that the content is fit for purpose and ready for approval), by a group/committee, prior to its approval. Endorsement can be provided by more than one group/committee, if relevant.

**Q: My policy has been approved. How do I get to the PRC?**
A: Email the Assistant Trust Secretary (Daryl Judges, daryl.judges1@nhs.net), who will allocate you a slot on one of the future meetings. It is preferable to make contact during the consultation process, rather than wait until your policy has been approved, to avoid any delays.

**Q: Is a policy that has been approved guaranteed to be reviewed at the next available PRC meeting?**
A: Every effort will be made to add approved policies to the agenda of the next PRC meeting. However, there is a limit to the number of policies that can be reviewed in a meeting (though as noted above, it is possible to hold extraordinary meetings). Therefore early notice of the timing of a policy review should be given to the Assistant Trust Secretary, to enable policies to be scheduled in timely manner. If a policy is not able to be reviewed at the next PRC meeting, the Assistant Trust Secretary will discuss this with the policy author.

**Q: I'm presenting a policy for review at PRC. What can I expect at the meeting?**
A: The steps involved are as follows:

- Each review takes approximately.30 minutes. You will be allocated a time slot for you to attend the meeting (these times are estimated, so you may have to wait a short time).
- Policies and procedures are reference documents to support staff who are not experts in the subject matter. They therefore need to be well-written, and make sense to the most junior member of staff to whom the policy applies. PRC members will have read the document before the PRC meeting, and will have a number of comments/proposed amendments.

- When your slot is reached, you may be asked to give an introduction to the policy, for example to explain its 'journey' to PRC (including the changes made since the previous version, the reason why the policy is required (if it is a new policy) etc.
- The policy will then be reviewed in the meeting in detail, page by page. Comments will range from typographical errors (which you will just be expected to correct) to more significant matters. Minor corrections will not be discussed in the meeting, but issues that may be discussed include:
  - Whether the requirements of the latest 'Policy template' have been met
  - Whether the content reads well, and makes sense (or whether it should be worded differently)
  - Whether any flowcharts in the document 'flow' well, and are clear to understand (particularly in relation to choices to be made by staff)
  - Whether consistent language/terminology is used throughout the document
  - Whether certain content conflicts with other content in the same policy
  - Whether all the external cross references listed are truly relevant
  - Whether all 'Associated documents' have been listed
  - Whether all the appropriate personnel have been included in the policy consultation
  - Whether the document has been correctly approved
  - Whether the 'Owner' is appropriate

**Q: What if I disagree with an amendment proposed at PRC?**

A: The vast majority of amendments proposed at PRC will be non-contentious. However, if you feel strongly that a proposed amendment is without merit, the point can be debated at PRC, and a consensus will be reached. If a proposed amendment represents a lone opinion of a PRC member, the point will be considered in this context, and a decision will be made on the merits of the point. If a point remains in dispute, the policy and procedure contains a dispute resolution process, which will be applied.

**Q: What are the common themes arising from the policies that PRC has reviewed?**

A: Some of the commonly-made issues that arise when PRC reviews policies are as follows:

- Consultations may not have included all of the mandatory consultees.
- The responsibility for carrying out key tasks is not clear.
- The duties of key staff involved in implementing the policy may be omitted.
- Flowcharts may not flow properly (e.g. there may be multiple exit points from a box without a clear indication of which route to follow; there may be important steps missing).
- There is poor grammar (e.g. misuse of apostrophes, spelling errors).
- The legal name of the Trust ('Maidstone and Tunbridge Wells NHS Trust') is often mis-represented as 'Maidstone & Tunbridge Wells NHS Trust'. Any '&' in the Trust's name should therefore be amended to 'and'
- Abbreviations and/or acronyms are not spelt out in full at the point of first use
- A four-year review is acceptable (rather than annual or two-year).
- Paragraph and/or page numbering is incorrect.
- Key terms and/or abbreviations are not included in the 'Definitions/glossary' section.
- Tables that span more than one page often do not have the 'Repeat Header Rows' option selected (which means the title of each column may not be clear).
- Terminology is inconsistent throughout the document.
- Unofficial language is used (e.g. 'Medical notes' or 'case notes' instead of 'Healthcare records'; 'Middle grade' rather than 'Specialty and Associate

Specialist').

- Colloquial language is used (e.g. 'pull the notes', 'chase a response', 'big issue', 'ups and downs' etc.).
- The correct names of departments, job titles and/or committees are not used (e.g. 'A&E' rather than 'the Emergency Department').
- Mis-numbering of paragraphs, sections or internal references (e.g. 'See Appendix 7' when this should be 'See Appendix 8').
- Formatting errors are present (e.g. bullets are mis-aligned).
- Relevant documents are not included in the 'Cross references' and/or 'Associated documents' sections.
- For the Equality Impact Assessment (Appendix 3), authors often state a series of 'No' response, when many policies do in fact reflect differences based on certain characteristics. It is therefore more accurate to state 'Yes – refer to policy' rather than 'No'.
- 'Biennial' or 'biannual' must not be used, as this can be confusing. These should be replaced with 'every two years' (biennial) or 'twice yearly' (biannual).
- The consultation table (Appendix 2) is often not completed.
- Additional appendices (i.e. beyond the standard Appendices 1-3) might not be created as separate/stand-alone files (this is required).
- Capital letters and/or italics and/or coloured text are inappropriately used for emphasis.
- Documents might be written in non-standard fonts (which should be Arial, 12 point).
- Thresholds might omit certain scenarios (e.g. a policy may describe what should occur for patients aged 18 to 24, and over 25, but omit those who are aged 25).
- 'Weak' language may be used in relation to what staff are expected to do (e.g. using 'should' instead of 'must').
- Using old versions of the Trust's logo.
- Not using bullets to make large sections of text easier to read and/or follow.
- Just 'copying and pasting' text from external guidance without adapting/tailoring this to the Trust's circumstances / needs.
- Knowledge of certain processes may be assumed, and therefore not adequately explained.
- Policies containing unrealistic requirements for which the resource implications may not have been properly considered (N.B. This should come under the remit of the approving committee).
- Documents that are expected to be referred to and/or used by a policy's target audience (i.e. as part of the policy and procedure) not being included as appendices.
- Internet hyperlinks may not be correctly listed (and therefore do not work).
- Appendices that are expected to be filed within patient's healthcare records not being sent to the Heath Records Department for review.
- Separate 'Standard Operating Procedures' being used to describe key aspects of a procedure that should more usefully be included within the main policy document.
- Monitoring and/or reporting arrangements being incorrectly described (e.g. referring to reports being submitted to the Trust Board or other senior committees that are not in fact submitted).
- Policy exclusions not being adequately described.
- Advice on policy exclusions not being appropriately signposted (e.g. noting that a policy does not include certain situations, but failing to include a reference as to how to obtain advice on those excluded situations).

**Q: The policy I'm presenting is largely unchanged from the previous policy. Will the PRC take this into account?**

A: No. When PRC reviews a policy, it needs to make sure that the policy reads well and makes sense when considered in its entirety. It is also possible that errors were overlooked when the policy was previously ratified. This is particularly true for policies that were ratified before July 2014 (when PRC was established), but may also apply to polices previously ratified by PRC. Therefore PRC will review all policies in detail, disregarding whether the changes from the previous policy are minor or substantial.

**Q: What are the possible outcomes from PRC?**

A: Policies reviewed at PRC are either 'Ratified as submitted'; 'Ratified subject to amendment' or 'Deferred for further development and re-submission'. The vast majority of policies reviewed so far have been 'Ratified subject to amendment'.

**Q: What happens next?**

A: If a policy is 'Ratified as submitted', it will be uploaded to Q-Pulse at the earliest opportunity. This outcome is unlikely however, as there will almost certainly be some changes required, even if minor. For this 'Ratified subject to amendment' scenario, policy authors are required to make the agreed amendments, and then email the revised document/s to the Chair of PRC, confirming that the changes have been made. Following a check to validate this, the Chair of PRC will then authorise the documents to be uploaded to Q-Pulse. Authors will receive an email confirmation once this has been done. If a policy is 'Deferred for further development and re-submission', this is because there are significant concerns that the policy is not fit for purpose in its current state. Authors will therefore need to reflect on the comments made at PRC, and, most likely make significant revisions. It is also likely that the revised policy will need to be subject to further consultation and approval.

**Q: I'm interested in joining PRC. Can I?**

A: Yes, PRC is always happy to accept new members. In addition to having an interest in how the Trust functions; an enquiring mind; a keen eye for detail; and a desire to improve the quality of the Trust's processes, PRC members need to be able to commit to attend PRC meetings (these are held monthly, and last for circa three hours); and be committed to reading and critiquing policy documents. Given the time commitment, the support of your line manager is important. If, having considered the above you are still interested, obtain the support of your line manager. If all is OK, email the Chair of PRC (Kevin Rowan, Trust Secretary, kevinrowan@nhs.net) to confirm you would like to be involved. If you would like to have an informal chat with the Chair before deciding whether you would like to join, please contact Kevin on x28698.

**TEMPLATE FOR TRUST-WIDE POLICIES AND PROCEDURES**

# Insert document title here (Arial font, bold, size 20)

| | |
|---|---|
| **Target audience:** | Insert staff groups for whom this document is intended (e.g. 'all Trust staff', 'all Trust clinical staff') |
| **Author:** | Insert job title and contact details<br>**Contact details: Ext.** |
| **Other contributors:** | Insert job title [optional] |
| **Owner:** | Insert job title of the Owner |
| **Division:** | Insert division under which the author sits |
| **Directorate:** | Insert directorate under which the author sits |
| **Specialty:** | Insert specialty under which the author sits |
| **Supersedes:** | List all existing documents superseded by this document |
| **Approved by:** | List committee and date where the document was approved |
| **Ratified by:** | Policy Ratification Committee, DD$^{xx}$ MMMMMMM YYYY |
| **Review date:** | Insert date of next review<br>*(a maximum of four years)* |

*N.B. The text in italics is guidance which should be followed and then deleted from the template (unless it refers to optional content which the author wishes to include).*

*The text in red is guidance which should be followed and over-typed or replaced with the relevant content or text (and then the text colour should be changed to black).*

*The text in non-italicised black should be left unchanged. The font style and size has been set to enable appropriate accessibility and should not be amended.*

**Document history**

| | |
|---|---|
| **Requirement for document:** *(Why is this document necessary?)* | *e.g.*<br>• Trust strategies/other policies<br>• legislation<br>• standards<br>• external recommendations<br>• audit |
| **Cross references (external):** *(List all external best practice documents supporting this document)* | 1. Please use numbered bullet points<br>2. These should then be used for cross referencing within the policy and procedure text. |
| **Associated documents (internal):** *(List all internal documents associated with this document, in alphabetical order)* | • Please use un-numbered bullet points |

| | | | |
|---|---|---|---|
| **Keywords:** *(Search terms to assist staff in finding this document on Q-Pulse)* | Keyword or string | Keyword or string | Keyword or string |
| | Keyword or string | Keyword or string | Keyword or string |
| | Keyword or string | Keyword or string | Keyword or string |
| | | | |
| | | | |

***Keyword notes:***

- *Searching on a string of text will only retrieve documents that contain that exact string within the Q-Pulse title or the keyword fields. So, by including likely 'search strings' in the* ***Keywords:*** *section above, the document will become far more accessible. Ideally strings should only be two to three words long. Think, amongst staff, how is this policy familiarly known?*
- *Searching for documents using a single keyword search term is more likely to retrieve the required documents but may also retrieve a large number of additional documents that also contain that word in their title or keywords.*
- *If possible, aim to strike a balance between the most likely to be used search strings, but avoiding words that may appear in many other documents, although this may be unavoidable.*
- *Do not use the word "policy" as a keyword*

| **Version control:** *Details of approved versions* | | |
|---|---|---|
| **Issue:** | **Description of changes:** *This needs to be brief, but able to accurately describe the major changes. For major changes, text such as 'Complete overhaul of previous policy and procedure' should be used. For new policies, explain why it has been introduced. Only versions dating back to the last full review need to be included; older versions can be removed from the table. An example is given below.* | **Date:** |
| Issue number | Description of changes | Date |
| *3.0* | *Full review. Policy and procedure revised to reflect new committee structure. Amendments to job titles and duties.* | *July 2015* |
| *3.1* | *Non-material amendments to telephone numbers of department contacts. No approval or ratification required.* | *February 2016* |
| *3.2* | *Material amendment made to sections 3.0 and 5.0, and introduction of an additional appendix, to reflect new procedure introduced. Approved at XXX Committee dd/mmmm/yyyy and ratified at Policy Ratification Committee dd/mmmm/yyyy* | *April 2017* |
| *3.3* | *Non-material amendment. An extension to the review date was approved by the approving committee dd/mmmm/yyyy and agreed by the Policy Ratification Committee Chair dd/mmmm/yyyy* | *July 2018* |
| *4.0* | *Full review. No material amendments made.* | *May 2019* |

**Summary for**

# Insert document title here

*Insert policy summary here*

A policy summary should be a brief declaration of what the policy is intending to do, including the situation/s and staff to which it applies. The summary should be one to two paragraphs maximum.

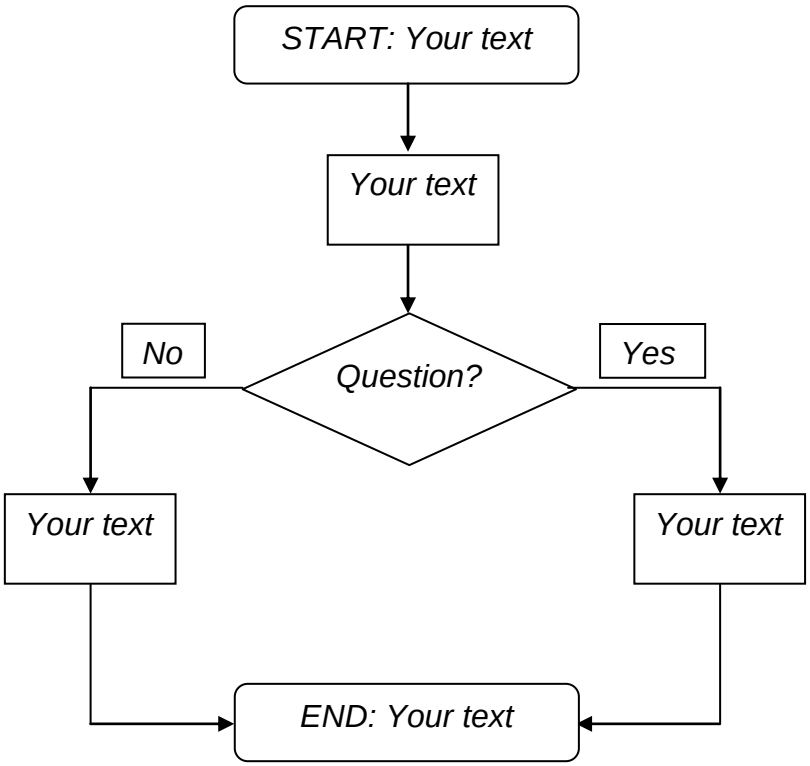
# Contents

*N.B. The table of contents below is designed to update using the headings that have been used in the policy. Do not therefore amend the text in the Table of contents – just right-click the mouse and choose the 'Update Field' option once the content of the document is finalised.*

## Flowchart / diagram of procedure to be followed *[optional]*

*Flowcharts are optional but can be inserted within this section if they will help staff understand and follow required procedures. Alternatively, flowcharts or diagrams can be inserted at the relevant place/s in the procedure or added as appendices.*

*A simple flowchart is shown below; this demonstrates good flowchart design. Authors are not obliged but may choose to base their own flowcharts on this. The key aspect is that the flowchart 'flows', when worked through.*



## 1.0 Introduction, purpose and scope *[compulsory]*

Why is the document needed?

What does the document hope to achieve?

Which staff and situations does the document apply to?

Which staff and situations are excluded from the document? *(i.e. which may otherwise be considered to apply, from the title of the document).* The document should indicate who staff should contact for advice on any exclusions.

## 2.0 Definitions/glossary *[compulsory]*

*Insert the definitions or explanations of key terms and acronyms that are used in the policy and procedural document here.*

*These should be listed in alphabetical order, using the following format:*

| Term | Definition |
|---|---|
| Term | Definition |
| | |

*It is not acceptable to state "There are no definitions".*

## 3.0 Duties *[compulsory]*

*For staff in implementing the policy and procedure*

*Please use the following format:*

| Person/Group | Duties |
|---|---|
| **Heading** ***(e.g. job title, staff group, committee name)*** | • Description of key duties and actions to be undertaken (listed as bullets if more than one duty is given) |
| **Heading** ***(e.g. job title, staff group, committee name)*** | • Description of key duties and actions to be undertaken (listed as bullets if more than one duty is given) |

Those listed should be ordered by seniority, starting with the most senior (which may be the Trust Board, if applicable), and ending with 'All staff', or 'All other relevant staff'.

## 4.0 Training and competency requirements *[compulsory]*

Details of information, instructions and training required to implement the policy and procedure.

If there are no training or competency requirements please state 'No training or competency requirements at this time. However, advice and guidance is available from XXXXX':

Department name Contact telephone number

## 5.0 Additional sections *[optional]*

Please detail the procedure itself in numbered sections from this point onwards; if your policy has no supporting procedures please use this and any additional sections required to present any further supporting information.

### *Tables [optional]*

*You may choose to use tables to present certain information. If your table won't fit on one page please ensure you use the 'Repeat Header Rows' function (which can be found on the 'Layout' tab in Word when you are editing a table). The following table template has this feature 'switched on' if you wish to adapt it for your use:*

| ***Column 1*** | ***Column 2*** | ***Column 3*** |
|---|---|---|
| | | |
| | | |

*When writing document content, please note the following guidance, which has been developed from reviewing the common pitfalls from policies reviewed by the Policy Ratification Committee (PRC); please also see the Trust-wide style guide*: Add hyperlink:

- *Please ensure that the current Trust logo is used.*
- *The Trust's legal name ('Maidstone and Tunbridge Wells NHS Trust') should always be used (rather than 'Maidstone & Tunbridge Wells NHS Trust'). Any '&' in the Trust's name should therefore be amended to 'and'.*
- *Policies and appendices should be written using Arial font, with a 12 point size (although exceptions may be considered if the use of alternative fonts and sizes can be justified).*
- *Text should be left justified (as this is considered easier to read).*
- *Block capitals should not be used for emphasis, as this may cause confusion with acronyms or abbreviations, which are usually capitalised. If emphasis is considered essential, use either bold or underlined text.*
- *Spelling and grammar should be thoroughly checked (for example, for misuse of apostrophes).*
- *Paragraph and page numbering should be checked and corrected.*
- *Tables that span more than one page should have the 'Repeat Header Rows' option selected (to ensure the title of each column is clear on each page).*
- *Formatting errors should be corrected (for example, mis-aligned bullets should be aligned correctly).*
- *Bullets should be used to make large sections of text easier to read or follow.*
- *Flowcharts should 'flow' properly (for example, avoid multiple exit points from a box without a clear indication of which route to follow; there may be important steps missing).*
- *All relevant documents should be included in the 'Cross references' and 'Associated documents' sections.*
- *Check that hyperlinks work correctly.*
- *All key terms and abbreviations should be included in the 'Definitions/glossary' section.*
- *Policy exclusions must be adequately described.*
- *Advice on policy exclusions must be appropriately signposted (for example, if noting that a policy does not include certain situations, do not fail to include guidance on how to obtain advice on those excluded situations).*

- *The responsibility for carrying out key tasks needs to be clear.*
- *The duties of all key staff involved in implementing the policy need to be included.*
- *Knowledge of certain processes should not be assumed, and therefore must be adequately explained.*
- *Policies should not contain unrealistic requirements for which the resource implications may not have been properly considered (**Note:** checking this should come under the remit of the approving committee)*
- *Colloquial language should not be used (for example, 'pull the notes', 'chase a response', 'big issue', 'ups and downs' etc.)*
- *Gender neutral terms must be used wherever possible. This means using 'people', 'they' and 'them' instead of 'women', 'men' and 'his' or 'her'. Where it is difficult to agree an encapsulating neutral substitute term then additive use of gender neutral language must be used to ensure gender inclusivity. For example 'expectant mothers' does not have to become 'expectant people', but could become 'pregnant women and individuals'.*
- *Abbreviations and acronyms should be spelt out in full at the point of first use.*
- *Internal references to appendices and section numbers should be checked for accuracy (for example, 'See Appendix 7' when this should read 'See Appendix 8').*
- *Unofficial language should not be used (for example, 'healthcare records' should be used instead of 'medical notes' or 'case notes'; 'Specialty and Associate Specialist' should be used instead of 'Middle grade').*
- *The correct names of departments, job titles and committees should be used (for example, 'the Emergency Department' rather than 'A&E')*
- *Ranges should not omit certain scenarios (for example, a policy may describe what should occur for people aged under 25 years and people aged over 25 years, but omit those who are aged 25).*
- *It is better to avoid 'weak' language in relation to tasks staff are required to do (for example, use 'must' instead of 'should').*
- *Writing in the first person should be avoided (for example, 'you', 'we'). The third person is more formal and should be used instead (for example,. 'The Trust', 'staff', 'managers', 'they', etc.).*
- *Terms should be used consistently throughout the document, for example, if 'Appointed Person' has been defined, this term should be used throughout, rather than any variations (for example, 'Authorised Person', 'Appointed Manager', etc.).*
- *It is not acceptable to simply copy and paste text from external guidance without adapting or tailoring this to the Trust's circumstances or needs. Acknowledgement to the originator should be made when borrowing and adapting text from other sources.*
- *A four year review is acceptable (rather than annual or two year).*
- *Monitoring and reporting arrangements must be correctly described (for example, avoid referring to reports being submitted to the Trust Board or other senior committees that are not in fact submitted).*
- *'Biennial' and 'biannual' must not be used, as they can be confusing. These should be replaced with 'every two years' (biennial) or 'twice yearly' (biannual).*
- *Consultations must include all of the mandatory consultees, and the consultation table (Appendix 2) should be fully completed.*
- *For the Equality Impact Assessment (Appendix 3), authors often state a series of 'No' responses, when many policies do in fact reflect differences based on certain characteristics. It is therefore more accurate to state 'Yes – refer to policy' rather than 'No'.*

- *If an additional document is expected to be read and understood by the policy and procedure's target audience, the document should be included as an appendix; however, if it describes key aspects of a procedure the content should probably be absorbed within the main policy and procedure document.*
- *Additional appendices (that is, those beyond the compulsory Appendices 1-3) should be created as separate, stand-alone files.*
- *Each separate appendix document can be an appendix to more than one policy and procedure. However, each appendix should be primarily linked to only one policy. Additional appendix footers should include the name of the 'primary' overarching policy and the author of that policy, for example:*

Insert document title
***Author:*** insert job title of appendix author
***Review date:*** insert date for next review RWF-TBC
***Version no.:*** X.X *Page 1 of 1*
***Overarching policy title:*** Insert document title
***Overarching policy author:*** insert job title of policy author

- *Appendices that are expected to be filed within patients' healthcare records must additionally be approved by the Health Records Department before they can be ratified.*
- *The title of any appendices in the 'FURTHER APPENDICES' section should match the title used on the actual appendix document.*

**Appendix 1**
***[Compulsory]***

## Process requirements

### 1.0 Implementation and awareness

- Once ratified, the Chair of the Policy Ratification Committee (PRC) will email this policy and procedure to the Corporate Governance Assistant (CGA) who will upload it to the Trust policy database on the intranet, under 'Policies & guidelines'.
- A monthly publications table is produced by the CGA which is published on the Trust intranet under 'Policies & guidelines'. Notification of the posting is included on the intranet 'News Feed' and in the Chief Executive's newsletter.
- On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.
- Add bullet pointed details of any further plans for implementing this document or bringing it to the attention of relevant staff.

### 2.0 Monitoring compliance with this document

- Insert details of how the implementation of this policy and procedure will be monitored and audited **[compulsory].**
- State details of all monitoring committees and groups.
- *Please note that monitoring described here may be expected to be completed by inspectors from external agencies. Do not record monitoring which realistically cannot be completed.*
- *If no structured monitoring is completed the author should, as a minimum, record any ad-hoc monitoring.*

### 3.0 Review

This policy and procedure and all its appendices will be reviewed at a minimum of once every one/two/three/four years.

*If changes in legislation or practice occur before the document reaches its review date, which require extensive or potentially contentious amendments to be made, a full review, approval and ratification must be undertaken. If non-material amendments are required to the document between reviews these do not require consultation and further approval and ratification. Such amendments include changes to job titles, contact details, ward names etc.; they are 'non-contentious'. For a full explanation please see the 'Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures' ('Policy for Policies') [RWF-OPPPCS-NC-CG25].*

### 4.0 Archiving

The Trust approved document management database on the intranet, under 'Policies & guidelines', retains all superseded files in an archive directory in order to maintain document history.

**Appendix 2**
***[Compulsory]***

**CONSULTATION ON:** Insert title of document

**Consultation process** – Use this form to ensure your consultation has been adequate for the purpose.

**Please return comments to:** Insert title of author and email address

**By date:** Insert date

| **Job title:** *List staff to be included in the consultation.* | **Date sent dd/mm/yy** | **Date reply received** | **Modification suggested? Y/N** | **Modification made? Y/N** |
|---|---|---|---|---|
| **The following staff must be included in all consultations:** | | | | |
| Corporate Governance Assistant ruthdickens@nhs.net | | | | |
| Counter Fraud Specialist Manager (tiaa) david.kenealy@tiaa.co.uk | | | | |
| Clinical Audit Lead *(Clinical Audit is often included in policies in the monitoring section)* stephanie.smith29@nhs.net | | | | |
| Head of Fire, Safety and Environment, *via* mark.vince@nhs.net *(if energy and sustainability issues are included in the document)* | | | | |
| Chief Pharmacist and Formulary Pharmacist *(if prescribing or medicine is included in the document)* mildred.johnson@nhs.net | | | | |
| Formulary Pharmacist *(if the document includes antibiotic use)* amanda.lepage@nhs.net | | | | |
| Staff-Side Chair *(if workforce/Human Resources issues are included in the document)* mtw-tr.JCFchair@nhs.net | | | | |
| Complaints & PALS Manager *(if the document makes any reference to the Trust's Complaints or PALS service)* angelasavage@nhs.net | | | | |
| Emergency Planning Team *(a vast majority of Policies have some form of Emergency Planning aspect, even if this is* | | | | |

| **Job title:** *List staff to be included in the consultation.* | **Date sent dd/mm/yy** | **Date reply received** | **Modification suggested? Y/N** | **Modification made? Y/N** |
|---|---|---|---|---|
| *only minor)* Epo.mtw@nhs.net | | | | |
| Head of Staff Engagement and Equality *(Equality & Diversity agenda must be considered within all Policies)* jo.garrity@nhs.net | | | | |
| Health Records Manager *(if the document contains any mention of patient record keeping and documentation)* louise.dunkley@nhs.net | | | | |
| All individuals listed on the front page | | | | |
| Authors of other policies with a content overlap | | | | |
| The relevant lead for the local Q-Pulse database *(to notify them of the intent to review or create a document that may duplicate or conflict with a document on their local Q-Pulse database)* | | | | |
| All members of the approving committee (state the committee). *To obtain a mailing list for the members of the approving committee please contact the committee's administrator. If you are unsure who this, please contact the Trust Secretary's office.* | | | | |
| **Other individuals the author believes should be consulted** | | | | |
| | | | | |
| | | | | |
| The following staff have given consent for their names to be included in this policy and its appendices: Ruth Dickens, David Kenealy, Mark Vince, Mildred Johnson, Amanda LePage, Jo Garrity, Louise Dunkley, Angela Savage, Stephanie Smith | | | | |

**Appendix 3**
***[Compulsory]***

**Equality impact assessment**

This policy includes everyone protected by the Equality Act 2010. People who share protected characteristics will not receive less favourable treatment on the grounds of their age, disability, gender, gender identity, marital or civil partnership status, maternity or pregnancy status, race, religion or sexual orientation. The completion of the following table is therefore mandatory and should be undertaken as part of the policy development, approval and ratification process.

| | |
|---|---|
| **Title of document** | Title of document |
| **What are the aims of the policy?** | The aims of the policy |
| **Is there any evidence that some groups are affected differently and what is/are the evidence sources?** | Respond |
| **Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.** | **Is there an adverse impact or potential discrimination for the groups listed below (yes/no)? If yes give details.** |
| Gender identity | Yes or No. If yes give details. |
| People of different ages | Yes or No. If yes give details. |
| People of different ethnic groups | Yes or No. If yes give details. |
| People of different religions and beliefs | Yes or No. If yes give details. |
| People who do not speak English as a first language (but excluding Trust staff) | Yes or No. If yes give details. |
| People who have a physical or mental disability or care for people with disabilities | Yes or No. If yes give details. |
| People who are pregnant or on maternity leave | Yes or No. If yes give details. |
| Sexual orientation (LGB) | Yes or No. If yes give details. |
| Marriage and civil partnership | Yes or No. If yes give details. |
| Gender reassignment | Yes or No. If yes give details. |
| **If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?** | *A negative response is allowed provided a rationale is provided* |
| **When will you monitor and review your EqIA?** | Alongside this document when it is reviewed. |
| **Where do you plan to publish the results of your Equality Impact Assessment?** | As Appendix 3 of this document. |

*Authors often state a series of 'No' responses, when many policies do in fact reflect differences based on certain characteristics. It is therefore more accurate to state 'Yes – refer to policy' rather than 'No'.*

## Further appendices

The following appendices are published as related links to the main policy/procedure on the Trust approved document management database on the intranet, under 'Policies & guidelines':

| No. | Title | Unique ID | Title and unique id of policy that the appendix is primarily linked to |
|---|---|---|---|
| 4 | Title of appendix *(The title should match the title used on the actual Appendix document)* | Unique ID | *If the appendix is primarily linked to this policy, state "This policy"* |
| 5 | Title of appendix *(The title should match the title used on the actual Appendix document)* | Unique ID | *If the appendix is primarily linked to this policy, state "This policy"* |
| 6 | Title of appendix *(The title should match the title used on the actual Appendix document)* | Unique ID | *If the appendix is primarily linked to this policy, state "This policy"* |

## Style guide for Trust-wide policies and procedures

The Policy Ratification Committee agreed to adopt the style guide used by the National Institute for Health and Care Excellence (NICE), with some modifications and omissions.

The decision was taken to copy sections from the NICE style guide published on 25th January 2016, and to paste and modify them within a Maidstone and Tunbridge Wells NHS Trust-wide policy style guide.

Simplified style and content guidance can also be found within the policy template itself: Policy template [RWF-OP-DocTemp-Policy1]

## Contents

## 1.0 Talking about people, including deaf and blind, age, faith, family origin, gender

Use person-centred language; that is, language that focuses on the person and not on their condition. Language used should be respectful, empathetic and inclusive, reflecting good manners and sensitivity, not political correctness.

Avoid labelling people. Conditions describe what a person has, not what a person is. Diseases are treated, not people. Diseases, not people, respond to treatment. Conditions, not people, are monitored. People are not unsuitable for treatments: treatments are unsuitable for them. People have diseases, they do not suffer from them.

There are some important exceptions. See table 1 and The Department for Work & Pensions and the Office for Disability Issues guidance on inclusive language: words to use and avoid when writing about disability.

**Table 1 Talking about people: dos and do nots**

| Do use | Do not use |
|---|---|
| People with diabetes | Diabetics |
| People with schizophrenia | Schizophrenics |
| People who smoke | Smokers |
| People who use drugs | Drug users, drug addicts |
| People who are dependent on alcohol<br>People who misuse alcohol | Alcoholic<br>People who abuse alcohol |
| A person with depression | A person suffering from depression |
| People with behaviour that challenges services | People with challenging behaviour |
| People with a learning disability | People with learning disabilities, people with intellectual disabilities |
| Disabled people[1] | People with a disability |
| Autistic people[2] | People with autism |
| Surgery is unsuitable for some people | Some people are unsuitable for surgery |
| If the disease has already been treated | If the person has already been treated |
| The disease did not respond to | The patient did not respond to treatment |

[1] Although this recommendation appears to conflict with the use of person-centred language, it reflects the view that disability is seen by many as being an inherent part of their identities. Disabilityrightsuk.org and seap.org.uk both use the term ‘disabled people’.

[2] Although this recommendation appears to conflict with the use of person-centred language, it reflects the view that autism is seen by many as being an inherent part of their identities. Autism.org.uk and autisticadvocacy.org both use the term ‘autistic people’.

| Do use | Do not use |
|---|---|
| treatment | |
| When monitoring the disease | When monitoring the patient |

Try to use people, not patients or service users. Sometimes it will make sense to use other terms (for example, when talking about clinical trials or to distinguish from other groups), but even then, consider people in the trial or people who use X services.

### Deaf and blind

Deaf can be used to mean any range of hearing loss, but Deaf (with a capital D) may also refer to people who consider themselves to be part of a cultural or linguistic minority. Most members of this community use a sign language as their preferred language. People with hearing loss or people with hearing impairment may be more suitable.

Blind refers to total loss of vision. Visual impairment refers to any kind of partial sight that is below 'normal' levels. Remember to use whichever is appropriate for the context.

### Age

Use young people and older people (not adolescents, teenagers, the elderly or old people). It is often better to be specific: say 'people aged 90 and over', not 'very old people'.

Be accurate: men over 65 is different from men aged 65 and over (the latter includes men aged exactly 65, the former does not).

Do not use the age of… or …years of age. Saying X-year olds or over Xs is fine as long as it is accurate.

Do not use neonates. Instead use newborn babies. If the neonatal period (that is, up until 28 days) is meant specifically, say newborn babies under 28 days.

If specific age groups need to be used, they should be defined at first use, for example:

- babies or infants: 1 year and under
- children: up to 12
- young people: between 12 and 17
- adults: 18 and over
- older people: 65 and over.

### Faith

Avoid faith-specific language or terminology that may exclude some readers (use first name, or given name, or family name, not Christian name).

Use faith groups to refer to people with religious beliefs collectively. Take into account the customs and practices associated with particular beliefs, but avoid stereotyping or making assumptions. Give examples if possible, but do not try to list every possible faith group that shares a particular belief.

### Family origin

Use family origin not race. Try to avoid using skin colour as a catch-all. It is fine to use white or black but be more specific if possible ('people of south-east Asian family origin'; 'people of African family origin').

Use ethnicity generally ('there is no link between mental health problems and ethnicity') but avoid labelling people based on their ethnicity.

Do not use BME or BAME. Use black, Asian and minority ethnic groups to describe people in the UK who are not part of the white majority.

Do not use Caucasian.

Use Gypsies, Roma and Travellers to cover Romany gypsies and Irish travellers, among others.

### Gender

Use trans not transgender or transsexual. Trans is an umbrella term that refers to people whose gender identity or expression differs from their birth sex.

Use sexual orientation not sexuality. Do not confuse sexual orientation with gender identity.

Gender neutral terms must be used wherever possible. This means using 'people', 'they' and 'them' instead of 'women', 'men' and 'his' or 'her'. Where it is difficult to agree an encapsulating neutral substitute term then additive use of gender neutral language must be used to ensure gender inclusivity. For example ‘pregnant women’ does not have to become ‘pregnant people’, but could become ‘pregnant women and individuals’.

Sex-specific language may be more appropriate in some cases:

- If there are anatomical differences that are important for the recommendations (for example, if penile or vaginal surgery is used). In this case, it is usually better to use 'men and women' instead of 'people with a penis' and 'people with a vagina'.
- When describing sex-specific risk factors that could lead to inaccuracies in how the guidance is used. For example, if there are different treatment pathways based on biological factors.
- It is sometimes best to reword the sentence to avoid referring to 'people', 'men' or 'women' at all. See table 2 for some examples. The Head of Staff Engagement and Equality can advise if required.

**Table 2 Gender wording examples**

| Original | Gender-neutral | Reworded |
|---|---|---|
| Offer hormonal treatment to women with suspected, confirmed or recurrent endometriosis. | Offer hormonal treatment to people with suspected, confirmed or recurrent endometriosis. | Offer hormonal treatment if there is suspected, confirmed or recurrent endometriosis. |
| Warn men undergoing radical treatment for prostate cancer of the likely effects of the treatment on their urinary function. | Warn people undergoing radical treatment for prostate cancer of the likely effects of the treatment on their urinary function. | Explain how radical treatment for prostate cancer may have negative effects on urinary function. |

| Original | Gender-neutral | Reworded |
|---|---|---|
| Diagnose gestational diabetes if the woman has a 2-hour plasma glucose level of 7.8 mmol/litre or above following an oral glucose tolerance test. | Diagnose gestational diabetes if the person has a 2-hour plasma glucose level of 7.8 mmol/litre or above following an oral glucose tolerance test. | Diagnose gestational diabetes if an oral glucose tolerance test shows plasma glucose levels of 7.8 mmol/litre or above. |

### Other terms

Try not to use clinician. If a qualified professional is to be specified, the term 'Healthcare professional' is preferable. Healthcare worker is preferred for more general use.

**Table 3 Social and care terms: dos and do nots**

| Do use | Do not use |
|---|---|
| End-of-life care | Terminal care |
| Socioeconomic status | Class<br>Poor people<br>Wealthy people |
| People who are under served<br>(but be more specific if possible) | People who are neglected<br>Hard-to-reach people<br>Disadvantaged people |
| People who are homeless | The homeless<br>People who sleep rough<br>People without homes |
| People who take their own life<br>People who die by suicide | People who commit suicide<br>People who kill themselves |

Use frailer people for people whose age or physical characteristics may prevent their having certain treatments ('Older, frailer people for whom chemotherapy is not suitable').

Asylum seeker, refugee and migrant worker are not interchangeable.

Refer to the Care and Support Jargon Buster from "Think Local Act Personal?", for other helpful social care definitions.

## 2.0 Spelling and choosing the right word

### Spelling

Spelling and grammar should be thoroughly checked (for example, for misuse of apostrophes).

Use UK English spellings (for example, colour, tumour, authorise, optimise and leukaemia). See table 4 for some important examples and exceptions.

**Table 4 UK spelling: dos and do nots**

| Do use | Do not use |
|---|---|
| Adviser | Advisor |
| Among | Amongst |
| Dietitian | Dietician |
| Fetus | Foetus |
| Focused<br>Focusing | Focussed<br>Focussing |
| Formulas | Formulae |
| Homeopathy | Homoeopathy |
| Naive | Naïve |
| Organise | Organize |
| Rationalise and other words ending in …ise | Rationalize and other words ending in …ize |
| Recurring | Reocurring |
| Targeted | Targetted |
| While | Whilst |
| World Health Organization | World Health Organisation |

### Choosing the right word

If unsure about which word to use:

- look at previous publications on similar topics and be consistent if possible
- think about what is most appropriate for the intended audience
- remember to use the simplest and plainest words possible.

Terms should be used consistently throughout the document, for example, if ‘Appointed Person’ has been defined, this term should be used throughout, rather than any variations (for example, ‘Authorised Person’, ‘Appointed Manager’, etc.).

Look out for common errors and misuses that can lead to ambiguity. Although writing should be flexible and shaped to best suit the user, words and phrases should be used correctly. For example:

- **Can or may:** 'the drug can cause nausea' means that the drug definitely has the ability to cause nausea. 'The drug may cause nausea' means that there is a chance the drug causes nausea, but it is not a certainty.
- **Fewer or less:** use fewer when talking about something that is plural and countable ('people have fewer side effects'). Use less when talking about percentages or things that cannot be counted ('less than 12%'; 'there is less time than originally thought').
- **Compared with or compared to:** use compared with when talking about how two things are different from each other. Use compared to when talking about how two things are similar.
- **Regards:** use with regard to when referring to something else. Use with regards [to] when writing a letter.
- **Access, management and significant.** Words like these have multiple meanings depending on the context. It is usually better to explain what is meant.

For more examples and advice, see the rules of clear writing in the National Institute for Health and Care Excellence's "Writing for NICE: a guide to help you write more clearly".

Colloquial language should not be used (for example, 'pull the notes', 'chase a response', 'big issue', 'ups and downs' etc.).

Unofficial language should not be used (for example, 'healthcare records' should be used instead of 'medical notes' or 'case notes'; 'Specialty and Associate Specialist' should be used instead of 'Middle grade').

The correct names of departments, job titles and committees should be used (for example, 'the Emergency Department' rather than 'A&E').

'Weak' language should be avoided in relation to what staff are expected to do (for example, use 'must' instead of 'should').

Writing in the first person should be avoided (for example, 'you', 'we'). The third person is more formal and should be used instead (for example,. 'The Trust', 'staff', 'managers', 'they', etc.).

**Table 5 Preferred words: dos and do nots**

| Do use | Do not use |
|---|---|
| Twice per year | Biannual |
| Every two years | Biennial |
| Emergency Department | A&E |
| Healthcare records | Medical notes, patient notes, case notes |
| Must | Will, should |

## 3.0 Diseases and medical terms

**Table 6 Diseases and medical terms: dos and do nots**

| Do use | Do not use |
|---|---|
| Gonorrhoea | Gonorrhea |
| Cytological | Cytologic |
| Flu | Influenza<br>'Flu |
| Leukocyte | Leucocyte |
| Hodgkin lymphoma | Hodgkin's lymphoma |
| Neurological | Neurologic |
| Thrombocytopenia | Thrombocytopaenia |
| Neutropenia | Neutropaenia |
| Interferon alfa | Interferon alpha |
| Hormone-relapsed prostate cancer | Castration-resistant prostate cancer |
| Magnesium sulfate | Magnesium sulphate |

### Drugs and medicines

**Use generic names for drugs** (as listed in the British national formulary) unless a brand name makes more sense in context (for example, where a specific brand is used within the Trust and there is a requirement to name it). Use lower case for generic names. Always say generic, not non-branded.

**Use medicine if possible.** Drugs or medication are fine but if using the word ‘drugs’ make sure that it cannot be misinterpreted to mean illegal drugs.

Medicines are given according to a regimen, not a regime.

**Dose or dosage:** dose refers to the amount of drug ('patients had 500 mg paracetamol' or 'patients had paracetamol 500 mg'; either format is fine but be consistent). Dosage refers to both the amount and frequency of drug ('the recommended dosage is 500 mg, three times daily').

**Avoid Latin phrases if there are clear English alternatives.** If there is no simple English alternative (de novo, vice versa), do not italicise the Latin. Do not use shorthand dosing schedules ('as needed' not p.r.n.; 'three times daily' not t.d.s.).

**Italicise Latin names of bacteria and fungi.** Italicise virus species, bacteria and fungal species, genus and family when used taxonomically ('test for *S typhimurium*'). Do not italicise a virus name when used generically ('people with any hepatitis virus'). For more information see the Centers for Disease Control and Prevention's guide on “scientific nomenclature”.

## 4.0 Punctuation and bullet points

### Brackets

Use brackets sparingly. They are fine for adding technical details of trial results, but avoid them if possible for sub-clauses in sentences. They can be confusing, particularly for people using screen readers.

Do not put two sets of brackets next to each other. Use one set of brackets and other punctuation like commas, semi-colons or dashes to separate the text: (23.4 compared with 56.9; p<0.05) instead of (23.4 compared with 56.9) (p<0.05).

For brackets within brackets, use round brackets then square brackets (like this [for example]).

### Bullet points

Use bullet points to break up large chunks of text and to avoid long lists in sentences. Use the existing bullet style in the template being used.

**There are two bullet styles, for short entry lists and long entry lists.**

For both types, every bullet should follow from the stem.

Short lists should:

- start with a lower case letter
- not have a full stop
- until the last bullet.

For longer entries in bulleted lists, treat each bullet as a separate sentence:

- Each bullet should start with a capital letter and end with a full stop.
- Include as many bullets as necessary in the list.

### Quote marks

Use single quotes for everything except direct speech. For example, for unusual words, non-standard use, or phrases or words that have a specific meaning in the context ('In this guidance, 'rapidly' is used to mean within four hours'), and for words and phrases that are not in NICE style but cannot be changed (when quoting from a marketing authorisation or a research paper).

Use double quotes to reproduce direct speech. If the quote is a complete sentence, it should be put in this format (note the full stop inside the quotation marks):

- In the opening speech at the conference, Dr Brown said: "This guidance will help improve services for children."

If the quote is part of a sentence, use this format (note the full stop outside the quote marks):

- Dr Smith said the new guidance would lead to "a big improvement in care for many patients".

If quoting a large amount of text, use quote marks at the beginning of each paragraph but do not close them until the end of the quote:

- "The need for support at home is something that is likely to affect many of us. As we age, most of us will want to continue living in our own homes, surrounded by a lifetime of memories, for as long as we can.
- "Helping a person remain as independent as possible is an important component to maintaining their wellbeing."

If leaving text out, show this using '[…]'.

## 5.0 Hyphens and en dashes

Use a hyphen if not using one could cause confusion or it looks strange (for example because of doubled vowels except 'oo'):

- 'Associated Press interviews lion hunting dentist'
  Instead: 'Associated Press interviews lion-hunting dentist'
- reenter
  Instead: re-enter
- antiinflammatory.
  Instead: anti-inflammatory

**Antiepileptic, microorganism or antiarrhythmic do not have a hyphen.**

**Use hyphens for compound adjectives** ('a cost-effective treatment' but 'the treatment was cost effective'). Do not hyphenate adjectives that end in -ly ('strictly defined criteria' but 'well-defined criteria'). It is important to put hyphens in the proper place when using compound adjectives; compare pickled-onion seller with pickled onion-seller.

**Always hyphenate 'non-'.**

**Do not hyphenate compound words in common use** (healthcare, childcare, crossover, wellbeing, baseline, breastfeeding, birthweight).

**Do not hyphenate prefixes like pre, post or per.** Preoperative, postoperative and perioperative are fine but if possible change them to before surgery, after surgery and during surgery.

**Try to avoid multiple hyphens in a row**, although sometimes this may be needed (non-small-cell lung cancer).

Use an **en dash** (Ctrl+dash key on the number pad) to show when there is an equal relationship between two things, and names formed from two people's names. Examples are:

- Dose–effect response, cost–utility analysis, doctor–patient relationship
- Creutzfeldt–Jakob disease, Guillain–Barré syndrome, Kaplan–Meier.

**Do not use an en dash for ranges.** Some screen readers do not read them out. Instead, use 'from … to' or 'between … and':

- the ages ranged from 4 to 42 years
- he usually went to bed between 10pm and 11pm
- 95% confidence interval −78 to 87.

Note that it is fine to use an en dash in page ranges in references.

Do not use a hyphen when a minus sign is intended.

## 6.0 Abbreviations

**Avoid abbreviations whenever possible.** Do not use the abbreviation if it only appears once, unless it is more commonly used than the full term (see below for examples).

**Define each abbreviation or acronym the first time it is used in a section.** For example, disease-modifying antirheumatic drugs (DMARDs).

All key terms and abbreviations should be included in the 'Definitions/glossary' section.

**Do not use full stops in abbreviations** (US, NHS), contractions (Ms, Dr) or initials (Dr HJ Baker).

Many common abbreviations are better known than what they stand for, so they do not need to be defined (in fact, to define them may make things less clear!).

**Do not define:**

- UK
- US
- NHS
- GP
- MRI
- CT
- AIDS
- HIV
- USB

This list is not exhaustive. Use common sense and think about what the user is likely to be familiar with.

Use the US to refer to the country, not America or the USA.

Do not use NICE-specific abbreviations (use technology appraisal, guideline committee, appraisal consultation document; not TA, GC, ACD).

## 7.0 Capital letters

Write headings with a capital letter for only the first word, except for proper nouns.

Use capitals for proper nouns (Down's syndrome, Munchausen's syndrome, Parkinson's disease, Apgar score).

X-ray has a capital X.

Questionnaire titles should have initial capitals. For example, DLQI (Dermatology Life Quality Index).

Capitalise government legislation ('the Care Act 2014). If the context is clear, refer to legislation as 'the Act' after the first mention.

Titles of projects or campaigns should have initial capitals (Active for Life, No Smoking Day). The Accreditation Mark should also have initial capitals. But use 'national service framework for children, young people and maternity services'.

NICE Pathways is a brand so should be capitalised (see the NICE Pathway on prostate cancer).

Use lower case for everything else, including adjectival forms of proper nouns (caesarean, darwinian, parkinsonian), cross references to figures and tables ('see figure 1') and words that derive from a proper name but that have passed into common use (braille, doppler, gram stain).

Use a lower case n and p for patient numbers (n=43) and p values (p=0.001).

North, south, east and west are lower case (northern England; birds fly south for the winter) unless they form part of a proper name (West Lambeth).

The government should be lower case unless it is part of the title of a specific body ('Local Government Association'). Use an initial capital when referring to a specific organisation but lower case when speaking generally. For example: 'Local protocols have been developed by trusts. Guy's and St Thomas' NHS Foundation Trust was one of the first'.

Block capitals should not be used for emphasis, as this may cause confusion with acronyms or abbreviations, which are usually capitalised. If emphasis is considered essential, use either bold or underlined text.

## 8.0 Units and symbols

### Units

Do not put a space around symbols (p<0.01; −12°C; p=0.012).

Use non-breaking spaces between numbers and units (Ctrl+Shift+Space), except for percentages and temperatures (37°C, 76%).

Use the Bureau International des Poids et Mesures' (BIPM's) International System of Units (SI units) except for mmHg for blood pressure and other situations in which non-SI units are standard (for example, ml for millilitres). For some audiences imperial measurements may be preferable, for instance to describe weight. In these cases, always include the metric equivalent in brackets. Spell out imperial units rather than abbreviating them (inches not ").

Use kilocalorie for energy, but give values in kilojoules as well.

Give Body Mass Index (BMI) values as $kg/m^2$.

Use units people are most familiar with (100 ml rather than 1 dl), and be consistent throughout a document (do not use 100 ml in one place and 0.1 litres in another).

Always spell out:

- litre
- microgram (some programs convert µg to mg)
- microsecond
- nanogram.

For dates, use the format 4 September 2009. The format 4/9/2009 is acceptable to save space in a table. Use 2007/08 or 2007 to 2008 for ranges of years.

Write out most units of time in full (30 seconds, 24 hours, 5 years). It is acceptable to abbreviate ms (millisecond) and more complex units of time (such as 5 m/s [metres per second]). Consider spelling out other units if appropriate for the intended audience. For example, if the policy is required reading for the most junior or non-specialist member of staff, milligrams might be more understandable than mg.

Use 'a', not per or slashes wherever possible with units ('30 mg a day', 'pulse below 50 beats a minute').

Repeat units in lists and ranges to avoid ambiguity (5%, 15% and 25%; 5 ml to 15 ml).

### Symbols

Do not use <, >, ≤, ≥, × (multiply) and = in text except for expressing p values and other measures of significance. They can be used in tables if space is tight. When 'translating' symbols in text, use plain English. For example, say X or more rather than equal to or greater than X.

If a minus is required, use the proper symbol, not a hyphen. Use the 'symbols' section of the 'insert' tab in Microsoft Word. Go to 'More symbols' – where the minus sign can be found in 'Mathematical operators'.

Only use an ampersand (&) if it forms part of a company name (Johnson & Johnson). The Trust's legal name ('Maidstone and Tunbridge Wells NHS Trust') should always be used (rather than 'Maidstone & Tunbridge Wells NHS Trust'). Any '&' in the Trust's name should therefore be amended to 'and'.

Do not use ™ or ® marks after brand names.

Avoid using forward slashes. Do not use and/or: use just 'or', or 'X or Y, or both'.

Use alpha or alfa, not *α* (TNF-alpha inhibitor; interferon alfa).

## 9.0 Numbers and tables

### Numbers

With a few exceptions, numbers one to nine should be written out in full (one, two, three etc.); exceptions include section numbering, numbers within tables, ages, dates, times, percentages, ratios, measurements and representations of calculations. Common sense should be applied.

Spell out and hyphenate common fractions, such as one-half.

Spell out first to ninth. Use 10th and so on afterwards.

Avoid long strings of zeros by spelling out millions and billions (£4.2 million not £4,200,000).

Use US billions (1,000 million) not UK billions.

Use a comma for four digit numbers and above (4,000, 10,000).

Be consistent when rounding figures: '4.3 compared with 9.0' not '4.3 compared with 9'. Use a 0 when there is no digit before the decimal point (0.7 not .7).

### Tables

Use the table styles in the Trust-wide policy template. Always use numerals and align numbers to the right.

Tables that span more than one page should have the ‘Repeat Header Rows’ option selected (to ensure the title of each column is clear on each page).

Add an en dash or state “N/A” (for “not applicable”) if there is no data in a cell, rather than leaving the cell blank.

Do not use shading (as it is not usually necessary).

Define all abbreviations used in the table in the bottom row, unless the abbreviation has been used many times in the text (for example, HCV in hepatitis C guidance).

### Ranges

Ranges should not omit certain scenarios (for example, a policy may describe what should occur for people aged under 25 years and people aged over 25 years, but omit those who are aged 25).

## 10.0 Hyperlinks

Try to avoid using hyperlinks, as the links can become unreliable over time. Instead try to ensure that any cross-references are given in full, to enable the reader to access these via their own searches, should they wish to obtain further information from a cross-reference.

## 11.0 Referencing and citations

All relevant documents should be included in the 'Cross references' or 'Associated documents' sections of the policy, as appropriate. This includes cross references to best practice external documents, legislation, standards etc. and also references to internal associated documents (that is, policies and supporting documents that may need to be referred to when reading the policy being written).

- Entries in the 'Cross references' section of the policy template should be numbered and follow a consistent style of entry.
- Entries in the 'Associated document' section of the policy template should be bullet pointed, provide the document title as it appears on the front page of the document itself, and include the 'unique id' number (provided in the footer of all recently published Trust-wide documents [RWF-xxxxx]).

Do not:

- edit the titles of papers, policies etc.
- put a full stop at the end of the reference.

Using the following guidance is not compulsory, but would help create consistent and good quality referencing.

### Reference examples: journals and books

#### Journal article

1. Alfredson H and Cook J (2007) A treatment algorithm for managing Achilles tendinopathy: new treatment options. British Journal of Sports Medicine 41(4): 211–6
2. Layton A, Moss F, Morgan G (1998) Mapping out the patient's journey: experiences of developing pathways of care. Quality in Health Care 7 (Suppl. 2): S30–6
3. Tillon C, Cole AF, Shah RD et al. (2015) Outcome of surgery for chronic Achilles tendinopathy: a critical review. American Journal of Sports Medicine 29(3) (forthcoming)

#### Conference abstract (in a journal)

1. Anand R, Hartmann R, Gharabawi G (1997) Worldwide clinical experience with Exelon, a new generation cholinesterase inhibitor, in the treatment of Alzheimer's disease. European Journal of Neurology 4 (Suppl.1): S37 (Abstract)

#### Books, reports

1. Chartered Institute of Personnel and Development (2008) Annual survey report 2008: absence management. London: Chartered Institute of Personnel and Development
2. Department for Work and Pensions (2007) Ready for work: full employment in our generation. London: The Stationery Office

#### Chapter or article from a book or report with editors

1. McCrea C (1999) Good clinical audit requires teamwork. In: Baker R, Hearnshaw H, Robertson N, editors. Implementing change with clinical audit. Chichester: Wiley, p119–32
2. Marmot M, Wilkinson R, editors (2006) Social determinants of health. Oxford: Oxford University Press

### Reference examples: others

#### Acts

1. HM Government (1995) The Disability Discrimination Act

#### Cochrane review

1. Gagnon AJ (2000) Individual antenatal education for childbirth. Cochrane Database of Systematic Reviews issue 4: CD00287

#### Conference abstract (in conference proceedings)

1. Li TW, Jones PA (2006) Methylation changes in early embryonic genes in cancer [abstract]. In: Proceedings of the 97th Annual Meeting of the American Association for Cancer Research, 1–5 April 2006, Washington DC, USA. Philadelphia: AACR; p7. Abstract 30

#### Court case

1. A and others v the National Blood Authority and others (2001) EWHC QB 446
2. Rottman v MPC (2002) HRLR 32

#### Health Technology Assessment

1. Daniels J, Gray J, Pattison H et al. (2009) Rapid testing for group B streptococcus during labour: a test accuracy study with evaluation of acceptability and cost-effectiveness. Health Technology Assessment 13 (42)

#### Newspaper citation

1. Timmins N (2009) NHS managers' skill levels criticised by MPs. The Financial Times, 13 January, p2

#### Speeches

1. Foreign and Commonwealth Office (2013) The future of Europe in the global economy. Speech given by the Right Honourable David Lidington MP, Minister of State for Europe, to the Lord Mayor's Gala Dinner at the Great Hall, Guildhall on 23 May 2013. London: Foreign & Commonwealth Office

#### Websites

1. Department of Health NHS reference costs 2013–14 [online; accessed 2 November 2015]

### Citations

When citing in the text and not hyperlinking (in documents that have a reference list), use the Harvard style of referencing (author date).

Direct and indirect citation:

- Harrison (2012) argues that there are seven main principles.
- There are seven main principles that need to be considered (Harrison 2012).

### Use of uncited text taken from other sources

It is not acceptable to simply copy and paste text from external guidance without adapting or tailoring this to the Trust's circumstances or needs. Acknowledgement to the originator should be made when borrowing and adapting text from other sources.

## 12.0 Font, cosmetics and presentation

- Use the current version of the Trust's logo. The current logo is included in the Trust-wide policy template, but care should be taken when reviewing older policies to update the logo, and any other template elements as necessary.
- Policies and appendices should be written using Arial font, with a 12 point size (although exceptions may be considered if the use of alternative fonts and sizes can be justified).
- Text should be left justified (as this is considered easier to read).
- Paragraph and page numbering should be checked and corrected.
- Formatting errors should be corrected (for example, misaligned bullets should be aligned correctly).
- Flowcharts should 'flow' properly (for example, avoid multiple exit points from a box without a clear indication of which route to follow; there may be important steps missing).
- Internal references to appendices and section numbers should be checked for accuracy (for example, 'See Appendix 7' when this should read 'See Appendix 8').

## 13.0 Appendices

- Additional appendices (that is, those beyond the compulsory Appendices 1-3) should be created as separate, stand-alone files.
- All appendices to policies and procedures should be numbered sequentially, and must be referred to within the body of the policy and procedure, including appropriate text.
- Each separate appendix document can be an appendix to more than one policy and procedure. However, each appendix should be primarily linked to only one policy. Additional appendix footers should include the name of the 'primary' overarching policy and the author of that policy, for example:

**Insert document title**
**Author:** insert job title of appendix author
**Review date:** insert date for next review RWF-TBC
**Version no.:** X.X Page 1 of 1
**Overarching policy title:** Insert document title
**Overarching policy author:** insert job title of policy author

- Appendices that are expected to be filed within patients' healthcare records must additionally be approved by the Health Records Department before they can be ratified.
- If an additional document is expected to be read and understood by the policy and procedure's target audience, the document should be included as an appendix; however, if it describes key aspects of a procedure the content should probably be absorbed within the main policy and procedure document.
- The title of any appendices in the 'Further appendices' section should match the title used on the actual appendix document.

| Summary report from Audit and Governance Committee, 19/03/20 | Committee Chair (Non-Executive Director) |
|---|---|

The Audit and Governance Committee met on 19th March 2020.

1. **The key matters considered at the meeting were as follows:**
   - The previous decision regarding the removal of the "Payments for compensation under legal obligations" from future Committee agendas was reconfirmed
   - The **Safety moment** was noted (as was the Trust Board's decision to reinstate the Safety moment item at all Trust Board sub-committees)
   - Under the **"Review of the Board Assurance Framework and Risk Register for 2019/20",** the ratings for March 2020 were confirmed and it was noted that the Chair of the Audit and Governance Committee would present the BAF at the Trust Board meeting on 28/03/20
   - An **update on progress with the Internal Audit plan for 2019/20** (incl. progress with actions from previous Internal Audit reviews) was reported, and it was acknowledged that progress could be delayed due to COVID-19
   - The Committee **approved the Internal Audit plan for 2020/21** with the acknowledgement that the Internal Audit Plan would be subject to amendments resulting from COVID-19. It was also agreed to arrange for the Workforce Committee to review the Internal Audit plan for 2020/21 and propose any changes, if desired.
   - The **Internal Audit Charter was approved** as submitted and the Committee confirmed that the annual review and approval of the charter should continue to be scheduled each year.
   - The findings from the review/survey of Internal Audit service were reported and it was agreed Internal Audit should submit a response to the Audit and Governance Committee meeting on 05/05/20 (focusing on the responses scoring a "1", "2" or "Not able to say").
   - The latest Counter Fraud update was received
   - Under the "**Audit Progress report and Sector Update" from External Audit** it was noted that there would soon be an announcement from NHSI/E which could have implications for the External Audit timetable
   - The Committee **approved the External Audit plan for 2019/20**
   - Under the **Key Financial Indicators Benchmarking Report** it was agreed that the "NHS Trust and Foundation Trust Accounts - Key Financial Indicators 2018/19 benchmarking report from Grant Thornton LLP" should be scheduled at the April 2020 Finance and Performance Committee meeting
   - The **findings from the review/survey of External Audit service** were reported and it was agreed that Grant Thornton UK LLP should submit a response to the Audit and Governance Committee meeting on 05/05/20 (focusing on the "Not able to say" responses)
   - Under the **update on the 2019/20 accounts process** the Committee approved the accounting policies and approach to accounting estimates
   - The Chief Finance Officer provided a verbal **summary of the latest financial position**
   - Details of **the latest losses & compensations** data were received and it was agreed that the Trust Secretary should liaise with the Head of Financial Services and schedule an item at the Workforce Committee to review the data and underlying causes of salary overpayments (including consideration of the findings of the latest Internal Audit review on the issue). It was also agreed the Committee would be advised of the outcome of that review
   - The **latest single tender / quote waivers data** was reviewed
   - The latest **details of gifts, hospitality and sponsorship** declared were noted and the Chair of the Workforce Committee agree to liaise with the Chair of the Patient Experience Committee to consider the Trust's position on the implementation of the "My ESR" self-service portal and ensure the Audit and Governance Committee was advised on the outcome of such liaison.
   - The Trust Secretary presented **the findings from the Committee's latest self-assessment / compliance with Terms of Reference**, and it was confirmed that no action was required in response.

- Under any other business the Committee was informed that the Trust Board would be asked to approve a proposed amendment to the Reservation of Powers and Scheme of Delegation and agreed to waive the standard process in this instance (as there was insufficient time for the Audit and Governance Committee to be given the details proposals in written form).
- Under the evaluation of the meeting it was agreed to arrange for the Trust Board meeting on 26/03/20 to discuss the approach to be taken regarding the legal duty to hold Trust Board meetings in public during the COVID-19 period

2. **The Committee received details of the following completed Internal Audit reviews:**
   - "Critical Financial Assurance – Financial Accounting and Non Pay" (which received a "Reasonable Assurance" conclusion)
   - "Cyber Security Maturity" (Which was an assessment review and therefore did not receive an assurance level)
   - "Medical Staffing" (which received a "Reasonable Assurance" conclusion)
   - "Data Security and Protection Toolkit Part 1" (Assurance level to be submitted following the part 2 review)
   - "Data Security and Protection Toolkit Part 2" (which received a "Reasonable Assurance" conclusion)
   - "Assurance Framework and Risk Management" (which received a "Reasonable Assurance" conclusion)
   - "Payments for Additional Activity Undertaken by Trust Staff" (which received a "Reasonable Assurance" conclusion)
   - "Medicines Management" (which received a "Reasonable Assurance" conclusion)
   - "Electronic Patient Record Implementation" (which received a "Limited Assurance" conclusion due to delays with the project and other issues)

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:** N/A

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

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

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

| **Summary report from the Charitable Funds Committee, 24/03/20 (incl. approval of revised Terms of Reference)** | **Committee Chair (Non-Executive Director)** |
|---|---|

**Summary / Key points**

The Charitable Funds Committee (CFC) met on 24th March 2020.

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

- The updated Terms of reference including the proposed establishment of a "Charity Management Committee" as a sub-committee were agree and are attached in Appendix 1 for Approval by the Trust Board.
- The Terms of Reference for the Charity Management Committee were approved subject to the "Membership" section being amended to replace "Patient representative (as part of Patient Partners Model)" with "Patient representatives".
- The Safety Moment was noted.
- Under the "To confirm the audit approach for the 2019/20 Maidstone and Tunbridge Wells NHS Trust charitable fund accounts" item it was agreed that the Charitable Funds accounts should be audited as an independent examination rather than a full on-site audit.
- The financial overview at Month 11 was considered and it was noted that:
  - The fund balance stood at £1,032k, a decrease of £138.2k since 1st April 2019
  - Total year to date income was £703.5k with expenditure of £841.6k
  - 37 specific donations had been received exceeding £1k totalling £643.1k. The largest single donation was £195k to purchase Tomosynthesis Biopsy equipment.
  - One request for expenditure had been refused during the period
  - It was agreed that the Head of Financial services should ensure all future "Financial overview reports" to the Committee include comparative data for the same period of the previous year
  - It was agreed that the Head of Financial Services and the Fundraising Manager should provide Committee members with a comparison of the donations received by the Trust to those received by neighbouring Trusts
- The Committee reviewed the Fundraising Strategy and objectives where it was agreed that a third appeal related to staff welfare should be included. It was also agreed that the Trust Secretary should liaise with the Fundraising Manager to provide clarification on the communication to be given to donors on how donations to appeals would be managed if the fundraising target was not achieved.
- A fundraising update was provided for the period 21st October 2019 to 13th March 2020 and the Committee acknowledged the progress made in generating funds for the Trust. It was agreed that the Fundraising Manager should develop a strategy for digital marketing and fundraising. It was also agreed that the Fundraising Manager would with the Communications Team to improve the accessibility to charitable fund and donation information on the Trust's website
- The Committee was informed of the proposed partnership with Maggie's Centres (Regarding Cancer Health and Wellbeing Centre at Maidstone Hospital). It was agreed that the forward programme should be updated to include an "Update on the proposed partnership with Maggie's Centres" as a standing item

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:** The Trust Board is requested to approve the update Terms of Reference for the Charitable Funds Committee

**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

# CHARITABLE FUNDS COMMITTEE

## Terms of Reference

NHS
Maidstone and Tunbridge Wells NHS Trust

**1. Purpose**

The Charitable Funds Committee has been established as a sub-committee of the Trust Board 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.

**2. Membership**

Membership of the Committee is as follows:

- The Committee Chair – a Non-Executive Director or Associate Non-Executive Director appointed by the Chair of the Trust Board
- The Committee Vice-Chair - a Non-Executive Director or Associate Non-Executive Director appointed by the Chair of the Trust Board
- The Chief Finance Officer
- The Director of Strategy, Planning and Partnerships
- The Head of Financial Services
- The Deputy Director of Finance (Financial Governance)
- The Trust Secretary

If a member cannot attend a meeting, they may send a representative in their place.

**3. Quorum**

The Committee shall be quorate when one Non-Executive Director (or Associate Non-Executive Director) and three other members are present. Deputies representing members will count towards the quorum.

**4. Attendance**

The Committee Chair may invite other staff, Non-Executive Directors (or Associate Non-Executive Directors) to attend, as required, to fulfil the Committee's purpose and/or meet its duties.

## 5. Frequency

The Committee shall meet at least twice per financial year (and more frequently if required to fulfil its purpose and/or meet its duties.

## 6. Duties

The Committee will act on behalf of the Corporate Trustee (Maidstone and Tunbridge Wells NHS Trust) and will:

- Develop and approve the strategy and objectives of the Charitable Fund
- Ensure that the Charitable Fund complies with relevant law and with the requirements of the Charity Commission; in particular ensuring the submission of Annual Returns and Accounts
- Oversee the development and delivery of the Trust's fundraising strategy
- Oversee the Charitable Fund's expenditure and investment plans, including:
  - Approving relevant policies and procedures
  - Agreeing approval and authorisation limits for expenditure from charitable funds
  - Considering applications for support (as recommended by the Head of Financial Services)
  - Approving and monitoring investment strategies

The specific duties of the Committee in relation to the Charitable Fund are to:

**Policy matters**

- To approve, on behalf of the corporate Trustee:
  - A Reserves policy (if considered by the Committee to be required)
  - An Investment strategy (and to formally review the strategy annually)

- A Grant Making policy (if considered by the Committee to be required)
- Guidance for fundraising activities (if considered by the Committee to be required)

**Operational matters**

- To approve the annual management and administration fee payable to the Trust
- Be advised of and consider the application of all new legacies
- Approve proposals regarding the establishment of any new funds
- Authorise financial procedures and financial limits
- Receive details of any expenditure refused
- To approve the banking arrangements of Maidstone and Tunbridge Wells NHS Trust Charitable Fund
- To authorise expenditure at the limits reserved for the Committee (as stated in the Trust's Reservation of Powers and Scheme of Delegation)

**Internal and External control**

- To seek assurances that all income is secured and that expenditure is within the objects of the Maidstone and Tunbridge Wells NHS Trust Charitable Fund
- To ensure compliance of all statutory legislation and Charity regulations, and seek assurance on compliance
- To ensure there is adequate provision for the independent monitoring of investment activity
- To receive all relevant internal and external audit reports, and ensure compliance with any recommendations

**Financial reporting**

- To review income and expenditure reports for each of the reporting periods
- To review and agree the Principal Accounting Policies to be adopted
- To review, and agree the Annual Report and Annual financial accounts for the Charitable Fund, for approval by the Trust Board
- To receive, where appropriate, the annual investment report
- To ensure the Chief Finance Officer is compliant with the reporting requirements of the Committee and the Trust Board (as the agent of the Trustee)
- To review Fundholders' spending plans

## 7. Parent committees and reporting procedure

The Charitable Funds Committee is a sub-committee of the Trust Board.

A written summary report of each Charitable Funds Committee meeting will be provided to the Trust Board. The Chair of the Charitable Funds Committee will present the Committee report to the next appropriate Trust Board meeting.

## 8. Sub-committees and reporting procedure

The Committee has the following sub-committee:

- The Charity Management Committee

A written summary report from each sub-committee will be received at each meeting of the Charitable Funds Committee. The Terms of Reference of each sub-committee will be reviewed, and approved, at the Charitable Funds Committee every year.

The Charitable Funds Committee ~~has no standing sub-committees, but~~ may also establish fixed-term working groups, as required, to support the Committee in meeting its duties as it, or the Trust Board, sees fit.

## 9. Emergency powers and urgent decisions

The powers and authority which the Trust Board has delegated to the Charitable Funds Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted either the Chief Finance Officer or Director of Strategy, Planning and Partnerships. The exercise of such powers by the

Committee Chair shall be reported to the next formal meeting of the Charitable Funds Committee, for formal ratification.

## 10. 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 committee 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

## 11. Review

The Terms of Reference of the Committee will be reviewed annually, and approved by the Trust Board

**History**

Agreed at Charitable Funds Committee, July 2014
Approved at Trust Board, September 2014
Agreed at Charitable Funds Committee, July 2015
Approved at Trust Board, September 2015
Agreed at Charitable Funds Committee, November 2016
Approved at Trust Board, December 2016
Agreed at Charitable Funds Committee, 16th October 2017
Approved at Trust Board, 29th November 2017
Agreed at Charitable Funds Committee, 27th November 2018 (annual review)
Approved at Trust Board, 20th December 2018
Agreed at Charitable Funds Committee, 29th October 2019 (annual review)
Approved at Trust Board, 28th November 2019
Agreed at Charitable Funds Committee, 24th March 2020 (to include the Charity Management Committee as a sub-committee)
Approved at Trust Board, 30th April 2020

| Summary report from Workforce Committee, 26/03/20 (Incl. approval of revised Terms of Reference) | Committee Chair (Non-Exec. Director) |
|---|---|

The Workforce Committee met on 26th March 2020.

- **The key matters considered at the meeting were as follows:**
  - The actions from previous meetings were reviewed,
  - The Terms of Reference were reviewed as part of the annual process and some proposed amendments were agreed which included the establishment of an "Inclusion Committee". The revised Terms of Reference are enclosed in Appendix 1 (with the proposed changes 'tracked'), for the Trust Board's approval. It was also agreed that an extraordinary, one-hour, meeting of the Workforce Committee should be scheduled following the Trust Board in April.
  - The forward programme was reviewed and agreed following the change in secretariat to the Workforce Committee. It was agreed that the Committee should receive a standing item on "Employee engagement" which included details of Divisional engagement plans.
  - The **Safety moment** was noted (as was the Trust Board's decision to reinstate the Safety moment item at all Trust Board sub-committees)
  - The Director of Workforce reported the key **workforce implications of COVID-19** including the steps being taken by the Trust to ensure staff welfare and resilience. It was agreed by the Committee that accurate modelling on the number of Trust staff expected to need to self-isolate due to COVID-19 should be produced, to enable appropriate workforce planning to be undertaken. It was also agreed that the workforce implications of COVID-19 should be a standing item for the next six months.
  - The draft People and Organisational Development Strategy was deferred to April 2020 due to time constraints and will subsequently be presented to the Trust Board in May 2020.
  - The Committee reviewed the **equal pay annual audit return 2019/20** and it was agreed the gender pay gap action plan should be submitted to the Committee. It was also agreed that the Head of Staff Engagement & Equality should investigate if the pay differences illustrated in the gender pay gap annual audit return 2019/20 was for the same positions/posts or a reflection of differing positions/posts.
  - The Committee **approved the Workforce Race Equality Scheme (WRES) (including The Trust's Model Employer aspirational targets)** and the Chair of the Cultural and Ethnic Minorities Network agreed to provide the Chief Nurse with the complete list of complaints received from Canterbury Christchurch University nursing students in regards to racial aggression. It was also agreed that the Workforce Race Equality Scheme (WRES) (including The Trust's Model Employer aspirational targets) should be scheduled at the Trust Board with the Chair of the Cultural and Ethnic Minorities Network in attendance. Furthermore it was agreed that the forward programme for the Committee should be updated to reflect the fact that the Workforce Race Equality Scheme (WRES) item in July 2020 would need to approve the Trust's proposed national data submission (which was due at the end of July 2020).
  - The committee noted the **Flu vaccination campaign closure report**
  - The committee reviewed and noted the two relevant targets from the **Board Assurance Framework**.
  - The committee noted the conclusions and actions of the most recent **Health and Safety committee**
  - Under **any other business** it was agreed that the scheduling of the 2020 Workforce Committee meetings should be reviewed with the consideration that they should not be scheduled on the same day as Trust Board Meetings
  - It was subsequently confirmed in the days after the meeting that the Workforce Committee meetings would be held on the Friday before the Trust Board at 9:15am, via virtual means

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

- The Terms of Reference were reviewed and some proposed amendments were agreed. The revised Terms of Reference are enclosed in Appendix 1, for approval

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| **Which Committees have reviewed the information prior to Board submission?** N/A |
| **Reason for receipt at the Board (decision, discussion, information, assurance etc.)**[1]<br>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

**Workforce Committee**

**Terms of Reference**

Maidstone and Tunbridge Wells NHS Trust

## 1 Purpose

The Workforce Committee is constituted at the request of the Trust Board to provide assurance to the Board in the areas of workforce development, planning, performance and employee engagement.

The Committee will work 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 ~~is~~ supportsing ~~business~~ success.

## 2 Membership

- Non-Executive Director (Chair)
- Non-Executive Director or Associate Non-Executive Director (Vice Chair)
- Chief Nurse
- Chief Operating Officer
- Deputy Medical Director
- Director of Medical Education (DME)
- Director of Workforce

Members can send an appropriate deputy if they are unable to be present at Workforce Committee meetings.

## 3 Quorum

The Committee shall be quorate when two members of the Executive Team and two Non-Executive Directors (or Associate Non-Executive Directors) are in attendance.

Deputies sent by members will count towards these quorum requirements.

## 4 Attendance

All other Non-Executive Directors (including the Chair of the Trust Board and any Associate Non-Executive Directors) and members of the Executive Team are entitled to attend any meeting of the Committee.

Other staff, including members of the Human Resources Directorate, may be invited to attend, as required, to meet the Committee's purpose and duties.

## 5 Frequency of meetings

The Committee will meet every two months. The Chair can call a meeting at any time if issues arise.

## 6 Duties

To provide assurance to the Trust Board on:

- workforce planning and development, including alignment with business planning and development;
- equality and diversity in the workforce;
- employee relations trends e.g. discipline, grievance, bullying/harassment, sickness absence, disputes;
- occupational health and wellbeing in the workforce
- external developments, best practice and industry trends in employment practice;
- staff recruitment, retention and satisfaction;
- employee engagement

- terms and conditions of employment, including reward;
- organisation development, organisational change management and leadership development in the Trust;
- training and development activity in the Trust including prioritisation;
- reporting from the Guardian of Safe Working Hours (in relation to the Terms and Conditions of Doctors in Training)
- The Trust's Freedom to Speak Up Guardian (FTSUG) arrangements

To convene task & finish groups to undertake specific work identified by the Committee or the Trust Board.

To review and advise upon any other significant matters relating to the performance and development of the workforce.

## 7 Parent committees and reporting procedure

The Workforce Committee is a sub-committee of the Trust Board.

A summary report of each Workforce Committee meeting will be submitted to the Trust Board. The Chair of the Workforce Committee will present the Committee report to the next available Trust Board meeting.

## 8 Sub-committees and reporting procedure

The following Committees report to the Workforce Committee through their respective chairs or representatives following each meeting. The frequency of reporting will depend on the frequency of each of the sub-committees:

- ~~Senior HR meeting~~
- Health and Safety Committee
- Inclusion Committee
- Local Academic Board (LAB) (reporting to occur via the report from the DME)

## 9 Emergency powers and urgent decisions

The powers and authority which the Trust Board has delegated to the Workforce Committee may, when an urgent decision is required between meetings, be exercised by the Chair~~man~~ of the Committee, after having consulted at least two ~~Executive Director~~Committee members who are members of the Executive Team. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Workforce Committee, for formal ratification

## 10 Administration

~~The Committee will be serviced by administrative support from the Trust Management Secretariat.~~ The Trust Secretary will ensure that each committee 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 & agenda items
- The meeting agenda
- The meeting minutes and the action log

## 11 Review of Terms of Reference and monitoring compliance

The Terms of Reference of the Committee will be reviewed and agreed by the Workforce Committee at least annually, and then formally approved by the Trust Board. They will be reviewed annually or sooner if there is a significant change in the arrangements.

Terms of Reference agreed by Workforce Committee: 29th September 2016
Terms of Reference approved by Trust Board: 19th October 2016
Terms of Reference agreed by Workforce Committee: 30th October 2017
Terms of Reference approved by Trust Board: 29th November 2017

Appendix 1

Amended Terms of Reference agreed by Workforce Committee: 25th January 2018 (to change the frequency of meetings from quarterly to every two months)
Amended Terms of Reference approved by Trust Board: 1st March 2018
Terms of Reference agreed by Workforce Committee: 28th March 2019
Amended Terms of Reference approved by Trust Board: 25th April 2019
Amended Terms of Reference approved by Trust Board, 31st October 2019 (to add the Health and Safety Committee as a sub-committee)
Terms of Reference agreed by Workforce Committee: 26th March 2020 (as part of the annual review, and to include the Inclusion Committee as a sub-committee, to add the Deputy Medical Director as a member, and to reflect the agreement that members can send deputies if they are unable to be present)
Terms of Reference approved by Trust Board: 30th April 2020 (as part of the annual review)

NHS Maidstone and Tunbridge Wells NHS Trust

**Summary report from Quality Committee, 02/04/20 Committee Chair (Non-Exec. Director)**

The Quality Committee met (virtually, via webconference) on 2nd April 2020 (a Quality Committee 'deep dive' meeting).

1. **The key matters considered at the meeting were as follows:**
   - The **Safety moment** (which was the same as that received at the Trust Board in March 2020) was noted
   - The Clinical Director for Imaging and General Manager for Radiology attended to present the **Outcome of the review of radiology incidents and complaints involving concerns in relation to unreported plain X-rays that was requested at the Quality Committee 'deep dive' meeting on 14/08/19.** The presentation gave assurance on the progress that had been made in relation to the recommendations in the Care Quality Commission's report "A national review of radiology reporting within the NHS in England", but it was noted that the priority of the department would now be exclusively COVID-19, so many of the actions within the presentation would be paused.
   - The Committee then had a lengthy discussion on **proposals for the functioning of the Quality Committee during the COVID-19 period.** Some of the proposals were agreed as submitted i.e. that the Committee would meet for two-hours each month for the next few months, in the guise of a 'main' Quality Committee, and that Quality Committee 'deep dive' meetings would not be held. It was however also agreed that the Deputy Director of Quality Governance, Chief Nurse and Medical Director would liaise to consider the comments made at the meeting and confirm the agenda and information that should be considered at the meetings from May 2020 onwards.
   - Under the **…any other business** item, the Medical Director responded to a concern that had been raised by an eternal agency to the Chair of the Quality Committee and gave assurance that the Trust was not discriminating against patients with learning disabilities.

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

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

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

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

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

| Summary report from the Finance and Performance Committee, 28/04/20 | Committee Chair (Non-Exec. Director) |
|---|---|

The Committee met on 28th April, via a webconference. A shorter (two-hour) meeting was held because of the COVID-19 situation. At 11am, the meeting also paused to observe the minute's silence that was held to commemorate the key workers who had died as a result of COVID-19.

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

- The **"Safety moment"** report, which focused on safeguarding children, was noted, but the Chief Executive agreed to liaise with the Chief Nurse regarding the inclusion of some safeguarding-related indicators in the monthly Integrated Performance Report.
- A lengthy discussion was held on **the 2020/21 Operating Plan**. The approach to managing the costs associated with COVID-19 was explained, as was the proposed process for establishing the budgets for the first four months of 2020/21. The approach was supported, although it was acknowledged that there remained some uncertainty on the practical process of COVID-19 funding, particularly in relation to capital expenditure.
- A brief **update on the options being considered in relation to the PFI contract at Tunbridge Wells Hospital** (which is received every six months), was given.
- The key aspects of the **month 12 financial performance** were reported, which noted that, subject to audit, the Trust had delivered its financial plan for 2019/20, and ended the year with a surplus of just below £7m. The Committee commended the achievement.
- The Committee agreed a **monitoring programme for Business Cases that had been approved** at the Committee or Trust Board from 2018/19, and the Chief Finance Officer also agreed to arrange for the establishment of a separate group, involving the Non-Executive Director members of the Committee, to oversee the development of any large-scale projects involving commercial contracts (such as the outsourcing of outpatient pharmacy services or the real-time patient flow IT system). It was further agreed that the Trust Secretary should liaise with the Chair of the Committee to finalise the scheduling of the reviews.
- The latest information from the **Costing Transformation Programme (CTP) (i.e. the national cost collection exercise)** was reviewed.
- The **month 11 non-finance related performance** was discussed, which included the Emergency Department 4-hour, cancer, and Referral to Treatment waiting time targets. The significant adverse impact of COVID-19 on the latter was emphasised, as was the scale of the work to recover the position that the Trust had achieved before the COVID-19 period.
- The Outline Business Cases (OBCs) for the **Kent and Medway Pathology Service change, Laboratory Information Management System (LIMS), and Managed Service Contract (MSC)** were reviewed and supported as submitted, to enable them to be submitted to the Trust Board in May. It was also agreed that the Chief Executive should ensure that the options regarding the transfer of staff under the Transfer of Undertakings (Protection of Employment) regulations were properly explored as part of the Full Business Case (FBC) for the Pathology Service change; and ensure that the FBC for the LIMS explored whether the two-year implementation timescale stated in the OBC could be shortened. The Chief Executive also agreed to ensure that the versions of the OBCs submitted to the Trust Board gave greater clarity on how the implementation risks would be mitigated
- The Director of IT gave the latest **six-monthly update on IT strategy** and related matters, which included the work done to facilitate the changes had occurred during the COVID-19 period (such as home working), and the continuing development of various strategic projects.

**2. In addition the agreements referred to above, the Committee agreed that:**

- The Trust Secretary, Chief Executive and Chair of the Trust Board should Liaise to confirm the information that would be submitted to the Trust Board meeting on 21/05/20 in relation to the OBCs for the Kent and Medway Pathology Service change, LIMS and MSC

**3. The issues that need to be drawn to the attention of the Board are as follows:**

- The OBCs for the Kent & Medway Pathology Service change, LIMS, & MSC were reviewed and supported as submitted, to enable them to be submitted to the Trust Board in May.

**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