NHS
Maidstone and Tunbridge Wells NHS Trust

Trust Board Meeting ('Part 1')

21 May 2020, 09:45 to 12:00
Virtual meeting, via webconference

Agenda

N.B. Following the government's 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).

05-1
To receive apologies for absence

David Highton

05-2
To declare interests relevant to agenda items

David Highton

05-3
To approve the minutes of the 'Part 1' Trust Board meeting of 30th April 2020

David Highton

Board minutes 30.04.20 (Part 1).pdf (9 pages)

05-4
To note progress with previous actions

David Highton

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

05-5
Report from the Chair of the Trust Board

David Highton

Chair's Report.pdf (1 pages)

05-6
Report from the Chief Executive

Miles Scott

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

05-7
Update on the Trust's response to COVID-19

This will be a verbal report.

Miles Scott

05-8
Integrated Performance Report for April 2020 (incl. planned and actual ward staffing for April 2020)

Miles Scott and colleagues

IPR month 1.pdf (27 pages)

Planning and strategy

05-9
Kent and Medway STP Pathology Programme: Outline Business Cases (OBCs) for Service change; a Laboratory Information Management System (LIMS); and a Managed Service Contract

N.B. The full OBCs have been made available to Trust Board members as “supplements” to the main set of reports (in the "documents" section of Admincontrol)

Miles Scott

Kent and Medway STP Pathology Programme Outline Business Cases (OBCs).pdf (90 pages)

05-10
Annual approval the Sustainable Development Management Plan (SDMP)

N.B. The item has been scheduled for 11.30am

Miles Scott / Doug Ward

Annual approval of the Sustainable Development Management Plan (SDMP).pdf (22 pages)

Assurance and policy

05-11
NHS Provider licence: self-certification for 2019/20

Kevin Rowan

Provider Licence self-certification 2019-20.pdf (15 pages)

Reports from Trust Board sub-committees

05-12
Workforce Committee, 30/04/20 and 15/05/20

N.B. The written report only covers the meeting on 30/04/20. A verbal report will be given for the meeting on 15/05/20

Emma Pettitt-Mitchell

Summary of Workforce Cttee, 30.04.20.pdf (1 pages)

05-13
Quality Committee, 06/05/20

Sarah Dunnett

Summary of Quality C'ttee, 06.05.20 (incl. revised Terms of Ref).pdf (5 pages)

05-14
Finance and Performance Committee, 19/05/20

Please note that the report will be issued after the meeting on 19/05/20

Neil Griffiths

Other matters

05-15
Annual review of the Trust Board's Terms of Reference

David Highton / Kevin Rowan

Revised Terms of Reference for Trust Board.pdf (6 pages)

05-16
To consider any other business

David Highton

05-17
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.

David Highton

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 30TH APRIL 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)
	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:	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)
	Rantimi Adodele	Chair of the Cultural and Ethnic Minorities Network (for item 4-18)	(RA)

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

04-5 To receive apologies for absence

No apologies were received.

04-6 To declare interests relevant to agenda items

No interests were declared.

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

The minutes were approved as true and accurate records of the meetings.

04-8 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") and 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 there had been a brief discussion on the Integrated Performance Report (IPR) at a meeting of the Non-Executive Directors that had been held earlier that day, and some concerns had been raised regarding the format and content. DH also noted that the Non-Executive Directors had seen the "Second phase of NHS response to COVID19" letter from the NHS Chief Executive and NHS Chief Operating Officer. MS proposed that he and SO liaise to address the concerns, by applying the principle of focusing on priorities, rather than on the same issues each month. DH agreed, but added that the objective should be to ensure efforts were focused on the correct issues. MS acknowledged the point but highlighted that there needed to be ongoing monitoring of lots of

indicators that were collected routinely so judgement was required to determine which of these were worthy of discussion. MS stated that he and SO should consider the issue during the next two weeks. DH therefore proposed that that the two existing actions be closed and be replaced with a new action to reflect MS' comments. This was agreed.

Action: Liaise to consider the comments made at the Trust Board meeting on 30/04/20 regarding the Integrated Performance Report (IPR), and agree the format of the IPR that would be submitted to future Trust Board meetings (Chief Executive and Chief Finance Officer, April 2020 onwards)

DM then noted that the aforementioned meeting with Non-Executive Directors had also discussed the daily COVID-19 scorecard and a query had been raised as to whether the Trust's decision-makers were receiving the correct information they needed to make decisions. MS acknowledged that the correct data had not always been collected and reported, but explained that the process had evolved and there was now a good 'live' system in place. SB agreed and highlighted that the Trust had had to respond to significant volumes of data requests during the COVID-19 period. SO added that the Trust had to complete and submit 11 different 'sitreps' (situational reports) each day, and that the capturing of COVID-19 information had developed from being a manual process to being more electronic. SO continued that although there would be lessons learned after the COVID-19 period, some lessons had already been put into practice. DH commented that there had probably been some dissonance between the data on the whiteboard in the COVID-19 Incident Command Centre and the data within the daily COVID-19 scorecard that was issued by email, as the latter contained some errors, such as an increased sickness absence rate, that had continued until these had been identified by the Non-Executive Directors. DH continued that the situation had called into question the intended audience for the daily scorecard, if decision-makers were using different data. The point was acknowledged and PM added his perspective on how data was used by the COVID-19 Clinical Reference Group.

- **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)").** DH reported that the action could be closed as the Freedom to Speak Up Guardian report that had now been submitted under item 04-19 contained a reference to the Case Reviews published by the National Guardian's Office.
- **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").** DH noted that the Board Assurance Framework (BAF) may need to reflect COVID-19 and post-COVID-19 objectives. KR agreed and noted that the content of the BAF would be dependent on what was agreed under item 04-17. DH acknowledged the point but clarified that he was highlighting that the BAF may need to change during 2020/21. KR agreed.

04-9 Safety moment

COB firstly pointed out that this would be the last "Safety moment" report submitted to the Trust Board (and therefore to all Trust Board sub-committees), as the value of the "Safety moment" report had been reconsidered in response to the feedback from recent Trust Board meetings.

COB then referred to the relevant attachment highlighted the key points therein, which included the action being taken regarding domestic abuse in pregnancy and safeguarding children, neglect and non-accidental injury, and the concept of "think family". MC remarked that she had been impressed by the safeguarding teams, following her attendance at the Joint Safeguarding Committee meeting on 29/04/20, but asked how the team had been involved in supporting staff during the COVID-19 period. COB replied that most support was provided after training events, and the safeguarding team was adept at signposting staff to the appropriate support services. COB added that the COVID-19 wellbeing group was the main forum to identify staff in need of support.

RF noted the relevance of the subject matter, given the national media coverage regarding increased reports of domestic abuse, but appealed for the "Safety moment" to not be lost completely, as RF believed it was an important way of changing the culture of an organisation.

COB acknowledged the point but referred RF to the update given in the 'actions log' for action 02-5, which confirmed that work on learning would continue via other means.

04-10 Report from the Chair of the Trust Board

DH firstly reported that he and the Non-Executive Directors continued to be hugely impressed by the work and commitment of the staff, and noted that the extraordinary 'Part 2' Trust Board meeting held on 16/04/20 had suggested that a 'Thank You' letter be issued to staff from the Trust Board, in recognition of their hard work and commitment during the COVID-19 period. DH continued that he would like such a letter to be sent, with all Trust Board members signing. KR offered to draft a letter. This was agreed.

Action: Draft a letter of gratitude, to be signed by all Trust Board members, to staff in recognition of their hard work and commitment during the COVID-19 period (Trust Secretary, April 2020 onwards)

SDu proposed that the Trust Board also consider doing something different, such as recording a video message. MS agreed that a short video from Trust Board members would be welcomed by staff. COB however pointed out that many staff had welcomed the letter they had recently received from MS, and the power of written communication should not be underestimated. The point was acknowledged.

DH then referred to relevant attachment and stated that he understood the second "Paediatrics" appointment had been a locum appointment. MC, who had been on the Advisory Appointments Committee panel for that appointment, confirmed the appointment had been for a fixed term of one-year. DH therefore asked KR to amend the report that had been uploaded to the Trust's website. KR agreed and stated that he would also confirm the terms of the appointment with the Medical Staffing department.

Action: Confirm, with the Medical Staffing department, that the second paediatric consultant appointed on 02/04/20 was only appointed for a fixed-term (one year) period, and amend the relevant "Report from the Chair of the Trust Board" on the Trust's website to clarify that point (Trust Secretary, April 2020 onwards)

04-11 Report from the Chief Executive

MS referred to the relevant attachment and highlighted the following points:

- The achievements for 2019/20 should be acknowledged, as it was important that the Trust delivered what it had committed to do. Those achievements included delivering the financial plan for the second year in a row, achieving the cancer access, Referral to Treatment (RTT) and Emergency Department (ED) 4-hour waiting time targets, and preparing for the Care Quality Commission (CQC) inspection.
- Staff engagement had also been developed significantly, and the clinically-led changes that were introduced in 2019 had assisted in the achievements that had been made.
- The Trust had 'made its own luck' in the sense that changes it had made, such as opening a new Acute Medical Unit (AMU) and recruiting significant numbers of overseas nurses, had enabled it to respond to the challenges posed by COVID-19.
- The Trust should therefore take a moment to celebrate the achievements of 2019/20.
- The CQC inspection report of Medway NHS Foundation Trust would be published later that day, and MS understood that the overall rating of "Requires Improvement" would be retained, although the rating for the "Well led" domain had deteriorated.

DH endorsed everything MS said regarding the achievements of 2019/20.

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

MS reported the following issues:

- The Trust had seen 313 COVID-19 positive patients thus far and there had been 186 discharges and 78 deaths, which was a crude mortality rate of 30%. For critical care, there had been 40 COVID-19 positive patients, 14 discharges and 10 deaths i.e. a crude mortality rate of 42%, which was lower than some of the rates seen elsewhere in the country. The critical care numbers had started to reduce. ED attendances had been 40% to 50% less that 'normal', but

were rising - daily attendances for February 2020 had been between 420 and 470, while in April, they were between 190 and 270. The number of 'Medically Fit For Discharge' (MFFD) patients was 70% lower.

- There had been 80 staff with COVID-19 symptomatic sickness absence, 40 of whom had tested positive for COVID-19. 230 staff were shielding and isolating. 200 staff were also taking Annual leave (A/L), which was below expected levels, so staff had been encouraged to take a reasonable amount of their A/L during the first quarter of 2020/21, to ensure they had a break and also to avoid a problem later in the year. No staff had died due to COVID-19, but one member of staff was currently in critical care.
- The Trust was basing its approach to Personal Protective Equipment (PPE) on guidance from the World Health Organization (WHO), but was adapting its approach in response to feedback from staff. Other support being provided to staff included refreshments, psychological support, guidance on social distancing, and communications.
- There had been an incredible response and support from the Trust's local community, in terms of volunteering, gifts, messages of support and donations. As the Trust was a member of NHS Charities Together, it would receive a proportion of the donations that had been made via that route, including the £30m that had been raised by Captain Tom Moore.
- The Trust had benefited from having strong procurement and materials management teams and the Trust had maintained a good supply of PPE. There had been good engagement with staff and PPE Safety Officers were in place.
- The Trust had more than played its part in testing for COVID-19, and was currently testing admissions, Same Day Emergency Care (SDEC) patients, ED patients, discharges, staff and families of NHS and key workers. The Trust had also been able to borrow equipment from the University of Kent, which had helped increase the Trust's testing capacity. The Trust was also testing patients who were being discharged to care homes and vulnerable households, and had not discharged COVID-19 positive patients to care homes.
- ICU activity had peaked at 30 patients on 11/04/20, which was double the number of patients seen during the ICUs' busiest day in February 2020. Four wards were currently closed and the staff from those wards were supporting critical care, COVID-19 wards and absence. A new vacuum insulated evaporator (VIE) had been ordered for Maidstone Hospital, to ensure there was an adequate oxygen supply.
- There had been an increased incidence of COVID-19 among Black, Asian, and Minority Ethnic (BAME) nurses, but not doctors. A letter would therefore be issued on 30/04/20 to all BAME staff and their managers; and SM had recommended that BAME staff be provided with a face covering for use when travelling via public transport.
- The national framework for recovery and reset had been set out by the NHS Chief Executive and NHS Chief Operating Officer. That outlined a six-week programme and MS felt that the Trust was well placed to respond. The Trust's immediate priorities would be focused on the clinical impact of delays and changes to pathways; outpatients; elective activity (noting that the Trust's RTT position had declined by 10% in one month); discharge and patient flow (which included supporting colleagues in Kent Community Health NHS Foundation Trust and the Councils to deliver on their responsibilities); support for the workforce; and promoting social distancing for the longer term. All of the priorities need to be based on a thorough 'lessons learned' exercise.
- The key issues and challenges included the physical separation of patients and staff between COVID-19 and 'clean' areas; fatigue; maintaining critical care capacity and re-establishing elective work simultaneously; and A/L.

DH noted that the Non-Executive Directors were keen on ensuring the recovery plan was monitored, and the framework set out by the NHS Chief Executive and NHS Chief Operating Officer had been welcomed. DH added that he concurred with MS that time needed to be taken to plan the recovery properly, but the Trust Board was keen to monitor that recovery, including the elements of the Trust's response to COVID-19 that would likely be retained. MS stated that he was keen to have two more weeks before sharing a recovery plan, but much of the plan would be in progress at that point, although MS would like to hear initial comments from the Non-Executive Directors on any aspects they felt should be retained. DH remarked that the use of video outpatient appointments would be useful to be monitored, as the concern was that telephone outpatient

appointments would just revert back to being face-to-face appointments in the future. MS stated that the current arrangements should neither be retained nor should there be a reversion back to the pre-COVID-19 arrangements, and illustrated the point that physiotherapy appointments would be far better via video than via the telephone. JW then gave her perspective on the use of video appointments and PM noted that the current arrangements had illustrated the fact that a large number of outpatient follow-up appointments had probably not been necessary.

NG asked whether some of the command and control arrangements that had been applied during the COVID-19 period would be retained. MS replied that that question would be best asked during the 'lessons learned' exercise, as although there were some good examples of where a centralised approach had worked well, such as with PPE, there were also some good examples of devolved autonomy achieving success, such as in critical care. MS continued that it was therefore important to distinguish between the aspects that worked well and those that did not. PM agreed that he believed that some of the less successful responses from the divisions had not necessarily been related to a lack of a command and control approach. DH stated that it was important when empowering divisions not to lose the cross-cutting programmes of work. RF opined that pathway accountability was important i.e. someone taking responsibility for the whole pathway. RF also remarked that it would be a mistake to think that command and control had been the successful factor, as he believed that although centrally-set boundaries were important, allowing autonomy within such boundaries was equally important. KC opined that enabling and allowing frontline staff to act within a framework, and have permission to proceed, was important. KC also emphasised the importance of responding to staff fatigue, given the significant efforts that would be required to recover and retain the improvements that had been made. The points were acknowledged.

Integrated Performance Report

04-13 Integrated Performance Report for March 2020
04-13.1 Safe (incl. planned and actual ward staffing for March 2020)
04-13.2 Safe (infection control)
04-13.3 Effective
04-13.4 Caring
04-13.5 Responsive
04-13.6 Well-Led (finance)
04-13.7 Well-Led (workforce)

In the interests of time, DH referred to the relevant attachment and invited questions or comments. SDu commended the achievements for 2019/20, and congratulated all members of the Executive Team for their hard work and efforts. DH echoed SDu's congratulations.

Board Assurance Framework (BAF)

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

KR referred to the relevant attachment and highlighted the following key points:

- The ratings for each objective had been agreed at the Executive Team Meeting on 21/04/20
- Of the 12 objectives, eight had been rated as "fully achieved" and three "not achieved". One objective, to "implement the planned surgical reconfiguration by the end of 2019/20", had however not been allocated a rating, as the Trust had made a deliberate decision in March 2020 to stop the reconfiguration because of the COVID-19 period. The rationale for each rating was contained on pages 2 to 5
- The final ratings for each objective would be reported in the Trust's Annual Report for 2019/20. The Trust Board was therefore asked to either confirm the ratings as valid or agree alternative ratings.

The Trust Board confirmed the year-end ratings for each objective as submitted.

Planning and strategy

04-15 Update on the 2020/21 Operating Plan

SO referred to the relevant attachment and highlighted the following points:

- The traditional business planning process had been paused as the COVID-19 period started and the NHS would need to operate within the current financial framework for the first four months of 2020/21.
- Trust Board approval was required for the approach to budget setting.
- For 2019/20, one of the concerns approaching the year-end had been the refinement from central funding providing 'any resources that the NHS needed', to providing 'any resources that were deemed reasonable'. SO had however received confirmation that the circa £1.8m of COVID-19 related costs incurred by the Trust during the end of 2019/20 had been accepted, and the anticipated loss of income had not materialised. SO therefore had no major concerns.

SO then gave details of the proposed approach to budget setting, noting that this was proposed to last for the first four months of 2020/21, and would then be reviewed for the remainder of the year.

DM asked what the implications were, for 2020/21 of releasing the £8m of reserves that had helped achieve the 2019/20 financial plan. SO explained the key issues, and noted that although the Trust would be funded to a break-even position during the first four months of 2020/21, which meant it did not need to make any savings, there remained an underlying financial challenge. SO added that there was also much uncertainty for the future. DM asked what the value of the underlying structural deficit was. SO estimated that this was circa £20m, which compared to an underlying structural deficit of £40m when the Trust was within Financial Special Measures. DH emphasised the importance of not diverting busy managers from important COVID-19 work, but stated that there was congruence between the aforementioned recovery from COVID-19 and the need to retain many of the benefits, and the need to deliver future savings, although it may not be helpful to label the efforts on the latter as being part of a Cost Improvement Programme. SO acknowledged the point and gave assurance that discussions of such nature had commenced.

The Trust Board approved the proposed four month budget process as submitted.

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

SB referred to the relevant attachment and highlighted the key points therein, which included the work to transfer stroke rehabilitation patients to independent sector facilities; and the approach that had been agreed regarding recruitment.

DH noted that the report asked the Trust Board to confirm the expenditure of the £280k capital on estates preparatory work; support exploring options for stroke rehabilitation to remain off site to support winter plan and possible continuation of the stroke build; and support the recruitment of a consultant outside of current establishment. The requested confirmation and support was duly granted.

JW asked whether there was any further information on when the outcome of the appeal of the Judicial Review would be known. SB confirmed there was no further information beyond that included in the report.

SB then concluded by thanking the staff that had implemented the changes to stroke services that had taken place during 2019/20.

04-17 Agreement of key objectives for 2020/21

AJ referred to the relevant attachments, noting that an updated version (2) had been issued earlier that morning, and highlighted that there had not been, as yet, detailed guidance regarding national indicators such as RTT, nor of the work that was intended in relation to Western Sussex Hospitals NHS Foundation Trust. AJ continued that he had therefore submitted a hybrid approach but confirmed that the only difference between versions 1 and 2 was a minor change to the temporary staffing aspects. AJ then explained the relationship between the PRIDE values, objectives and progress objectives, as well as the content of the "how we deliver" section.

EPM acknowledged the difficulty of setting the objectives, but asked whether the Friends and Family Test objective would include specific details of the baseline and target scores, rather than just refer to the national benchmark. AJ confirmed specific details could be added to that objective.

Action: Amend the 2020/21 objective to "Improve Friends and Family Score to national standards" to include specific details of the baseline and target scores (Director of Strategy, Planning and Partnerships, April 2020 onwards)

EPM also asked whether the "Excellence" objective was not just an enabler of "Patient First", as it represented the 'how' rather than the 'what'. AJ replied that he believed that EPM's query reflected the confusion that staff experienced between the "Excellence" and "Patient First" aspects of the PRIDE values, although these values had been retained because staff generally recognised them. AJ added that he would however recommend that the PRIDE values be reviewed during the year.

EPM then acknowledged the pause in the work with Western Sussex Hospitals NHS Foundation Trust, so asked whether it was worth agreeing any objectives at that point, given the likelihood that the objectives would change. MS answered that he believed it was worthwhile, as the objectives that were agreed now may end up being the objectives for the whole of 2020/21, as the Western Sussex Hospitals NHS Foundation Trust work was more likely to completely re-set the approach for 2021/22 rather than 2020/21. DH agreed.

RF acknowledged the benefit of having a small number of objectives, but asked where the cultural and leadership aspects would be considered. MS stated that the "Train all of our staff in QSIR and ensure that they have the opportunity to deploy those skills" element on page 3 of 3 was most pertinent in that regard, although it was recognised that that was only one element of the Exceptional People Outstanding Care programme. MS proposed that the yellow boxes therefore be changed to reflect the whole programme. This was agreed.

Action: Liaise with the Chief Executive to amend the "objective", "progress objective" and "how we deliver" aspects of the "Respect" value in the 2020/21objectives, to reflect the comments made at the Trust Board meeting on 30/04/20 (Director of Strategy, Planning and Partnerships, April 2020 onwards)

JW stated that the "Ensure that patients are discharged appropriately at weekends" aspect would be dependent on other organisations within the Sustainability and Transformation Partnership (STP). PM responded that that aspect was more related to the Trust being able to influence its partners and he was content to accept that challenge.

KR then asked, on behalf of SDU, whether the Trust should seek to maximise the cultural and ethnic differences of staff. MS agreed and stated that this could be incorporated into the aforementioned changes to the yellow boxes that would be made following RF's comments.

The objectives for 2020/21 were approved, subject to the agreed changes.

Assurance and policy

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

RA referred to the relevant attachment and highlighted the key points therein, which included that the report had been submitted to the Workforce Committee in March 2020 (but the Committee had felt it important to be submitted to the Trust Board); the background to the Workforce Race Equality Standard (WRES); the results from the latest WRES data; and the highlights for the Trust.

RA then gave some examples of the negative experiences and racial micro-aggression that staff and students from Canterbury Christchurch University had relayed, which had identified the need for action. RA then reported on the ideas for racial diversity and inclusion at the Trust, but emphasised the need for action to be driven from the Trust Board rather than from herself as the Chair of the Cultural and Ethnic Minorities Network. RA noted four areas for action, as follows:

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; and
4. Reduce the percentage of BME staff experiencing harassment, bullying or abuse

RA added that she would also like to introduce a form of 'reverse mentoring', to raise the understanding of why diversity was important. DH confirmed that the proposal regarding the reverse mentoring scheme was unanimously supported by the Non-Executive Directors.

MS asked whether there were any specific differences between different BAME staff, or whether the issues should considered as a whole. RA stated that it was an insightful question and she had had been shocked by the comments that had been reported as being received by black and asian nursing students, but confirmed that the differences appeared to be related to the seniority of staff.

RF referred to the second area for action and emphasised the importance of separating recruitment from selection process, which included considering having 'blind' processes for the latter. RA agreed that the differential was crucial.

AJ then referred to the examples reported by RA and asked about removing cultural bias, as opposed to racial bias, from the process. RA acknowledged the point but noted that the WRES was primarily focused on racial issues, not cultural issues, although there was work to be done to address AJ's point.

DH confirmed that the Trust Board was fully supportive of RA and her work.

04-19 Quarterly report from the Freedom to Speak Up Guardian

MC referred to the relevant attachment and highlighted the key points therein, which included the themes and issues that had emerged, as well as the actions planned to 'grow' the speaking up agenda.

DH noted the reference to resources and asked if the lack of resources had inhibited progress. SH explained that a Business Case had started to be developed and SH was aiming to identify some resource to enable the Freedom to Speak Up Guardian to complete the Case.

04-20 The outcome of the Estates and Facilities review undertaken by The Grichan Partnership

MS reported that a draft report had been issued, but more work was required, so it was intended to submit the report to the Trust Board's next meeting.

04-21 Ratification of the Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ('Policy for Policies')

KR referred to the relevant attachment and highlighted the following key points:

- The Policy and procedure for the production, approval and ratification of Trust-wide Policies and procedures ("Policy for Policies") provided the framework within which all Trust-wide polices were approved and ratified
- Although the existing policy was still within its review date, the policy had been revised because several changes were required. The proposed changes were described on the front cover and the most significant change was the amended definition of a "Trust-wide policy" to be a policy that covers the method of working across more than one Division, rather than one Directorate. That change was aligned to the increased autonomy given to Divisions under the clinically-led management changes that took place in 2019.
- The process for issuing policies for use involved two stages: approval and ratification. The revised policy had been approved by the Executive Team Meeting, and had been submitted to the Trust Board for ratification.
- The document had also been reviewed by the Policy Ratification Committee (PRC). The PRC ratified all policies apart from those that were reserved for ratification by the Trust Board. There

were three such polices: the Risk Management Policy, the health and Safety policy and the "policy for policies".

DH asked whether there were sufficient members of the PRC. KR explained that the PRC was always open to new members but confirmed that there was a sufficient pool of current members to enable the PRC to meet each month.

MC asked about the support available to staff in determining whether a policy was genuinely needed and KR explained approach.

The Trust Board ratified the Policy and procedure for the production, approval and ratification of Trust-wide Policies and procedures ("Policy for Policies") as submitted.

Reports from Trust Board sub-committees

04-22 Audit and Governance Committee, 19/03/20

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

04-23 Charitable Funds Committee, 24/03/20 (to include approval of revised Terms of Reference)

DM referred to the relevant attachment and highlighted the key points therein, which included that the Committee had agreed a proposal to establish a Charity Management Committee. Questions were invited. None were received.

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

04-24 Workforce Committee, 26/03/20 (to include approval of revised Terms of Reference)

EPM referred to the relevant attachment and highlighted the key points therein, which included that future meetings would not be held on the same day as Trust Board meetings. Questions were invited. None were received.

The Trust Board approved the revised Terms of Reference for the Workforce Committee as submitted.

04-25 Quality Committee, 02/04/20

SDu referred to the relevant attachment and highlighted the key points therein. Questions were invited. None were received.

04-26 Finance and Performance Committee, 28/04/20

NG referred to the relevant attachment and highlighted the key points therein, which included that the Committee had reviewed, and confirmed its support for, the STP Pathology Outline Business Cases, which would be submitted to the Trust Board in May 2020.

04-27 To consider any other business

The Trust Board approved a 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.

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]
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 it is intended to adapt the format of the Board Assurance Framework (BAF) for 2020/21 to align with the forecast ratings within the Integrated Performance Report ((IPR) (noting that the format of the IPR is itself subject to changes at the current time). This would mean that the rating of "Confidence that the objective will be achieved by the end of 2020/21" would not feature in the BAF, provided that objective was monitored and reported on within the IPR. It is likely that a "Confidence…" rating would still however be needed for the objectives that did not have a forecast rating within the IPR.
04-17a	Amend the 2020/21 objective to "Improve Friends and Family Score to national standards" to include specific details of the baseline and target scores	Director of Strategy, Planning and Partnerships	April 2020 onwards	A meeting has been scheduled between the Chief Nurse and Director of Strategy Planning and Partnerships to agree a target score and the objective will be updated following this.

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
04-8	Liaise to consider the comments made at the Trust Board meeting on 30/04/20 regarding the Integrated Performance Report (IPR), and agree the format of the IPR that would be submitted to future Trust Board	Chief Executive and Chief Finance Officer	May 2020	Amendments have been made to the IPR for month 1 (2020/21) reporting. Further review and changes will take place in future months as the implications of the changed reporting regime in which we are now operating are understand more fully.

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	meetings			
04-10a	Draft a letter of gratitude, to be signed by all Trust Board members, to staff in recognition of their hard work and commitment during the COVID-19 period	Trust Secretary	May 2020	It was instead agreed that an all-users email would be issued from the Chair of the Trust Board, on behalf of all Trust Board members, and that email was issued on 07/05/20. In addition a video message from the Non-Executive Directors was recorded and uploaded to the Trust's YouTube channel. The link to the message was included in the all-users email to staff.
04-10b	Confirm, with the Medical Staffing department, that the second paediatric consultant appointed on 02/04/20 was only appointed for a fixed-term (one year) period, and amend the relevant "Report from the Chair of the Trust Board" on the Trust's website to clarify that point	Trust Secretary	April 2020	The situation was checked with the Medical Staffing department and it was confirmed that the individual was appointed as a locum consultant for six months. Trust Board members were notified of this by email on 01/05/20, and the "Report from the Chair of the Trust Board" on the Trust's website had a clarification point added.
04-17b	Liaise with the Chief Executive to amend the "objective", "progress objective" and "how we deliver" aspects of the "Respect" value in the 2020/21objectives, to reflect the comments made at the Trust Board meeting on 30/04/20	Director of Strategy, Planning and Partnerships	May 2020	Liaison occurred and the requested amendments were made.

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

NHS Maidstone and Tunbridge Wells NHS Trust

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

I and the Non-Executive Directors (NEDs) would like to thank all the staff of the Trust and our partners in the community and social care for their professionalism, dedication, compassion and care for all the patients of the Trust, both Covid and non-Covid. We were pleased to be able to send a video to all the staff on the Chair Update on May 7th, which was issued in place of the CEO Update.

I have continued to keep our NEDs up to date through daily messages in a WhatsApp group and through a weekly videoconference. As Covid-19 moves beyond the peak and the numbers of positive patients on our wards and ITU continues to fall, the NEDs will support emerging work streams of the recovery and reset programme. The Trust Board Sub-Committees will consider the different work streams of the programme and will work with the Executive Team to ensure that staff welfare and safety continue to be at the forefront of our approach to restarting services and capturing the best of new ways of working which have emerged.

We will have a commitment to working with other partners across health and social care, more locally in the West Kent Integrated Care Partnership and at a system level across the Kent & Medway STP. The NHS Trust Chairs in Kent & Medway also have a WhatsApp Group and fortnightly videoconferences to facilitate a partnership approach.

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.

No Advisory Appointments Committee (AAC) panels have been held since my last report to the Trust Board. The next AAC is scheduled for 18/05/20, and the outcome of that will be formally reported to the Trust Board in June 2020

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

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

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

NHS Maidstone and Tunbridge Wells NHS Trust

Report from the Chief Executive **Chief Executive**

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

1. We continue to see a steady decrease in the numbers of patients we're caring for who have tested positive for coronavirus (Covid-19). This is welcome news and it is thanks to the efforts of our local communities in following social distancing measures that our hospitals – and the country – are now moving into a more positive position. As a result, and in line with national guidance, we are now focusing on our detailed plans to reinstate routine and non-urgent activity in a safe and sustainable way.

   We have continued to deliver our essential and urgent services such as cancer, emergency and stroke throughout the pandemic. This was achieved by making some changes to the way we worked, from collaborating with the independent sector to implementing virtual patient consultations and adapting patient pathways and criteria for assessment. We now need to review this as we to adapt to a world where coronavirus remains with us, and the healthcare challenges this presents.

   Over the next few weeks we will review how we deliver our planned (elective), cancer and urgent care services during the second phase of the pandemic as well as staff wellbeing measures and enhanced staff and patient safety initiatives to prevent the spread of the virus as hospital activity increases. The draft programme is being updated on Tuesday 19 May and a copy is being sent to the Non-executive Directors (NEDs). Further details will be shared once the plans are confirmed.

2. Our dedicated Covid-19 charity fund currently has a total of £128,549, which includes a grant from NHS Charities Together of £77,500 and donations from successful fundraising initiatives organised by our charity team. The national NHS Charities Together fund has so far raised more than £103 million. Our Covid-19 charity donations will be used to fund Trust initiatives to support the health and wellbeing of our staff, helping to make MTW a great place to work. We will have more details about these projects over the coming weeks.

3. This month MTW marked international nurses and national midwives and operating department practitioner (ODP) days, with a series of special events and activities to celebrate and thank our staff for their contribution to the care we give our patients. Staff received hampers hand-delivered by our Executives and special messages, videos, photos and case studies were put together to honour the work of our colleagues. You can view the videos here.

4. We delivered all eight cancer patient access standards in March. This is the eighth month in a row we've achieved the national targets and MTW is now one of the top performing cancer centres in the country.

5. Secure video messaging application vCreate has been rolled out on the Neonatal Unit permanently following a successful three month pilot. This means parents of premature and sick babies being cared for on the unit can see their child when they're unable to be with them. The technology, which allows clinical teams to send video updates to parents when they're not able to be at the hospital, was made possible thanks to the Morrisons Foundation, part of the supermarket chain, which donated £9,600 to the Trust's charity.

6. Additional iPads are being provided to wards to allow more of our patients to FaceTime or Skype their family and friends during their hospital admission, while visiting restrictions are in place.

7. We are the first trust in Kent to welcome Project Wingman to our hospitals. Furloughed and grounded airline and cabin crew are now offering a first-class lounge experience to our staff at both Tunbridge Wells and Maidstone hospitals. The volunteer team are offering free refreshments to staff in a dedicated area to enable them to rest, relax and recharge. The cabin crews have a good understanding of what it's like to work in a high pressure environment and help to provide a friendly listening ear to support staff during the coronavirus pandemic.

8. Congratulations to our Infant Feeding Team, who won a Johnson's Excellence in Maternity Care and Innovation Award in the Royal College of Midwives annual awards. The video Colostrum Collection in Pregnancy: 'When to start and how to do it', shows those who are pregnant how to express their first breast milk (colostrum) by hand in the late stages of pregnancy and then collect and store it. Infant feeding Baby Friendly Initiative (BFI) Lead Sally Sidhu, who features in the film alongside retired Infant Feeding BFI Lead Jan Gatehouse, put the educational film together to support women and their babies who are anticipated may experience difficulties with feeding or maintaining their blood sugar levels directly after birth.

9. The MTW staff choir came together virtually to release a cover version of Michael Jackson's hit song 'Beat it' to remind our local communities that they need to do all they can to help save lives and beat the virus. Instead of the original lyrics, the choir switched the words to deliver their hard-hitting musical message. Each member of the staff choir recorded the song individually to ensure they followed social distancing measures with the video edited together to provide a fantastic rendition of the song.

10. The voices of two of our nurse practitioners featured in Colonel Tom Moore and Michael Ball's version of 'You'll never walk alone', which made number one in the official UK singles chart. Heather Callaghan and Gerry Finney, who work in the emergency departments at both hospitals, successfully applied to be part of the NHS Voices of Care Choir, which provided the backing vocals on the track that is raising money for NHS Charities Together.

11. Once again, I'd like to extend my thanks 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.

12. 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
    - Discussion of the operating plan for 2020/21
    - Update on RTT, Emergency Department and Cancer waiting times performance
    - Update on the Workforce Race Equality Scheme (WRES)
    - 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, April 2020	**Chief Executive / Members of the Executive Team**

Enclosed is the Integrated Performance Report for month 1, 2020/21 (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, 19/05/20 (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

April 2020

MTW
exceptional people, outstanding care

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Maidstone and Tunbridge Wells NHS Trust

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- Summary Scorecard — Pages 5
- COVID-19 Summary — Pages 6-8

Appendices (Page 10 onwards)

- Making Data Count Project Plan
- Finance Report
- Safe Staffing Report

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

Executive Summary

Executive Summary

The Trust has achieved the National Cancer 62 Day FDT Standard of 85% for eight consecutive months at 85.3%. Both the 2 week wait cancer waiting times target and the 2 week wait Beast Symptoms were also achieved in March and have been above target for the last seven months (with a slight dip for Breast Symptoms in January). In addition April performance increased to 98.8% for the A&E 4hr standard and is the third best performing Trust in the UK partly due to lower attendance numbers, greater bed availability & changes to working practices and patient pathways forced by the pandemic. As expected due to the COVID-19 pandemic activity levels have decreased significantly in April for both elective and outpatient appointments which will have adversely impacted the RTT performance for April, currently being finalised. Some cancer and urgent activity has also been transferred and undertaken in the independent sector.

The rates of falls, pressure ulcers and infection control will have been impacted by the COVID-19 pandemic in April due to the Trust having a lower level of occupied beddays and admissions. There have been no cases of Mixed Sex Breaches reported in April and the closure of SIs in a timely manner has continued to show an improving trend month on month. The number of new complaints received in April was significantly lower than in previous months and the number of compliments received increased.

Items for Escalation

- **Infection Control:** There was 1 case of C.Diff reported in April and the Trust is therefore on trajectory. Cases of E.Coli increased by 1 to 5 in April equating to a rate of 51.9 per 100,000 occupied beddays which is above the threshold. The level of occupied beddays were lower in April due to the COVID-19 Pandemic. There have been no cases of MRSA reported.

- **Falls:** The level of Falls has reduced in April to 75. However, due to the lower level of occupied beddays (excluding ITU) due to COVID-19 this equates to a rate of 7.84 per 1,000 occupied bed days which is therefore above the maximum trajectory. To reduce the number and rate of falls, there will be a greater focus on multifactorial risk assessments for patient at risk of falls to improve identifications of risk factors and the informing of intervention required to be implemented to reduce the risk of falls.

- **Pressure Ulcers:** The level of hospital acquired pressure ulcers (HAPU) has remained similar in April with 12 reported but again this equates to a higher rate of 3.6 due to the lower level of admissions. The monitoring process for hospital acquired pressure ulcers has been adapted to triangulate pressure ulcer incidence in COVID positive patients. The Tissue Viability Nurses are liaising with NHS England and the Tissue Viability Society for up to date skin care advice under PPE for staff.

- **Stroke:** Performance against the metrics that constitute the Best Practice Tariff came in at 42.6% for 2019/20 (data runs one month behind) which is 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. Daily identification of the patients that have been moved to COVID-19 wards to ensure that MDT is aware of their location.

- **A&E 4 hour Standard:** performance in April reached 98.08%, thanks to lower attendance numbers, greater bed availability and changes to working practices and patient pathways in response to the COVID-19 Pandemic. The Trust is the 3rd best performing Trust in the UK (and 2nd best last month) for the 4hr standard whilst remaining the top performing Trust regionally. The pandemic has reduced A&E attendance to 40-50% of the normal levels since mid-March, with average daily attendances falling to 226.3 per day in April. Emergency Admissions have been around 30% lower than the normal levels, with the total bed occupancy dropping below 50% in April.

- **Referral to Treatment (RTT) Incomplete Pathway:** As expected due to the COVID-19 pandemic activity levels have decreased significantly in April for both elective and outpatient appointments which will have adversely impacted the RTT performance for April which is currently being finalised.

Performance Wheel and Executive Summary

Items for Escalation

- **Cancer 2weeks (2ww):** Both the 2 week wait cancer waiting times target and the 2 week wait Beast Symptoms were achieved in March and have been above target for the last seven months (with a slight dip for Breast Symptoms in January).

- **Cancer 2weeks (2ww) Referrals:** There has been a significant decrease in the number of referrals per day due to Covid-19 (including GP referrals), with a monthly total of 1963 referrals in January, reducing to 1539 in February, 1263 in March and overall 738 referrals received in April 2020

- 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 eight consecutive months (85.3%). This is a significant improvement over last year when only 67.9% of our patients were treated in 62 days. This report covers the 62 day standard for March 2020 treatments and at this point there was not a significant impact from Covid-19. The impact is expected to be noted in April 2020 treatments.

- **Diagnostics Waiting Times <6 weeks:** As expected performance for April (still being finalised) will have been adversely impacted by COVID-19.

- **Finance:** The Trust delivered the financial plan in April by achieving a breakeven position. In line with national guidance this included £3.5m retrospective top up income support from NHSI/E. This funding is designed to cover the incremental step changes of COVID 19 above the baseline funding (November to January average) but is capped to the level of funding which is required for the Trust to breakeven. The Trust has identified £4.5m of costs associated with COVID 19 therefore underspends totalling £1m have been made to net the impact down to £3.5m. The key underspends against plan are: £0.6m underspend with drugs mainly due to reduction in high cost Ophthalmology activity, £0.3m pay underspend within Administration (£0.1m) and STT staff Groups (£0.2m) due to higher than planned vacancies and £0.4m reduction within non pay budgets due to reduction in elective activity.

- **Workforce - Fill Rate:** The Safe Staffing Nursing Fill Rate is currently showing 84.2%. There has not been any staffing level risk to wards. The bed occupancy has been much lower and staff have been redeployed to support COVID areas. This has happened through management of pathways and closures of some wards as well as the daily staffing level review and ensuring safe staffing levels across the organisation

- **Workforce - Vacancy Rate**: The Trust vacancy rate shows an increase from 8,1% in March to 9.6% in April. However, this is due to the number of staff in post increasing by 22 but the plan increasing by 130 at the start of the financial year. It is the difference between these two figures that is causing the jump in vacancy rate rather than a true increase in the rate.

- **Workforce - Staff Sickness:** The overall sickness rate has increased to 5.2% in April which was impacted by the COVID-19 Pandemic (at least 1.7% of total). Non-Covid related sickness has remained fairly constant in April. The COVID-19 related sickness which includes; confirmed cases, suspected cases and self-isolation increased sharply after the national lockdown on the 23rd March but has started to show a downward trend since mid-April. Staff Confirmed Covid-19 cases increased when the central sickness line was set up and as the swabbing capacity increased but these are now showing a downward trend.

- **Staff and their Families Swabbing:** Capacity is higher than uptake with an average utilisation of 26% in April (20% in May), although this was higher at weekends and bank holidays in April (32%). The drive-through is less utilised than the two PODs at Maidstone and Tunbridge Wells Hospitals which is bringing down the overall utilisation rate. All staff or members of their family who are symptomatic are being swabbed.

- **COVID-19 Tests:** There has been a gradual increase in the levels of testing and capacity has been increased to support the need. Currently our labs are able to process up to 400 tests per day. To date an average of 41% of the swabs tested are for NHS staff. As of the 28th April all non-elective patients who are admitted to the Trust and require an overnight bed are also being swabbed for Covid-19 whether they are symptomatic or asymptomatic.

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	FOT	
S1	Rate C-Diff (Hospital only)	24.8	10.4	44.6	10.4	22.6	21.9	↑
S2	Number of cases C.Difficile (Hospital)	5	1	9	1	55	51	↑
S3	Number of cases MRSA (Hospital)	0	0	0	0	0	0	↑
S4	Rate of E. Coli Bacteraemia	29.8	51.9	29.8	51.9	21.5	31.8	↘
S5	Rate of Hospital Pressure Ulcers	*2.30*	3.6	1.1	3.6	2.3	1.4	↘
S6	Rate of Total Patient Falls	*5.80*	7.79	*6.94*	7.79	*5.80*	5.00	↘
S7	Number of Never Events	*0*	0	0	0	0	0	→
S8	Number of New SIs in month	11	5	17	5	132	126	↗
S9	SIs not closed <60 Days Monthly Snapshot	24	9	97	9	24	9	↗
S10	Overall Safe staffing fill rate	93.5%	84.2%	94.8%	84.2%	93.5%	84.2%	↓

Effective		Curr Month		Year to Date		Year End		Change on Prev Mth
ID	Key Performance Indicators	Plan	Actual	Prev Yr	Curr Yr	Plan	FOT	
E1	Hospital-level Mortality Indicator (SHMI)	Band 2	1.0203	1.0391	1.0203	Band 2	Band 2	→
E2	Standardised Mortality HSMR	Lower conf <100	92.0	96.3	92.0	Lower conf <100	92.0	→
E3	% Total Readmissions	14.1%	10.5%	14.1%	14.4%	14.1%	14.4%	↗
E4	Readmissions <30 days: Emergency	14.8%	10.7%	14.8%	15.0%	14.8%	15.0%	↗
E5	Readmissions <30 days: Emergency (excl SDE	14.0%	9.4%	14.0%	14.4%	14.0%	14.4%	↑
E6	Readmissions <30 days: Elective	6.8%	7.0%	6.8%	7.9%	6.8%	7.9%	↗
E7	Stroke: Best Practice (BPT) Overall %	50.0%	49.3%	49.9%	42.6%	50.0%	42.6%	↑
E8	Nat CQUIN: % Dementia Screening	90.0%	99.6%	99.7%	95.9%	90.0%	95.9%	↗
E9	Nat CQUIN: % Dementia Risk Asssessed	90.0%	100.0%	94.5%	101.2%	90.0%	101.2%	↗
E10	Nat CQUIN: % Dementia Referred to Specialist	90.0%	100.0%	99.3%	99.0%	90.0%	99.0%	↗

Caring		Curr Month		Year to Date		Year End		Change on Prev Mth
ID	Key Performance Indicators	Plan	Actual	Prev Yr	Curr Yr	Plan	FOT	
C1	Single Sex Accommodation Breaches	0	0	0	0	0	0	→
C2	Rate of New Complaints	3.92	1.25	2.28	1.25	2.96	2.89	↑
C3	% complaints responded to within target	75.0%	64.9%	66.7%	64.9%	75.0%	74.4%	↓
C4	IP Resp Rate Recmd to Friends & Family	25.0%						
C5	IP Friends & Family (FFT) % Positive	95.0%						
C6	A&E Resp Rate Recmd to Friends & Family	15.0%						
C7	A&E Friends & Family (FFT) % Positive	87.0%	Data not collected or reported due to COVID-19					
C8	Mat Resp Rate Recmd to Friends & Family	25.0%						
C9	Maternity Combined FFT % Positive	95.0%						
C10	OP Friends & Family (FFT) % Positive	84.0%						

Responsive		Curr Month		Year to Date		Year End		Change on Prev Mth
ID	Key Performance Indicators	Plan	Actual	Prev Yr	Curr Yr	Plan	FOT	
R1	Emergency A&E 4hr Wait	87.9%	98.1%	90.6%	98.1%	88.0%	98.1%	↑
R2	Emergency A&E >12hr to Admission	0	0	0	0	0	0	→
R3	Ambulance Handover Delays >30mins	358	161	494	161	4084	3887	↑
R4	RTT Incomplete Pathway (October)	Data currenlty being finalised						↓
R5	RTT 52 Week Waiters (New in Month)							↓
R6	% Diagnostics Tests WTimes <6wks							↓
R7	Cancer two week wait	93.0%	93.3%	88.7%	93.3%	93.0%	93.3%	↘
R8	Cancer two week wait-Breast Symptoms	93.0%	99.0%	73.2%	99.0%	93.0%	99.0%	↗
R9	Cancer 31 day wait - First Treatment	96.0%	98.0%	96.1%	98.0%	96.0%	98.0%	↘
R10	Cancer 62 day wait - First Definitive	85.0%	85.3%	67.9%	85.3%	85.0%	85.3%	↘

Responsive - Flow		Curr Month		Year to Date		Year End		Change on Prev Mth
ID	Key Performance Indicators	Plan	Actual	Prev Yr	Curr Yr	Plan	FOT	
R11	Average LOS Non-Elective	6.90	6.36	7.12	6.36	6.40	6.36	↘
R12	Theatre Utilisation	90.0%	77.2%	88.4%	77.2%	90.0%	77.2%	↓
R13	Primary and Non-Primary Refs	15,794	3979	16,485	3979	199,800	187985	↓
R14	Cons to Cons Referrals	6,025	3100	6,399	3100	76,216	73,291	↓
R15	OP New Activity	18,438	9167	17,596	9167	233,240	223969	↓
R16	OP Follow Up Activity	29,519	18184	27,556	18184	372,228	360893	↓
R17	Elective Inpatient Activity	597	97	546	97	7,557	7057	↓
R18	Day Case Activity	3,998	523	3,781	523	50,576	47101	↓
R19	Non Elective Activity (inc Maternity)	5,843	3228	5,158	3228	71,089	68474	↓
R20	A&E Attendances : Type 1	14,309	6790	13,401	6790	176,581	169062	↓

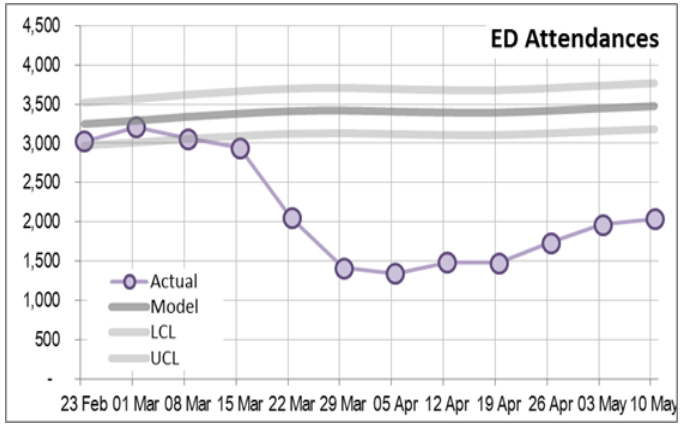
Well-Led		Curr Month		Year to Date		Year End		Change on Prev Mth
ID	Key Performance Indicators	Plan	Actual	Prev Yr	Curr Yr	Plan	FOT	
W1	Surplus (Deficit) against B/E Duty	-	0	- 2,001	0	-	-	→
W2	CIP Savings	Suspension of CIPs Nationally						
W3	Cash Balance	-	49,528	41,294	49,528	1,000	1,000	→
W4	Capital Expenditure	-	934	358	934	-	-	→
W5	Finance use of Resources Rating	3	-	-	-	3	3	→
W6	Staff Turnover Rate (%)	10.0%	11.9%	9.5%	11.9%	10.0%	11.9%	↗
W7	Vacancy Rate (%)	8.0%	9.6%	10.7%	9.6%	8.0%	9.6%	↘
W8	Total Agency Spend	833	1,184	1,649	1,184	17.738	18.574	↘
W9	Statutory and Mandatory Training	90.0%	85.6%	87.1%	85.6%	90.0%	85.6%	↘
W10	Sickness Absence	3.3%	5.2%	3.4%	5.2%	3.3%	5.2%	↘

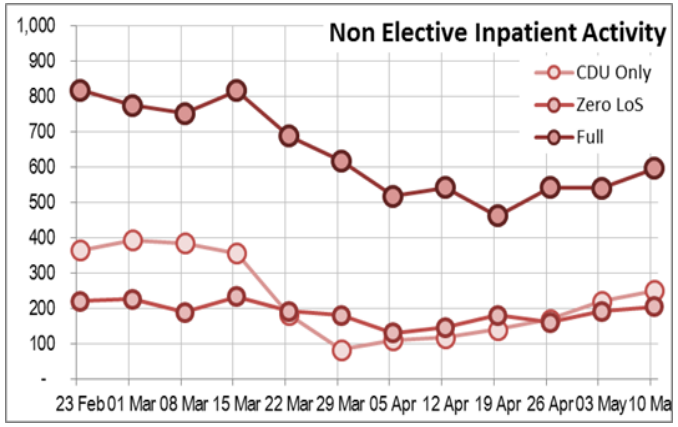
Target Indicator Key:	
On or above Target	
Review and Corrective Action required	
Significantly below target - urgent action required	
KPI Used in Performance Wheel Scoring	

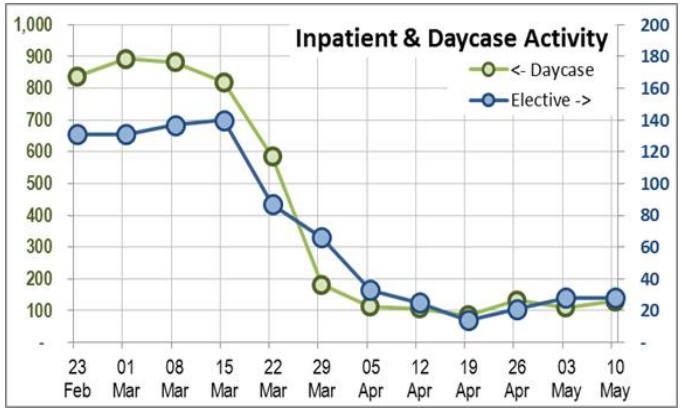
Change on Previous Indicator Key:	
Significant improvement on Previous (>5%)	↑
Improvement on previous (<5%)	↗
No Change	→

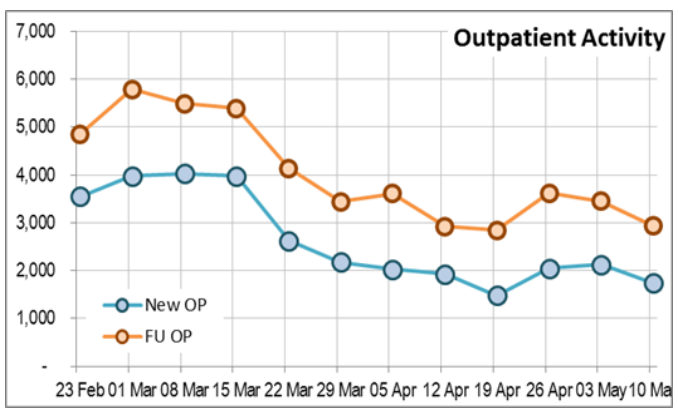
Change on Previous Indicator Key:	
Deterioration on previous (<5%)	↘
Significant deterioration on previous (>5%)	↓

Escalation: COVID-19









ED Attendances: Attendances were already below model in February, and started to reduce noticeably in early March the week ending 08-Mar. On 13-Mar, the day after the UK threat level was increased to 'high', we saw daily attendances fall below the normal ranges, and the slide continued for about 10 days before levelling off shortly after the lockdown at 55-60% down on normal. They have since picked up to around 35-40% down. Minor attendances have reduced more than majors. Ambulance arrivals are now around 20% down on normal levels, whilst non ambulance are reduced by 40-50%.

Emergency Admissions: Non-Same Day Emergency Care (SDEC) admissions have been around 29% down on normal levels over the past 3 weeks, whilst SDEC admissions are down around 19%. Admissions in CDU only is down by 43%, but this is due to a reduction in use of CDU. In line with ED, activity took 2-3 weeks to reduce

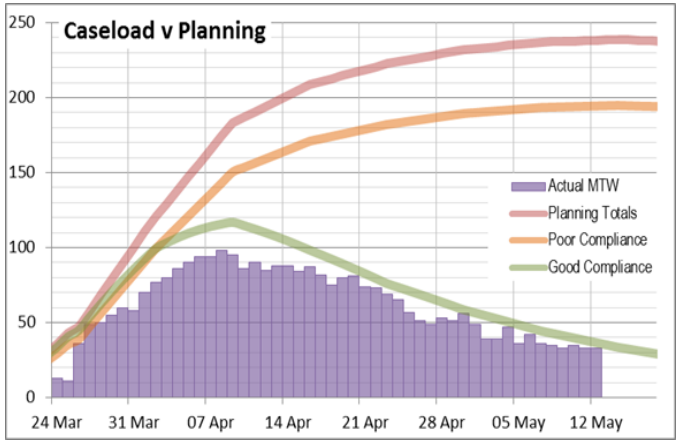
Elective / Daycase Activity : Large scale cancellations of elective activity has resulted in admitted electives reducing by 80-85% on normal levels, and daycases by 85-90% - though both have recovered slightly. Elective has taken longer to fall off than non-elective, as it reflects our cancellation / postponement practices rather than patient's behaviour. Levels of Daycases declined more sharply. Due to the COVID response most of the elective activity has ceased apart from urgent cancers being undertaken internally. However, some urgent and cancer activity has also been transferred and undertaken in the Independent Sector.

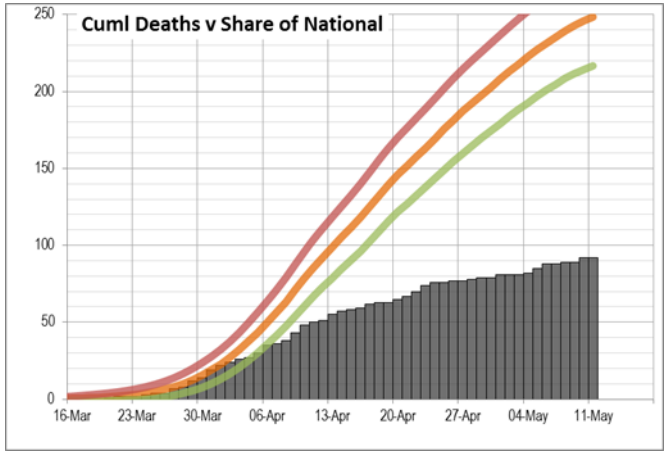
Outpatient Activity : New Outpatient activity has reduced by around 50-60%, and follow up by around 40-50%, though it is suspected that the last weeks figures are still slightly undercounting as uncashed appointments are still in the system. As with elective activity, the week-by-week reduction has been slower than seen in emergency activity. Outpatient attendances have been impacted by COVID-19 but where clinically appropriate appointments have been moved to either a telephone or virtual appointment to avoid cancellations & DNAs.

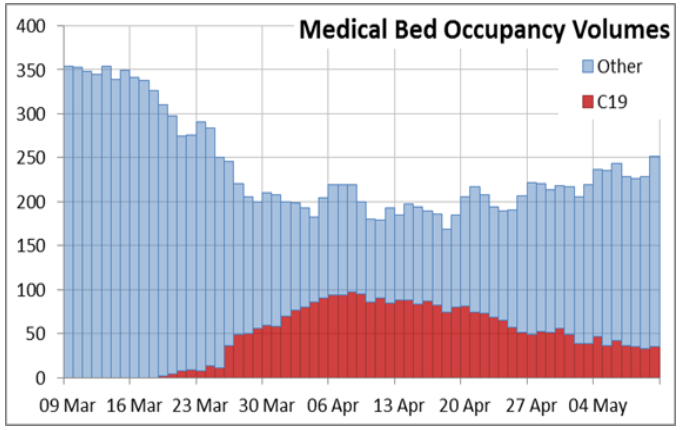
Summary : All activity levels have reduced:

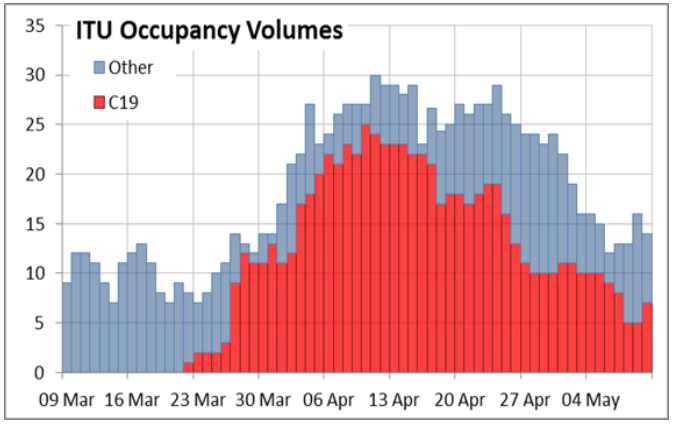
- Minor ED attendances now 40-50%,
- Major down ~20%
- Emergency admissions down ~30%
- Daycase & elective activity down 80-90%
- Outpatient activity down 40-60%

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 reduction. Bed planning totals were set at this level, plus around 22%. So far, MTW has consistently tracked 10-20% below the good compliance totals.

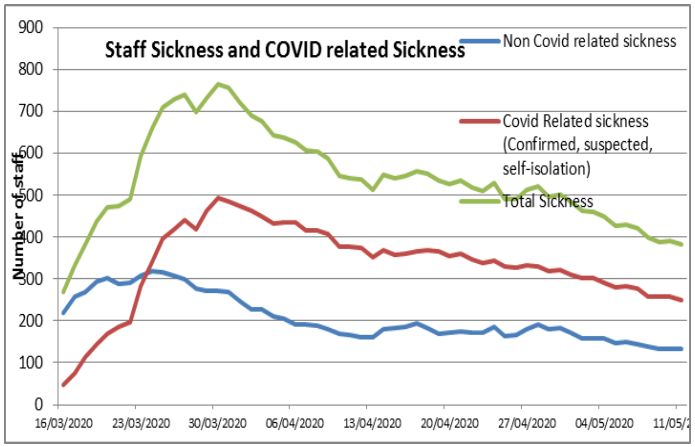
Deaths : The national total being quoted daily is hospital deaths. Since our local population is 0.88% of the national total, then if deaths were spread evenly throughout the country, then by Sun 10-May, we would have expected our cumulative total to be 240-250. In reality it was less than half that at 92. This, along with our caseload, indicates that our local area has not been hit as badly as others.

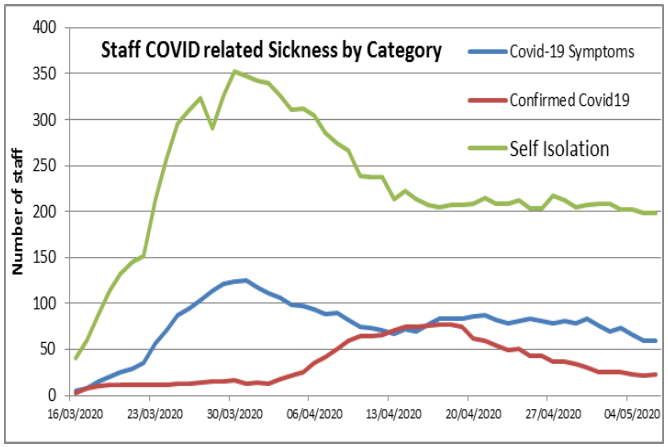
Bed Occupancy: Medical bed occupancy started to reduce from its normal level of 330-360 patients around 16-Mar, as a combination of reduced emergency demand, and the emergency plan to clear beds & reduce elective activity took effect. Occupancy was below 300 as the first cases came in, and has levelled off at 180-220. In the past 2 weeks, 15-20% of medical bed occupancy has been Covid Patients

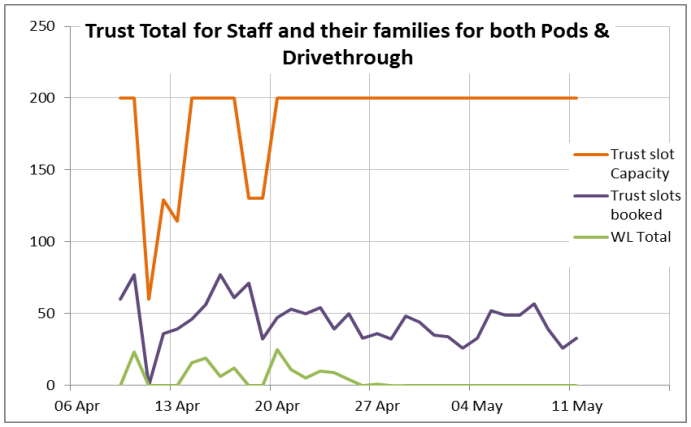
ITU Occupancy: This was around normal levels of 8-12 for the two weeks before the first patients arrived, before rising sharply to 25-30. In the past 2 weeks, 50-55% of ITU occupancies have been Covid positive

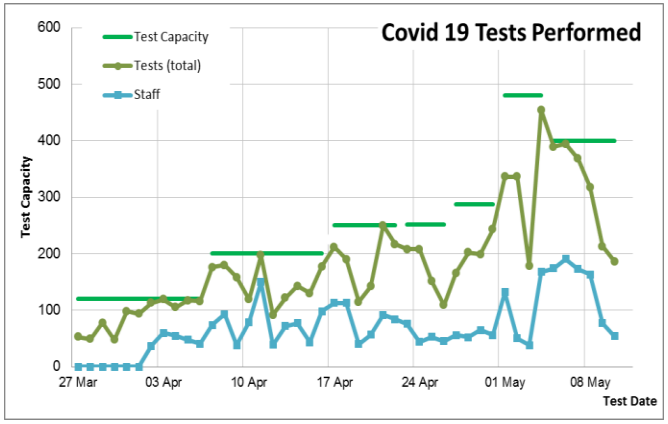
Summary :
MTW caseloads & deaths have both been tracking well below what we would expect, indicating that our region has been hit less than others. Covid patients currently account for 14% of medical & 50% of ITU bed occupancy

Escalation: COVID-19









Staff Sickness: Non-Covid related sickness rose slightly in March (average of 285 staff absences per day). Since the beginning of April this decreased back down to an average of 185 per day and has remained fairly constant.

Covid-19 Related Sickness: The COVID-19 related sickness which includes; confirmed cases, suspected cases and self-isolation increased sharply, especially after the national lockdown on the 23rd March up to the end of March but then started to show a gradual downward trend from the beginning of April from an average of 432 cases per day in March to 413 early April, 345 late April and 279 so far in May.

Self-Isolation: The number of people self-isolating rose sharply in March to a high of 348 at the end of March (72% of all COVID-19 related sickness). From April this showed a downward trend and then stabilised from Mid-April (to an average of 63%).

Swabbing: Overall Trust slot capacity for staff and their families increased throughout April and is now at 200 slots available per day (a slot could have 1 to 6 people attending depending how many in the family require swabbing). The level of slots booked has remained below the capacity with utilisation ranging from 13% to 55% on a particular day. Average utilisation was 26% in April and 20% in May. However there was a higher utilisation at weekends and bank holidays (32%) in April. MTW is performing swabbing for other local NHS Trusts and local partners in West Kent. MTW makes up 25% of the total (278 swabbed to date), 26% Other NHS Trusts, 36% Private Healthcare and 7% for Other Agencies .

Pathology – COVID-19 Tests Performed: Testing capacity has increased throughout April and May to meet demand. During April the overall level of tests performed (both staff and patients) averaged 83% of the total capacity during weekdays and 64% of total capacity at the weekends. The proportion of all tests undertaken that are for NHS Staff is around 41%. The Trust laboratories are carrying out tests for other parts of Kent.

Summary: Non-Covid related sickness remained fairly constant in April.

Covid-19 related sickness increased sharply after national lockdown but now showing a downward trend.

Staff Confirmed Covid-19 cases increased when central sickness line was set up as swabbing capacity increased.

Swabbing Capacity is higher than uptake

Pathology Tests performed has increased along with capacity (41% on NHS Staff)

Appendices

NHS
Maidstone and Tunbridge Wells NHS Trust

Making Data Count Project Plan - Produced in May 2020

As at: 13/05/2020

No.	Item	Action	Action Owner(s)	Deadline	Status	Update
1	Metrics	Review metrics by CQC Domain	JJ/TJ	31/03/2020	Action Complete	
		Agree Metric 'Owners'	JJ / EMT	31/03/2020	Action Complete	
		Review and agree targets for each metric	JJ/TJ	29/05/2020	Action On Track	
		Review which metrics influence the 'Performance Wheel'	JJ/SO	29/05/2020	Action On Track	
		Cross-reference metrics with Single Oversight FW and other relevant guidance	JJ/TJ	31/03/2020	Action Complete	
		Add Data Quality Kite Marks for each metric	TJ / IBPs	03/07/2020	Action Not Due	
2	Layout	Agree format for Scorecard	JJ/SO	31/03/2020	Action Complete	
		Agree content and flow of sections	JJ/SO	31/03/2020	Action Complete	
		Confirm Exec Leads for section / domain review and sign off	JJ/EMT	31/03/2020	Action Complete	
		Confirm and document rules for escalation	JJ/TJ/SO	24/06/2020	Action On Track	
		Agree design of escalation pages	JJ/TJ/SO	29/05/2020	Action On Track	
		Agree appendices and supporting information	JJ/TJ/SO	24/06/2020	Action Not Due	
3	Performance Wheel	Review which metrics influence the 'Performance Wheel' and thresholds	JJ/TJ/SO	24/06/2020	Action Not Due	
		Review, agree and document the methodology using SPCs	JJ/TJ/SO	24/06/2020	Action Not Due	
		Agree which versions of the wheel are shown e.g. FOT, YTD	JJ/TJ/SO	24/06/2020	Action Not Due	
4	Training and Engagement	Identify MDC Ambassadors at Team and Ward level	JJ/SB	29/05/2020	Action On Track	Have spoken to Sean and agreed approach. Delayed asking for names
		Arrange launch event for Ambassadors	JJ/SON	10/07/2020	Action Not Due	This will now be virtual
		Set up dedicated session with lead Execs with Sam Riley (NHS E&I)	JJ/SR	04/07/2020	Action Not Due	
		Arrange Analyst Training with NHSE&I leads (to be shared with K&M colleagues)	JJ/SR	26/05/2020	Action Not Due	
		Launch with OPs leads, GMs and AGMs	JJ/SR	10/07/2020	Action Not Due	
		Set up dedicated session with CCG and Optum leads	JJ /MP	10/07/2020	Action Not Due	
5	Report Build	Revise / update data models behind report	TJ/ IBPs	10/07/2020	Action Not Due	
		Build new scorecards and escalation pages	TJ/ IBPs	10/07/2020	Action Not Due	
		Build SPCs for all Metrics	TJ/ IBPs	10/07/2020	Action Not Due	
		Build Performance Wheel using new methodology	TJ/ IBPs	10/07/2020	Action Not Due	
		Share for review and comment	JJ/TJ	13/07/2020	Action Not Due	
		Publish to Board	JJ/TJ	17/07/2020	Action Not Due	
6	DPR Process and Report	Review process in light of the move to SPCs	JJ/HF	29/07/2020	Action Not Due	
		Redesign Scorecards	JJ/TJ/HF	29/07/2020	Action Not Due	
		Review Metrics	JJ/TJ/HF	29/07/2020	Action Not Due	
		Review Targets and Thresholds	JJ/TJ/HF	29/07/2020	Action Not Due	
		Updated Performance Management FW	JJ/TJ/HF	26/08/2020	Action Not Due	
		Agree priority order and timescales for implementation	JJ/TJ/HF	29/07/2020	Action Not Due	
		Launch with Divisional Leads	JJ/TJ/HF	26/08/2020	Action Not Due	

MTW
exceptional people, outstanding care

Safe		2018/19 Outturn	2019/20 Target	Q4			Q1			Q2			Q3			Q4			YTD	FOT	YTD Var from Plan
ID	Key Performance Indicators			Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
S1	Rate of Cdifficile per 100,000 beddays	21.4	22.6	13.7	19.6	23.2	10.4												10.4	21.9	-58.1%
S2	CDifficile (Post 72hrs) - Hospital	52	55	3	4	4	1												1	51	-4
S3	MRSA Bacteraemia (Post 48hrs) Hospital	2	0	0	0	1	0												0	0	0
S3.1	% Elective MRSA Screening	0.0%	98.0%	100.0%	96.6%	No data	No data												No data	No data	
S3.2	% Non-Elective MRSA Screening	94.3%	95.0%	92.3%	95.8%	94.3%	91.8%												91.8%	91.8%	-3.2%
S4	Rate of E. Coli Bacteraemia per 100,000 beddays	30.8	21.5	36.6	24.6	23.2	51.9												51.9	31.8	22.2
S4.1	MSSA Bacteraemia (Post 48hrs)	27	27	1	0	2	2												2	28	1
S4.2	E. Coli Bacteraemia (Post 48hrs)	75	75	8	5	4	5												5	74	-1
S4.3	Cases of Gram Negative Bactareamia	95	95	8	7	4	10												10	97	2
S4.4	Catheters inserted	2,162	225	No data	No data	185	101												101	101	- 124
S5	Rate of Hospital Acquired Pressure Ulcers	1.74	2.30	2.28	2.14	2.49	3.61												3.61	1.41	1.3
S5.1	Rate of All Pressure Ulcers	15.8	16.0	23.7	33.4	29.3	46.9												46.9	46.9	30.9
S5.2	Pressure Ulcers Grade 2	33	36	6	3	4	2												2	35	- 1
S5.3	Pressure Ulcers Grades 3	-	-	0	0	0	0												0	0	-
S5.4	Pressure Ulcers Grades 4	2	-	0	0	0	0												0	0	-
S5.5	Pressure Ulcers Deemed "Un-gradeable"	27	24	2	1	2	2												2	24	-
S5.6	Pressure Ulcers DTIs	65	36	7	9	7	8												8	41	5
S5.7	Pressure Ulcers MASD	-	-	0	0	0	0												0	0	-
S5.8	Pressure UlcersTotal	127	96	15	13	13	12												12	100	4
S6	Rate of Patient Falls	6.08	5.80	6.50	6.09	5.80	7.79												7.79	5.00	1.79
S6.1	Rate of Patient Falls TWH	7.01	6.10	7.39	6.69	6.81	8.61												8.61	5.68	2.31
S6.2	Rate of Patient Falls MH	4.70	4.80	5.29	5.31	4.41	6.66												6.66	4.00	1.66
S6.3	Falls resulting in "No Harm"	1,163	900	116	106	84	63												63	888	- 12
S6.4	Falls resulting in "Low Harm"	262	240	23	16	13	10												10	230	- 10
S6.5	Falls resulting in "Moderate Harm"	25	24	3	0	1	0												0	22	- 2
S6.6	Falls resulting in "Severe Harm"	27	24	0	1	2	2												2	24	-
S6.7	Falls resulting in "Death"	2	-	0	1	0	0												-	-	-
S6.8	Total Number of Patient Falls	1,479	1,188	142	124	100	75												75	1164	- 24
S6.9	Total Number of Patient Falls TWH	1,021	808	93	77	68	48												48	789	- 19
S6.10	Total Number of Patient Falls MH	458	380	49	47	32	27												27	375	- 5
S7	Never Events	3	0	1	1	0	0												0	0	0
S8	Number of New SIs in month	131	132	11	10	8	5												5	126	- 6
S8.1	Serious Incidents rate	0.54	0.54	0.50	0.49	0.46	0.52												0.52	0.54	0.00
S8.2	Number of Open Sis	97	95	48	46	44	40												40	40	- 55
S9	SIs not closed <60 Days Monthly Snapshot	24	24				9												9	9	- 15
S10	Overall Safe staffing fill rate	95.9%	93.5%	100.3%	97.3%	93.0%	84.2%												84.2%	84.2%	-9.3%
S11	Safety Thermometer % of Harm Free Care	87.2%	95.0%	86.7%	88.0%	87.2%	No data												0.0%	0.0%	-95.0%
S11.1	Safety Thermometer % of New Harms	5.4%	3.0%	7.4%	5.4%	5.4%	No data												0.0%	0.0%	-3.0%
S12	Number of Central Alerting System Alerts Overdue	15	1	5	0	1	0												0	0	-1
S13	Medication Errors - Low Harm	87	72	4	5	0	0												0	66	-6
S13.1	Medication Errors - Moderate Harm	8	12	0	2	0	0												0	11	-1
S13.2	Medication Errors - Severe Harm	0	0	0	0	0	0												0	0	0
S14	Number of Incidents reported in month	12,266	11,700	1,209	1,189	875	659												659	11384	-316
S14.1	Rate of Incidents that are Harmful	0.91	1.23	0.33	0.76	0.46	0.61												0.61	0.90	-0.62
S14.2	Number of Incidents open >45 days	1,931	1,058	1,724	1,461	1,058	750												750	750	-308

Effective		2018/19 Outturn	2019/20 Target	Q4			Q1			Q2			Q3			Q4			YTD	FOT	YTD Var From Plan
ID	Key Performance Indicators			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	1.0249	1.0132	1.0080	1.0203												1.0203	1.0203	Band 2
E2	Standardised Mortality HSMR		Lower Confidence <100	91.70	91.80	91.80	92.00												92.0	92.0	-8.0
E2.1	Crude Mortality	1.00%	1.00%	1.07%	1.01%	0.73%	1.01%												0.92%	0.92%	-0.1%
E3	% Total Readmissions	14.13%	14.13%	13.56%	14.58%	10.46%	14.91%												14.44%	14.44%	0.3%
E4	Readmissions <30 days: Emergency	14.76%	14.76%	13.89%	15.17%	10.71%	15.56%												14.98%	14.98%	0.2%
E5	Readmissions <30 days: Emergency (excl SDEC)	14.00%	14.00%	13.69%	15.74%	9.44%	15.24%												14.40%	14.40%	0.4%
E6	Readmissions <30 days: Elective	6.84%	6.84%	9.40%	8.06%	6.98%	7.73%												7.87%	7.87%	1.0%
E7	Stroke: Best Practice Tariff Overall %	41.7%	50.0%	49.1%	47.5%	43.1%	36.9%												42.6%	42.6%	-7.4%
E7.1	Stroke BPT Part 1: First Ward	74.1%	80.0%	81.1%	83.6%	75.9%	64.6%												74.6%	74.6%	-5.4%
E7.2	Stroke BPT Part 2: Cons <=14 Hours	50.9%	58.0%	62.3%	49.2%	50.0%	50.8%												51.0%	51.0%	-7.0%
E7.3	Stroke BPT Part 3: 90% Time on Stroke Ward	78.9%	80.0%	90.57%	91.80%	89.66%	80.0%												79.5%	79.5%	-0.5%
E7.4	% TIA <24hrs	58.1%	60.0%	No data															58.1%	58.1%	5.9%
E8	Nat CQUIN: % Dementia Screening	99.7%	90.0%	100.0%	99.8%	98.8%	94.3%												95.9%	95.9%	#VALUE!
E9	Nat CQUIN: % Dementia Risk Asssessed	94.5%	90.0%	100.0%	100.0%	98.7%	98.2%												101.2%	101.2%	#VALUE!
E10	Nat CQUIN: % Dementia Referred to Specialist	99.3%	90.0%	100.0%	100.0%	100.0%	98.1%												99.0%	99.0%	#VALUE!
E10.1	NE LOS for Patients with Dementia	0.0%	0.0%				7.7												8.6	0.0	#VALUE!
E10.2	Readmissions <30 Days for Pt with Dementia	0.0%	0.0%				21.0%												23.4%	23.4%	#VALUE!
E11	C-Section Rate (elective or non-elective)	27.9%	25.0%	25.2%	26.6%	28.6%	30.0%												14.3%		-10.7%
E11.1	% Mothers initiating Breastfeeding	82.2%	78.0%	83.89%	77.91%	83.22%	79.4%												79.4%	79.4%	1.4%
E11.2	% Stillbirths Rate	0.17%	0.47%	0.22%	1.36%	0.66%	0.00%												0.00%	0.00%	-0.5%

Caring		2018/19 Outturn	2019/20 Target	Q4			Q1			Q2			Q3			Q4			YTD	FOT	YTD Var from Plan
ID	Key Performance Indicators			Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
C1	Single Sex Accommodation Breaches	0	0	0	0	0	0												0	0	0
C2	Rate of New Complaints	2.43	2.96	2.20	2.60	3.54	1.25												1.25	2.89	-1.73
C3	% complaints responded to within target	75.0%	75.0%	80.4%	67.5%	75.0%	64.9%												64.9%	74.4%	-10.1%
C3.1	Total Open Complaints	160	140	125	141	160	119												119	119	- 21
C3.2	Number of new complaints received	591	720	48	53	61	12												12	672	- 48
C3.3	Number of Nursing Complaints	90	108	7	10	10	4												4	103	- 5
C3.4	Number of Medical Complaints	362	336	34	32	38	7												7	315	- 21
C3.5	Number of Complaints open 60-90 days	168	180	6	13	9	15												15	180	-
C3.6	Number of Complaints open >90 days	324	348	29	22	22	34												34	353	5
C4	% IP Response Rate Friends & Family	16.4%	25.0%	16.0%	16.7%	No data due to COVID-19													No data due to COVID-19		
C5	IP Friends & Family (FFT)% positive	95.7%	95.0%	96.3%	97.8%																
C6	% A&E Response Rate Friends & Family	8.5%	15.0%	1.9%	10.0%																
C7	A&E Friends & Family (FFT) % positive	87.7%	87.0%	87.2%	89.5%																
C8	% Maternity Combined Q2 Response Rate	53.7%	25.0%	20.1%	10.6%																
C9	Maternity Combined FFT % Positive	95.5%	95.0%	96.9%	96.0%																
C10	OP Friends & Family (FFT) % Positive	82.6%	84.0%	83.6%	83.2%																
C10.1	OP Friends & Family (FFT) Response Rate	57.1%	68.0%	59.2%	61.2%																
C11	VTE Risk Assessment (%)	95.5%	95.0%	96.4%	95.8%	95.5%	97.0%												96.5%	96.5%	1.5%

Responsive		2018/19 Outturn	2019/20 Target	Q4			Q1			Q2			Q3			Q4			YTD	FOT	YTD Var From Plan
ID	Key Performance Indicators			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)	90.65%	88.00%	91.13%	90.59%	93.13%	98.08%												98.08%	98.08%	10.1%
R1.1	A&E % 4hrs Arrival to Exit - Maidstone	95.07%	95.23%	91.05%	88.11%	92.82%	97.96%												97.96%	97.96%	2.7%
R1.2	A&E % 4hrs Arrival to Exit - TWells	86.25%	85.08%	87.80%	89.14%	90.77%	97.60%												97.60%	97.60%	12.5%
R1.3	A&E Conversion Rate	20.8%	20.8%	20.6%	19.9%	21.6%	26.8%												26.8%	26.8%	6.0%
R1.4	A&E Left without being Seen Rate (%)	2.8%	2.8%	2.0%	2.2%	1.6%	0.3%												0.3%	0.3%	-2.4%
R1.5	A&E Time to Assessment 15 mins	95.3%	95.0%	89.2%	56.8%	57.0%	No data												No data	No data	-13.3%
R1.6	A&E Time to Treatment 60 mins	55.9%	55.9%	60.1%	59.6%	68.7%	89.3%												89.3%	89.3%	33.4%
R1.7	A&E Unplanned Re-Attendance Rate (%)	8.0%	8.0%	8.7%	8.9%	0.0%	No data												No data	No data	0.0%
R1.8	A&E Average Time in Department (Hours)	0.14	0.13	0.15	0.14	0.13	No data												No data	No data	0.10
R2	A&E 12hr Breaches	0	0	0	0	0	0												0	0	0
R3	Ambulance Handover Delays >60mins	549	53	14	21	15	9												9	38	-62.9%
R3.1	Ambulance Handover Delays >30mins	5,695	4,084	370	416	260	161												161	3887	-55.0%
R4	RTT Incomplete Pathway	79.53%	86.66%	85.03%	87.30%	79.53%	No data												No data	No data	No data
R4.1	RTT Incomplete Admitted Backlog	1,986	651	2,153	1,332	1,986	No data												No data	No data	No data
R4.2	RTT Incomplete Non-Admitted Backlog	4,036	3,397	2,632	2,529	4,036	No data												No data	No data	No data
R4.3	RTT Specialties Not Achieved Nat Target	12	11	11	10	12	No data												No data	No data	No data
R4.4	RTT Incomplete Total Backlog	6,022	4,048	4,785	3,862	6,022	No data												No data	No data	No data
R5	RTT 52 Week Waiters (New in Month)	16	0	5	3	16	No data												No data	No data	No data
R6	% Diagnostics Tests WTimes <6wks	93.7%	99.0%	98.2%	99.5%	93.7%	No data												No data	No data	No data
R7	*Cancer two week wait	88.7%	93.0%	87.6%	89.2%	88.7%	82.6%												93.3%	93.3%	0.3%
R8	*Cancer WT - Breast Symptons 2WW	73.2%	93.0%	69.4%	74.7%	73.2%	56.4%												99.0%	99.0%	6.0%
R9	*Cancer 31 day wait - First Treatment	96.1%	96.0%	95.9%	96.2%	96.1%	96.5%												98.0%	98.0%	2.0%
R9.1	*Cancer 31 day - Subs Treatment - Surgery	92.9%	94.0%	82.4%	96.0%	92.9%	87.1%												100.0%	100.0%	6.0%
R9.2	*Cancer 31 day - Subs Treatment - Drugs	99.0%	98.0%	96.7%	98.2%	99.0%	100.0%												100.0%	100.0%	2.0%
R9.3	*Cancer 31 day Subs Treatment Radio	92.8%	94.0%	90.5%	94.5%	92.8%	92.5%												96.4%	96.4%	2.4%
R10	*Cancer 62 day wait - First Definitive	67.9%	85.0%	65.6%	56.0%	67.9%	64.5%												85.3%	85.3%	0.3%
R10.1	*Cancer 62 day wait - First Definitive - MTW	72.8%	85.0%	69.2%	58.8%	72.8%	68.6%												88.1%	88.1%	3.1%
R10.2	*Cancer WT - 62 Day Screening Referrals	74.4%	90.0%	80.6%	55.2%	74.4%	84.6%												93.2%	93.2%	3.2%
R10.3	*Cancer WT - 62 Day Cons Specialist	82.4%	85.0%	64.0%	86.7%	82.4%	100.0%												90.9%	90.9%	5.9%

Well-Led		2018/19 Outturn	2019/20 Target	Q4			Q1			Q2			Q3			Q4			YTD	FOT	YTD Var From Plan
ID	Key Performance Indicators			Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
W1	Surplus (Deficit) against B/E Duty	7,003	-	1,720	- 798	1,815	No data												No data	No data	#DIV/0!
W2	CIP Savings	22,032	-	1,781	2,396	1,899	No data												No data	No data	#DIV/0!
W3	Cash Balance	3,356	-	17,669	21,922	3,356	49,528												49,528	1,000	#DIV/0!
W4	Capital Expenditure	16,001	-	539	321	10,909	934												934	-	#DIV/0!
W4.1	Income	513,401	-	43,346	38,567	57,025	44,613												44,613	- 169,169	5.5%
W4.2	EBITDA	37,315	-	4,177	1,623	3,484	2,558												2,558	10,401	-1.6%
W5	Finance use of Resources Rating	3	3	3	3	3	3												-	3	-3
W6	Staff Turnover Rate	12.3%	10.0%	12.61%	12.65%	12.29%	11.93%												11.93%	11.93%	1.9%
W7	Vacancy Rate (%)	8.1%	8.0%	9.03%	7.77%	8.11%	9.63%												9.63%	9.63%	1.6%
W7.1	Contracted WTE	5,474	-	5,472	5,474	5,474	5,536												5,536	5,536	-5.4%
W7.2	Establishment WTE	6,124	6,124	6,134	6,131	6,124	6,132												6,132	6,132	0.0%
W7.3	Substantive Staff Used	5,376	-	5,364	5,369	5,376	5,401												5,401	5,401	-7.7%
W7.4	Worked WTE	6,148	-	6,072	6,102	6,148	6,086												6,086	6,086	-0.8%
W7.5	Vacancies WTE	650	-	662	657	650	596												596	596	112.4%
W8	Total Agency Spend	19,388	18	1,618	1,426	1,853	1,184												1,184	19	0
W8.1	Nurse Agency Spend	- 6,787	-	- 628	- 475	- 522	- 313												- 313	- 313	136.5%
W8.2	Medical Locum & Agency Spend	- 20,852	-	- 1,685	- 1,440	- 2,112	- 1,902												- 1,902	- 1,902	50.3%
W8.3	Bank Staff Used	549	-	467	507	549	469												469	469	145.4%
W8.4	Agency Staff Used	188	-	-	-	-	- 15												173	173	93.0%
W8.5	Overtime Used	35	-	30	40	35	42												42	42	No data
W8.6	Temp costs & overtime as % of total pay bill	13.4%	0.0%	16.3%	15.6%	13.4%	16.0%												16.0%	16.0%	7.7%
W9	Statutory and Mandatory Training	86.3%	90.0%	85.3%	85.9%	86.3%	85.6%												85.6%	85.6%	-4.4%
W10	Sickness Absence	3.5%	3.3%	3.9%	3.7%	3.5%	5.2%												5.2%	5.2%	1.9%
W11	Staff FFT % recommended work	66.0%	57.0%	66.0%	66.0%	66.0%	72.2%												72.2%	72.2%	15.2%
W11.1	Staff Friends & Family (FFT) % rec care	74.0%	80.0%	74.0%	74.0%	74.0%	77.8%												77.8%	77.8%	-2.2%
W12	Appraisal Completeness	90.8%	95.0%	90.5%	90.4%	90.8%	88.0%												88.0%	88.0%	-7.0%

Apr-20		DAY				NIGHT				TEMPORARY STAFFING							
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)	Temporary Demand Unfilled -RM/N (number of shifts)	Overall Care Hours per pt day	Falls	PU ward acquired	Comments
MAIDSTONE	Stroke Unit (M) - NK551	92.6%	74.3%	-	100.0%	97.5%	118.8%	-	-	24.4%	18.4%	89	23	12.9.	1	0	
MAIDSTONE	Cornwallis (M) - NE959	99.1%	76.9%	-	100.0%	95.0%	50.0%	-	-	5.6%	7.1%	11	0	12.0.	2	0	
MAIDSTONE	Culpepper Ward (M) - NS551	87.2%	75.5%	-	-	100.8%	103.3%	-	-	19.1%	17.9%	51	2	10.4.	0	0	
MAIDSTONE	John Day Respiratory Ward (M) - NT151	116.5%	73.7%	-	-	104.0%	80.7%	-	-	32.3%	25.1%	141	50	11.5.	5	1	
MAIDSTONE	Intensive Care (M) - NA251	127.3%	127.4%	-	-	135.6%	99.8%	-	-	32.8%	3.2%	168	22	18.6.	0	2	CHPPD include ITU and MICUAMU.
MAIDSTONE	Pye Oliver (Medical) - NK259	53.8%	71.7%	-	-	44.4%	73.3%	-	-	4.7%	81.8%	34	17	30.5.	4	1	
MAIDSTONE	Chaucer Ward (M) - NS951	86.4%	80.9%	-	-	80.0%	68.1%	-	-	21.9%	37.0%	136	72		0	0	Ward Closed as part opathway planning - staff redeployed
MAIDSTONE	Whatman Ward - NK959	76.0%	82.2%	-	100.0%	123.3%	143.3%	-	-	23.7%	38.3%	80	15	10.4.	2	0	
MAIDSTONE	Lord North Ward (M) - NF651	92.0%	100.3%	-	100.0%	83.4%	100.0%	-	-	3.0%	0.0%	10	0	10.2.	2	0	
MAIDSTONE	Mercer Ward (M) - NJ251	86.7%	98.2%	-	100.0%	97.8%	96.7%	-	-	22.1%	52.9%	84	22	7.7.	7	1	2 falls above threshold
MAIDSTONE	Edith Cavell (M) - NS959	88.4%	86.1%	-	100.0%	103.4%	90.9%	-	-	21.6%	8.7%	50	6	11.2.	1	0	
MAIDSTONE	Acute Medical Unit (M) - NG551	88.4%	73.1%	-	-	113.3%	170.0%	-	-	26.1%	22.9%	111	32	16.7.	0	0	
TWH	Ward 22 (TW) - NG332	113.4%	82.4%	-	100.0%	102.3%	80.0%	-	-	30.1%	21.3%	112	23	6.5.	6	1	
TWH	Coronary Care Unit (TW) - NP301	106.9%	97.9%	-	-	103.5%	-	-	-	12.9%	10.2%	27	1	20.0.	0	0	
TWH	Ward 33 (Gynae) (TW) - ND302	96.7%	80.6%	-	-	92.1%	70.0%	-	-	19.7%	1.6%	57	3	20.0.	1	0	1 fall above threshold
TWH	Intensive Care (TW) - NA201	130.5%	168.2%	-	-	120.7%	113.3%	-	-	28.1%	0.0%	181	12	25.5.	0	1	
TWH	Acute Medical Unit (TW) - NA901	80.8%	76.5%	-	100.0%	75.1%	92.0%	-	-	9.3%	12.6%	78	33	17.3.	5	0	
TWH	Surgical Assessment Unit (TW) - NE701	101.8%	99.7%	-	-	100.0%	100.0%	-	-	16.1%	0.0%	13	0	51.0.	0	0	
TWH	Ward 32 (TW) - NG130	78.4%	70.0%	-	-	104.4%	66.7%	-	-	10.9%	5.6%	32	3	9.0.	3	1	1 fall above threshold
TWH	Ward 10 (TW) - NG131	61.6%	38.5%	-	100.0%	61.7%	51.7%	-	-	3.5%	34.8%	20	10	161.3.	0	0	Ward closed as part of pathway planning - staff redeployed . CHPPD not reflective of delivery on ward 10.
TWH	Ward 11 (TW) Winter Escalation 2019 - NG144	31.1%	27.8%	-	-	27.8%	18.4%	-	-	9.7%	45.3%	36	7	26.3.	0	0	Ward closed as part of pathway planning - staff redeployed . CHPPD not reflective of delivery on ward 11.
TWH	Ward 12 (TW) - NG132	107.7%	80.8%	-	100.0%	113.3%	94.9%	-	-	23.7%	23.0%	59	7	9.6.	7	0	1 fall above threshold
TWH	Ward 20 (TW) - NG230	128.1%	83.3%	-	100.0%	101.1%	96.7%	-	-	37.4%	21.9%	134	53	8.4.	8	0	1 fall above threshold
MAIDSTONE	Foster Clarke Ward - NR359	0.7%	0.0%	-	-	1.7%	0.0%	-	-	0.3%	100.0%	1	0	0.1.	1	0	Ward closed as part of pathway planning during COVID. Staff redeployed
TWH	Ward 21 (TW) - NG231	102.7%	77.7%	-	100.0%	88.0%	107.7%	-	-	21.4%	22.0%	126	51	15.9.	5	1	
TWH	Ward 2 (TW) - NG442	116.7%	100.3%	-	100.0%	112.8%	102.3%	-	-	22.9%	23.2%	76	17	11.5.	7	0	
TWH	Ward 30 (TW) - NG330	101.2%	72.6%	-	-	83.7%	91.1%	-	-	18.6%	22.5%	56	3	12.1.	1	0	
TWH	Ward 31 (TW) - NG331	93.8%	64.9%	-	100.0%	87.4%	82.1%	-	-	7.9%	2.5%	22	4	11.3.	4	2	
Crowborough	Crowborough Birth Centre (CBC) - NP775	55.8%	113.0%	-	-	100.7%	100.0%	-	-	6.1%	0.0%	27	2			0	
TWH	Midwifery (multiple rosters)	82.2%	56.8%	-	-	98.3%	63.2%	-	-	14.2%	2.4%	502	37	28.4.	0	0	
TWH	Hedgehog Ward (TW) - ND702	94.2%	45.9%	-	-	96.7%	-	-	-	12.4%	24.5%	59	3	16.2.	1	0	
MAIDSTONE	Maidstone Birth Centre - NP751	101.8%	-	-	-	96.1%	96.7%	-	-	14.3%	0.0%	24	0		0	0	
TWH	SCBU (TW) - NA102	76.2%	458.4%	-	-	96.7%	-	-	-	18.9%	0.0%	123	2	18.1.		0	
MAIDSTONE	Short Stay Surgical Unit (TW) - NE901	105.4%	20.5%	-	-	38.6%	0.0%	-	-	2.0%	0.0%	12	7		0	0	MSSU closed during COVID Pandemic - staffing levels reported redeployed to support COVID areas and other COVID workstreams
TWH	Short Stay Surgical Unit (TW) - NE901	105.4%	20.5%	-	-	38.6%	0.0%	-	-	2.0%	0.0%	12	7	13.6.	0	0	
MAIDSTONE	Accident & Emergency (M) - NA351	97.0%	90.4%	-	-	120.8%	96.7%	-	-	42.3%	32.5%	335	62		1	0	
TWH	Accident & Emergency (TW) - NA301	99.3%	113.7%	-	100.0%	99.5%	143.9%	-	100.0%	35.5%	26.7%	335	36		3	0	
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	47.2%	41.9%	-	-	0.0%	-	-	-	0.0%	No hours	No Demand	No Demand		0	0	MOU closed during COVID Pandemic - staffing levels reported redeployed to support COVID areas and other COVID workstreams
MAIDSTONE	Peale COVID - ND451	87.3%	43.7%	-	-	87.8%	84.7%	-	-	46.5%	63.8%	128	24	10.1.	2	1	1 fall above threshold

Additional Capacity beds — Cath Labs Whatman

RAG Key

Under fill — Overfill

Green: Greater than 90% but less than 110%

Amber Less than 90% OR greater than 110%

Red Less than 80% OR greater than 130%

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	2,082	1,928	1,304	969	0	0	234	234	1,320	1,287	660	781	0	0	0	0	92.6%	74.3%	No data	100.0%	97.5%	118.3%	No data	No data				
Cornwallis	100 - GENERAL SURGERY	101 - UROLOGY	1,071	1,061	644	495	0	0	60	60	660	627	330	165	0	0	0	0	99.1%	76.9%	No data	100.0%	95.0%	50.0%	No data	No data				
Culpepper (incl CCU)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	1,704	1,486	1,214	917	0	0	0	0	1,320	1,331	330	341	0	0	0	0	87.2%	75.5%	No data	No data	100.8%	103.3%	No data	No data				
John Day	340 - RESPIRATORY MEDICINE	300 - GENERAL MEDICINE	1,934	2,254	1,479	1,090	0	0	0	0	1,650	1,717	660	533	0	0	0	0	116.5%	73.7%	No data	No data	104.0%	80.7%	No data	No data				
Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE		2,836	3,611	283	361	0	0	0	0	2,410	3,269	357	356	0	0	0	0	127.3%	127.4%	No data	No data	135.6%	99.8%	No data	No data				
Pye Oliver	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	1,632	878	1,494	1,071	0	0	0	0	990	440	990	726	0	0	0	0	53.8%	71.7%	No data	No data	44.4%	73.3%	No data	No data				
Chaucer	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1,975	1,707	1,846	1,493	0	0	0	0	1,320	1,056	1,309	891	0	0	0	0	86.4%	80.9%	No data	No data	80.0%	68.1%	No data	No data				
Lord North	370 - MEDICAL ONCOLOGY	800 - CLINICAL ONCOLOGY	1,759	1,618	603	605	0	0	21	21	1,080	901	360	360	0	0	0	0	92.0%	100.3%	No data	100.0%	83.4%	100.0%	No data	No data				
Mercer	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1,586	1,375	1,380	1,355	0	0	104	104	979	957	660	638	0	0	0	0	86.7%	98.2%	No data	100.0%	97.8%	96.7%	No data	No data				
Edith Cavel	300 - GENERAL MEDICINE		1,291	1,141	990	852	0	0	75	75	968	1,001	242	220	0	0	0	0	88.4%	86.1%	No data	100.0%	103.4%	90.9%	No data	No data				
Urgent Medical Ambulatory Unit (UMAU)	180 - ACCIDENT & EMERGENCY	300 - GENERAL MEDICINE	2,535	2,240	1,451	1,061	0	0	0	0	990	1,122	330	561	0	0	0	0	88.4%	73.1%	No data	No data	113.3%	170.0%	No data	No data				
Ward 22	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	1,560	1,764	1,551	1,278	0	0	71	71	968	990	1,320	1,056	0	0	0	0	113.1%	82.4%	No data	100.0%	102.3%	80.0%	No data	No data				
Cornary Care Unit (CCU)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	1,148	1,227	360	353	0	0	0	0	990	1,025	0	0	0	0	0	0	106.9%	97.9%	No data	No data	103.5%	No data	No data	No data				
Gynaecology/Ward 33	502 - GYNAECOLOGY	100 - GENERAL SURGERY	1,502	1,452	735	593	0	0	0	0	990	912	330	231	0	0	0	0	96.7%	80.6%	No data	No data	92.1%	70.0%	No data	No data				
Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE		3,691	4,819	360	605	0	0	0	0	2,981	3,599	330	374	0	0	0	0	130.5%	168.2%	No data	No data	120.7%	113.3%	No data	No data				
Medical Assessment Unit	180 - ACCIDENT & EMERGENCY	300 - GENERAL MEDICINE	3,214	2,597	1,335	1,022	0	0	188	188	2,070	1,555	1,035	953	0	0	0	0	80.8%	76.5%	No data	100.0%	75.1%	92.0%	No data	No data				
SAU	180 - ACCIDENT & EMERGENCY	100 - GENERAL SURGERY	1,080	1,100	360	359	0	0	0	0	660	660	330	330	0	0	0	0	101.8%	99.7%	No data	No data	100.0%	100.0%	No data	No data				
Ward 32	300 - GENERAL MEDICINE		2,078	1,629	1,486	1,040	0	0	0	0	990	1,034	990	660	0	0	0	0	78.4%	70.0%	No data	No data	104.4%	66.7%	No data	No data				
Ward 10	100 - GENERAL SURGERY		2,223	1,370	1,308	504	0	0	36	36	1,320	814	660	341	0	0	0	0	61.6%	38.5%	No data	100.0%	61.7%	51.7%	No data	No data				
Ward 11 (TW) Winter Escalation 2019 - NG144	100 - GENERAL SURGERY		1,452	452	1,440	400	0	0	0	0	990	275	1,320	243	0	0	0	0	31.1%	27.8%	No data	No data	27.8%	18.4%	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	1,959	2,109	1,422	1,149	0	0	99	99	990	1,122	1,298	1,232	0	0	0	0	107.7%	80.8%	No data	100.0%	113.3%	94.9%	No data	No data				
Ward 20	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	885	1,134	1,223	1,019	0	0	12	12	990	1,001	1,320	1,276	0	0	0	0	128.1%	83.3%	No data	100.0%	101.1%	96.7%	No data	No data				
Foster Clarke Ward - NR359			1,605	12	1,448	0	0	0	0	0	660	11	990	0	0	0	0	0	0.7%	0.0%	No data	No data	1.7%	0.0%	No data	No data				
Ward 21	340 - RESPIRATORY MEDICINE	302 - ENDOCRINOLOGY	2,187	2,246	906	704	0	0	188	188	1,649	1,451	660	711	0	0	0	0	102.7%	77.7%	No data	100.0%	88.0%	107.7%	No data	No data				
Ward 2	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1,833	2,139	1,580	1,586	0	0	84	84	946	1,067	957	979	0	0	0	0	116.7%	100.3%	No data	100.0%	112.8%	102.3%	No data	No data				
Ward 30	110 - TRAUMA & ORTHOPAEDICS		1,839	1,861	1,421	1,032	0	0	0	0	946	792	990	902	0	0	0	0	101.2%	72.6%	No data	No data	83.7%	91.1%	No data	No data				
Ward 31	110 - TRAUMA & ORTHOPAEDICS		1,997	1,873	1,551	1,006	0	0	140	140	1,309	1,144	990	813	0	0	0	0	93.8%	64.9%	No data	100.0%	87.4%	82.1%	No data	No data				
Birth Centre (Crowborough).	501 - OBSTETRICS		2,339	1,304	593	669	0	0	0	0	690	695	345	345	0	0	0	0	55.8%	113.0%	No data	No data	100.7%	100.0%	No data	No data				
Midwifery Services (ante/post natal & Delivery Suite)	501 - OBSTETRICS		23,891	19,646	7,442	4,230	0	0	0	0	5,159	5,070	3,319	2,098	0	0	0	0	82.2%	56.8%	No data	No data	98.3%	63.2%	No data	No data				
Hedgehog	420 - PAEDIATRICS		2,375	2,237	405	186	0	0	0	0	1,771	1,712	0	127	0	0	0	0	94.2%	45.9%	No data	No data	96.7%	No data	No data	No data				
Birth Centre	501 - OBSTETRICS		819	833	0	7	0	0	0	0	660	634	323	312	0	0	0	0	101.8%	No data	No data	No data	96.1%	96.7%	No data	No data				
Neonatal Unit	420 - PAEDIATRICS		3,970	3,025	152	695	0	0	0	0	2,321	2,244	0	297	0	0	0	0	76.2%	458.4%	No data	No data	96.7%	No data	No data	No data				
MSSU	100 - GENERAL SURGERY		1,276	1,345	528	108	0	0	0	0	484	187	242	0	0	0	0	0	105.4%	20.5%	No data	No data	38.6%	0.0%	No data	No data				
Peale	100 - GENERAL SURGERY		1,233	1,076	719	314	0	0	0	0	990	869	330	280	0	0	0	0	87.3%	43.7%	No data	No data	87.8%	84.7%	No data	No data				
SSSU	100 - GENERAL SURGERY		1,276	1,345	528	108	0	0	0	0	484	187	242	0	0	0	0	0	105.4%	20.5%	No data	No data	38.6%	0.0%	No data	No data				
Whatman	300 - GENERAL MEDICINE		2,032	1,544	1,402	1,152	0	0	75	75	660	814	330	473	0	0	0	0	76.0%	82.2%	No data	100.0%	123.3%	143.3%	No data	No data				
MOU			1,197	564	769	323	0	0	0	0	660	0	0	0	0	0	0	0	47.2%	41.9%	No data	No data	0.0%	No data	No data	No data				

REVIEW OF LATEST FINANCIAL PERFORMANCE

- The Trust delivered the financial plan in April by achieving a breakeven position. In line with national guidance this included £3.5m retrospective top up income support from NHSI/E. This funding is designed to cover the incremental step changes of COVID 19 above the baseline funding (November to January average) but is capped to the level of funding which is required for the Trust to breakeven.
- In April the Trust operated with an EBITDA surplus of £2.6m which was in line with the plan.
- The Trust has identified £4.5m of costs associated with COVID 19 therefore underspends totalling £1m have been made to net the impact down to £3.5m. The key underspends against plan are: £0.6m underspend with drugs mainly due to reduction in high cost Ophthalmology activity, £0.3m pay underspend within Administration (£0.1m) and STT staff Groups (£0.2m) due to higher than planned vacancies and £0.4m reduction within non pay budgets due to reduction in elective activity.
- The key current month variances are as follows:
  - Income excluding Top up income support and pass-through related costs is £0.6m adverse to plan. The main pressures related to the reduction in catering and car parking income (£0.3m) which has been included in the COVID impact schedule and £0.2m adverse variance relating to private patients (although the PPU is net breakeven to plan). Clinical income has been funded on a block contract value (as per NHSI/E) and therefore is a fixed amount and is not impacted by changes in activity.
  - Pay budgets adjusted for pass-through items overspent by £0.7m in April which was due to pressures within Medical staffing (£0.9m) offset by underspends within A&C (£0.1m) and Scientific and Technical (£0.2m). Additional pay costs associated with COVID is estimated to equate to £1.1m in April of which £0.75m related to Medical staffing therefore £0.15m is due to pressures against budgets which is mainly in Surgery (£0.1m) due to the delay in surgery reconfiguration.
  - Non Pay budgets adjusted for pass through items overspent by £1.8m in April which includes £3m COVID related costs therefore a net £1.2m underspend within budgets. The key underspends to budget are: Drugs (£0.6m) mainly due to reduction in high cost ophthalmology drugs, clinical supplies (£0.3m) due to reduction in elective activity (mainly pacemakers), £0.1m reduction in expected credit losses and £0.1m reduction in outsourcing costs (reduction in MRI and Endoscopy activity).
- The closing cash balance at the end of April 2020 was £49.5m due to the Trust receiving both April and May's block SLA income within April.
- Capital spend in month one was £934k of which £665k related to Covid 19 equipment, ICT and estates costs – these costs are being submitted to NHSE/I as part of the funding claims. The main other area of cost was expenditure related to the EPR programme.
- Capital Planning has recommenced nationally, with STP/ICS draft allocations notified recently. Each patch is now planning across its organisations how it balances to the overall control totals, and a resubmitted plan is expected from organisations and STP/ICS level on the 29th May.

Maidstone and Tunbridge Wells NHS Trust

Finance Report

Month 1
2020/21

Maidstone and Tunbridge Wells NHS Trust

Trust Board - Finance Report for April 2020

1. Executive Summary

a. Dashboard

2. Financial Performacne

a. Consolidated I&E

b. COVID 19 Expenditure and Income

3. Balance Sheet and Liquidity

a. Balance Sheet

b. Cash Flow

4. Normalisation and Run Rate

4. I&E Run Rate

Maidstone and Tunbridge Wells NHS

1a. Dashboard

April 2020/21

	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	44.6	42.3	2.3	(0.1)	2.4		44.6	42.3	2.3	(0.1)	2.4	
Expenditure	(42.1)	(39.7)	(2.4)	0.1	(2.5)		(42.1)	(39.7)	(2.4)	0.1	(2.5)	
EBITDA (Income less Expenditure)	2.6	2.6	(0.0)	(0.0)	(0.0)		2.6	2.6	(0.0)	(0.0)	(0.0)	
Financing Costs	(2.6)	(2.6)	0.0	0.0	0.0		(2.6)	(2.6)	0.0	0.0	0.0	
Technical Adjustments	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	
Net Surplus / Deficit (Incl Top Up funding	**0.0**	**0.0**	**0.0**	**(0.0)**	**0.0**		**0.0**	**0.0**	**0.0**	**(0.0)**	**0.0**	
Cash Balance	49.5	0.0	49.5		49.5		49.5	0.0	49.5		49.5	
Capital Expenditure	0.9	0.0	(0.9)		(0.9)		0.9	0.0	(0.9)		(0.9)	

Summary:

- The Trust delivered the financial plan in April by achieving a breakeven position. In line with national guidance this included £3.5m retrospective top up income support from NHSI/E. This funding is designed to cover the incremental step changes of COVID 19 above the baseline funding (November to January average) but is capped to the level of funding which is required for the Trust to breakeven.

- The Trust has identified £4.5m of costs associated with COVID 19 therefore underspends totalling £1m have been made to net the impact down to £3.5m. The key underspends against plan are: £0.6m underspend with drugs mainly due to reduction in high cost Ophthalmology activity, £0.3m pay underspend within Administration (£0.1m) and STT staff Groups (£0.2m) due to higher than planned vacancies and £0.4m reduction within non pay budgets due to reduction in elective activity.

Risks:

- The Trust won't be notified by NHSI/E of the final retrospective top up value for April unitl the 15th June

2.a Income & Expenditure

Income & Expenditure April 2020/21

	Current Month				
	Actual £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m
Clinical Income	37.1	37.1	(0.0)	0.0	(0.0)
Top Up Income Support	5.0	1.9	3.1	0.0	3.1
Other Operating Income	2.5	3.2	(0.7)	(0.1)	(0.6)
Total Revenue	**44.6**	**42.3**	**2.3**	**(0.1)**	**2.4**
Substantive	(21.8)	(23.0)	1.2	0.0	1.2
Bank	(1.5)	(0.5)	(1.0)	(0.0)	(1.0)
Locum	(1.4)	(0.8)	(0.6)	0.0	(0.6)
Agency	(1.2)	(0.8)	(0.4)	0.0	(0.4)
Pay Reserves	(0.1)	(0.1)	(0.0)	0.0	(0.0)
Total Pay	**(25.9)**	**(25.2)**	**(0.7)**	**0.0**	**(0.7)**
Drugs & Medical Gases	(4.1)	(4.6)	0.5	0.0	0.5
Blood	(0.2)	(0.2)	(0.0)	0.0	(0.0)
Supplies & Services - Clinical	(4.4)	(2.8)	(1.6)	0.0	(1.6)
Supplies & Services - General	(0.9)	(0.4)	(0.5)	0.0	(0.5)
Services from Other NHS Bodies	(0.7)	(0.7)	0.0	(0.0)	0.0
Purchase of Healthcare from Non-NHS	(0.2)	(0.4)	0.1	(0.0)	0.1
Clinical Negligence	(1.7)	(1.7)	0.0	0.0	0.0
Establishment	(0.3)	(0.3)	(0.0)	0.0	(0.0)
Premises	(2.7)	(2.4)	(0.4)	0.0	(0.4)
Transport	(0.2)	(0.1)	(0.1)	0.0	(0.1)
Other Non-Pay Costs	(0.4)	(0.6)	0.1	0.0	0.1
Non-Pay Reserves	(0.4)	(0.4)	0.0	0.0	0.0
Total Non Pay	**(16.1)**	**(14.5)**	**(1.7)**	**0.1**	**(1.8)**
Total Expenditure	**(42.1)**	**(39.7)**	**(2.4)**	**0.1**	**(2.5)**
EBITDA	**2.6**	**2.6**	**(0.0)**	**(0.0)**	**(0.0)**
	0.0	*0.0*	*(0.0)*	*%*	
Depreciation	(1.2)	(1.2)	0.0	0.0	0.0
Interest	(0.0)	(0.0)	0.0	0.0	0.0
Dividend	(0.2)	(0.2)	0.0	0.0	0.0
PFI and Impairments	(1.2)	(1.2)	0.0	0.0	0.0
Total Finance Costs	**(2.6)**	**(2.6)**	**0.0**	**0.0**	**0.0**
Net Surplus / Deficit (-)	**(0.0)**	**0.0**	**(0.0)**	**(0.0)**	**(0.0)**
Technical Adjustments	0.0	0.0	0.0	0.0	0.0
Surplus/ Deficit (-) to B/E Duty Incl Top Up Funding Support	**0.0**	**0.0**	**0.0**	**(0.0)**	**0.0**

Commentary

The Trust delivered the financial plan in April by achieving a breakeven position.

Pass-through adjustments have been applied to account for: Sexual Health and Medical Education contracts.

Clinical Income includes the baseline funding (£36.8m) from NHSI/E which is a fixed payment and is therefore not impacted by activity changes. The remainder (£0.3m) relates to NHS provider to provider charges for Bowel Screening, Therapies Assisted Discharge (TADs) and the High Impact Team (HIT) both of which the Trust is negotiating block contract values in line with the simplified contract guidance approach recommended by NHSI/E.

Top Up support funding (£5m) constitutes of two funding streams; £1.44m baseline top up adjustment to increase the baseline funding to the average spend between November 19 and January 20 (the Trust has been informed of this value by NHSI/E) and a further £3.5m retrospective top up adjustment to fund the net incremental costs associated with COVID (upto breakeven). The Trusts internal plan (based on draft 2020/21 business plan) included £0.4m retrospective top up income plan to fund the cost base before the impact of COVID as a result compared to the internal plan the trust is £3.1m favourable to this income line rather than £3.5m.

Additional costs or income reductions associated with COVID (£4.5m) are reported within the appropriate subjective areas of spend and are offset by the retrospective top up (£3.5m) and other underspends within budgets.

Other Operating Income excluding pass-through costs was £0.6m adverse in April. The main pressures related to the reduction in catering and car parking income (£0.3m) which has been included in the COVID impact schedule and £0.2m adverse variance relating to private patients (although the PPU is net breakeven to plan).

Pay budgets adjusted for pass-through items overspent by £0.7m in April which was due to pressures within Medical staffing (£0.9m) offset by underspends within A&C (£0.1m) and Scientific and Technical (£0.2m). Additional pay costs associated with COVID is estimated to equate to £1.1m in April of which £0.75m related to Medical staffing therefore £0.15m is due to pressures against budgets which is mainly in Surgery (£0.1m) due to the delay in surgery reconfiguration.

Non Pay budgets adjusted for pass through items overspent by £1.8m in April which includes £3m COVID related costs therefore a net £1.2m underspend within budgets. The key underspends to budget are: Drugs (£0.6m) mainly due to reduction in high cost ophthalmology drugs, clinical supplies (£0.3m) due to reduction in elective activity (mainly pacemakers), £0.1m reduction in expected credit losses and £0.1m reduction in outsourcing costs (reduction in MRI and Endoscopy activity).

2.b COVID 19 Expenditure and Income Impact

2020/21 Summary of Cost Reimbursement

Total Revenue (£000s):	4,168

Breakdown by Allowable Cost Type	£000s
Expanding medical / nursing / other workforce	18
Sick pay at full pay (all staff types)	0
COVID-19 virus testing (NHS laboratories)	781
Remote management of patients	2
Support for stay at home models	0
Direct Provision of Isolation Pod	0
Plans to release bed capacity	0
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	725
Segregation of patient pathways	16
Enhanced PTS	0
Business Case (SDF) - Ageing Well - Urgent Response Accelerator	0
Existing workforce additional shifts	146
Decontamination	0
Backfill for higher sickness absence	363
NHS 111 additional capacity	0
Remote working for non patient activites	92
National procurement areas	1,440
Other	585

Summary: Loss of income

Total (£000s):	353

Breakdown by income type	£s
Car parking income	211
Catering	51
Other	91

Grand Total

Total (£000s):	4,521

Commentary:
The Trust has identified the financial impact relating to COVID to be £4.5m in April which includes £4.2m associated with additional expenditure and £0.3m due to lost income (mainly commercial income).

The main cost includes purchase of PPE, pathology testing, staff welfare such as providing meals, purchase of IT equipment and software licenses to enable staff working from home. Additional shifts required in ED, ITU areas, additional on calls and extended opening hours for support teams.

The Trust is still waiting to be notified whether or not a sample Audit will be commissioned to review the 2019/10 return (£2.08m), as a result payment is still pending.

3a. Balance Sheet

April 2020

The Trust Balance Sheet is produced on a monthly basis and reflects changes in the asset values,

£m's	April 2020 Reported	March 2020 Reported	Mth 1 Variance Reported
Property, Plant and Equipment (Fixed Assets)	291.1	291.1	0.0
Intangibles	3.8	4.0	(0.2)
PFI Lifecycle	0.0	0.0	0.0
Debtors Long Term	2.0	1.9	0.1
Total Non-Current Assets	**296.9**	**297.0**	**(0.1)**
Current Assets	0.0	0.0	0.0
Inventory (Stock)	8.8	8.8	0.0
Receivables (Debtors) - NHS	17.4	23.6	(6.2)
Receivables (Debtors) - Non-NHS	14.2	23.9	(9.7)
Cash	49.5	3.4	46.1
Assets Held For Sale	0.0	0.0	0.0
Total Current Assets	**89.9**	**59.7**	**30.2**
Current Liabilities			
Payables (Creditors) - NHS	(3.0)	(7.7)	4.7
Payables (Creditors) - Non-NHS	(43.2)	(42.7)	(0.5)
Deferred Income	(37.5)	(3.1)	(34.4)
Capital Loan	(2.2)	(1.6)	(0.6)
Working Capital Loan	(26.1)	(26.2)	0.1
Other loans	(0.2)	(0.4)	0.2
Borrowings - PFI	(5.3)	(5.4)	0.1
Provisions for Liabilities and Charges	(2.6)	(2.6)	0.0
Total Current Liabilities	**(120.1)**	**(89.7)**	**(30.4)**
Net Current Assets	(30.2)	(30.0)	(0.2)
non-current liabilities: Borrowings - PFI > 1yr	(181.6)	(181.9)	0.3
Capital Loans	(6.4)	(6.4)	0.0
Working Capital Facility & Revenue loans	0.0	0.0	0.0
Other loans	(1.3)	(1.3)	0.0
Provisions for Liabilities and Charges- Long term	(0.8)	(0.8)	0.0
Total Assets Employed	**76.6**	**76.6**	**0.0**
Financed By:			
Capital & Reserves			
Public dividend capital	216.4	216.4	0.0
Revaluation reserve	30.2	30.2	0.0
Retained Earnings Reserve	(170.0)	(170.0)	0.0
Total Capital & Reserves	**76.6**	**76.6**	**0.0**

Commentary:
The overall working capital within the month results in a decrease in Debtors of £15.9m and a reduction in Creditors of £4.2m compared to the March year end values. The cash balance held at the end of the month is slightly higher than the forecast value. Further information is given below.

Non-Current Assets -
The 2020/21 capital additions for month 1 are £0.9m and the depreciation for the month was £1.1m.

Current Assets -
Inventories of £8.8m is in-line with the year end balances. 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 March's position by £6.2m to £17.4m. Of the £17.4m reported balance, £8.3m relates to invoiced debt of which £2.6m is aged debt over 90 days. Invoiced debt over 90 days has increased since the March's position of £2.3m. The remaining £9.1m relates to uninvoiced accrued income including quarter 4 PSF of £2.7m, Covid 19 income accrual of £1.7m and partially completed spells £2m. 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 decreased by £9.7m to £14.2m from the reported March's position of £23.9m. Included within the £14.2m balance is trade invoiced debt of £2.5m and private patient invoiced debt of £0.4m. Also included within the £14.2m are prepayments and accrued income totalling £8.9m. Included within the accruals is £0.9m Clinical Pension Tax. 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 April 2020 was £49.5m due to the Trust receiving both April and May's block SLA income within April.

Current Liabilities -
Non-NHS trade payables have increased slightly from £42.7m to £43.2m and NHS payables have reduced from the March position by £4.7m to £3m giving a combined payables balance of £46.2m.

Of the £46.2m combined payables balances, £14.9m relates to actual invoices of which £6.2m are authorised with the remaining balance of £8.7m awaiting approval from budget managers.
The remaining balance of payables of £31.3m relates to uninvoiced accruals. These are journal ledger estimated entries where the Trust is waiting for invoices to be received from the supplier based on goods and services received. This includes agency shifts that have been worked but not yet invoiced.
Deferred income of £37.5m primarily relates to £26.4m Kent and Medway CCG advance SLA payment, £6.7m NHSE advance SLA payment and £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 in September 2020. The Trust will receive Public Dividend Capital (PDC) to repay the full amount.

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.

3b. Cash Flow

	Week Commencing:													
	April	04/05/2020	11/05/2020	18/05/2020	26/05/2020	01/06/2020	08/06/2020	15/06/2020	22/06/2020	29/06/2020	06/07/2020	13/07/2020	20/07/2020	27/07/2020
CASH RECEIPTS:														
NHS SLA Income	78,023	0	31,346	327	327	0	31,544	0	327	0	0	31,544	0	21,260
Other NHS Income	7,791	273	1,835	230	230	230	1,500	0	230	230	230	1,500	230	230
Other Non-NHS income	3,410	9	2,330	281	281	981	337	281	281	281	1,037	281	281	281
External financing - MRET Funding 20/21	0	0	1,550	0	0	0	0	0	0	0	0	1,550	0	0
External financing - PSF Funding 19/20	0	0	0	0	0	0	0	0	0	0	0	2,678	0	0
TOTAL CASH RECEIPTS:	**89,224**	**283**	**37,062**	**837**	**837**	**1,211**	**33,381**	**281**	**837**	**511**	**1,267**	**37,553**	**511**	**21,771**
CASH PAYMENTS:														
Payroll	20,708	1,027	4,526	19,026	734	834	834	10,526	12,934	834	834	4,526	18,934	834
Drug suppliers	5,079	737	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500
Rates and council payments	1,059	0	0	0	510	0	0	0	510	0	0	0	0	510
Other revenue payments	12,537	4,052	4,360	2,201	2,201	2,201	4,173	3,788	2,201	2,201	2,201	4,360	2,201	2,201
Prime Provider invoices	707	0	600	0	0	0	600	0	0	0	0	600	0	0
Capital payments	2,739	805	300	300	300	300	300	300	300	300	300	300	300	300
Account charges	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Repayment of Salix loan	222	0	0	0	0	0	0	0	0	0	0	0	0	0
Unitary payment	0	0	2,559	0	0	0	0	2,559	0	0	0	2,549	0	0
TOTAL CASH PAYMENTS:	**43,052**	**6,621**	**13,845**	**23,027**	**5,245**	**4,835**	**7,407**	**18,673**	**17,445**	**4,835**	**4,835**	**13,835**	**22,935**	**5,345**
OPERATIONAL CASH INFLOW/(OUTFLOW):	**46,172**	**-6,339**	**23,217**	**-22,190**	**-4,408**	**-3,624**	**25,974**	**-18,392**	**-16,608**	**-4,324**	**-3,568**	**23,718**	**-22,424**	**16,426**
CASH BALANCES B/F:	**3,356**	**49,528**	**43,189**	**66,406**	**44,216**	**39,809**	**36,185**	**62,159**	**43,767**	**27,159**	**22,835**	**19,267**	**42,985**	**20,560**
CASH BALANCES C/F:	**49,528**	**43,189**	**66,406**	**44,216**	**39,809**	**36,185**	**62,159**	**43,767**	**27,159**	**22,835**	**19,267**	**42,985**	**20,560**	**36,987**

Commentary:

The cash flow for the periods April to July 2020 is shown above. Due to the current Covid 19 pandemic 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 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. 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%).

4a. Run Rate Analysis

Analysis of 13 Monthly Performance (£m's)

		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	Change between Months
Revenue	Clinical Income	35.2	36.4	34.3	37.9	36.3	35.9	38.2	35.2	37.1	38.1	35.0	48.7	37.1	(11.6)
	2019/20 (PSF and MRET), 2020/21 Top Up Income	0.9	0.9	1.5	1.0	1.0	1.0	0.5	0.5	2.8	1.4	1.4	1.4	5.0	3.6
	High Cost Drugs														
	Other Operating Income	4.1	4.1	4.6	4.5	3.9	4.1	4.2	4.0	4.4	3.9	2.1	6.9	2.5	(4.4)
	Total Revenue	**40.2**	**41.4**	**40.4**	**43.4**	**41.2**	**41.0**	**42.9**	**39.7**	**44.3**	**43.3**	**38.6**	**57.0**	**44.6**	**(12.4)**
Expenditure	Substantive	(20.1)	(19.5)	(19.3)	(19.7)	(19.9)	(19.6)	(20.2)	(20.4)	(20.8)	(20.5)	(20.7)	(31.9)	(21.8)	10.1
	Bank	(1.3)	(1.1)	(1.1)	(1.2)	(1.3)	(1.2)	(1.2)	(1.3)	(1.3)	(1.2)	(1.4)	(1.7)	(1.5)	0.2
	Locum	(0.8)	(0.9)	(0.9)	(0.9)	(1.0)	(1.1)	(0.8)	(1.2)	(1.1)	(1.1)	(0.9)	(1.3)	(1.4)	(0.1)
	Agency	(1.6)	(1.7)	(1.5)	(1.9)	(1.8)	(1.8)	(1.7)	(1.1)	(1.5)	(1.6)	(1.4)	(1.9)	(1.2)	0.7
	Pay Reserves	(0.3)	(0.3)	(0.3)	(0.3)	0.7	(0.1)	(0.1)	0.6	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.0
	Total Pay	(24.2)	(23.5)	(23.1)	(23.9)	(23.3)	(23.9)	(24.1)	(23.3)	(24.8)	(24.5)	(24.5)	(36.9)	(25.9)	11.0
Non-Pay	Drugs & Medical Gases	(4.6)	(4.6)	(4.2)	(4.7)	(4.5)	(4.4)	(4.8)	(4.7)	(4.6)	(4.8)	(4.5)	(4.7)	(4.1)	0.6
	Blood	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.1)	(0.2)	(0.1)
	Supplies & Services - Clinical	(2.7)	(2.7)	(2.8)	(3.0)	(2.6)	(2.8)	(2.9)	(2.9)	(3.0)	(2.6)	(2.7)	(4.0)	(4.4)	(0.4)
	Supplies & Services - General	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.5)	(0.5)	(0.5)	(0.4)	(0.7)	(0.9)	(0.2)
	Services from Other NHS Bodies	(1.0)	(0.8)	(0.7)	(0.6)	(0.6)	(0.8)	(0.5)	(0.6)	(0.5)	(0.5)	(0.5)	(0.1)	(0.7)	(0.6)
	Purchase of Healthcare from Non-NHS	(1.5)	(1.7)	(1.6)	(1.2)	(1.2)	(1.1)	(1.1)	(1.1)	(1.2)	(1.3)	(1.3)	(1.4)	(0.2)	1.2
	Clinical Negligence	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.4)	(1.5)	(1.5)	(1.5)	(1.7)	(0.2)
	Establishment	(0.2)	(0.3)	(0.3)	(0.3)	(0.3)	(0.4)	(0.3)	(0.4)	(0.4)	(0.3)	(0.2)	(0.1)	(0.3)	(0.2)
	Premises	(2.3)	(2.2)	(2.4)	(1.9)	(2.1)	(1.9)	(2.2)	(1.9)	(1.8)	(2.3)	(2.6)	(2.8)	(2.7)	0.0
	Transport	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.2)	(0.2)	(0.2)	(0.2)	(0.0)
	Other Non-Pay Costs	(0.5)	(0.5)	(0.7)	(1.2)	(1.0)	(1.0)	(0.7)	(0.6)	(0.6)	(0.7)	1.6	(1.2)	(0.4)	0.7
	Non-Pay Reserves	(0.5)	(0.4)	(0.4)	0.7	0.1	0.4	0.0	0.5	0.0	0.0	0.0	0.0	(0.4)	(0.4)
	Total Non Pay	(15.4)	(15.4)	(15.4)	(14.3)	(14.4)	(14.3)	(14.8)	(13.9)	(14.4)	(14.7)	(12.5)	(16.7)	(16.1)	0.5
	Total Expenditure	(39.6)	(38.9)	(38.5)	(38.3)	(37.6)	(38.1)	(38.8)	(37.2)	(39.3)	(39.2)	(36.9)	(53.5)	(42.0)	11.5
EBITDA	EBITDA	0.5	2.5	1.9	5.1	3.6	2.8	4.1	2.5	5.1	4.2	1.6	3.5	2.6	(0.9)
		1%	*6%*	*5%*	*12%*	*9%*	*7%*	*9%*	*6%*	*11%*	*10%*	*4%*	*6%*	*6%*	
Other Finance Costs	Depreciation	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.0)	(1.1)	(1.0)	(1.1)	(1.1)	(1.1)	(1.1)	(1.2)	(0.1)
	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)	(0.0)	0.1
	Dividend	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.8	(0.2)	(1.0)
	PFI and Impairments	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(1.3)	(1.2)	(1.2)	(1.2)	(1.2)	(3.9)	(1.2)	2.7
	Total Other Finance Costs	**(2.6)**	**(2.6)**	**(2.5)**	**(2.6)**	**(2.6)**	**(2.4)**	**(2.6)**	**(2.5)**	**(2.5)**	**(2.5)**	**(2.5)**	**(4.2)**	**(2.6)**	**1.6**
Net Surplus / Deficit (-)	Net Surplus / Deficit (-)	(2.0)	(0.1)	(0.6)	2.5	1.0	0.5	1.4	(0.0)	2.6	1.7	(0.8)	(0.8)	(0.0)	0.7
Technical Adjustments	Technical Adjustments	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)
Surplus/ Deficit (-) to B/E Duty Incl pSF	Surplus/ Deficit (-) to B/E Duty	(2.0)	(0.1)	(0.6)	2.5	1.0	0.5	1.4	(0.0)	2.6	1.7	(0.8)	(0.8)	(0.0)	0.7

Kent and Medway STP Pathology Programme: Outline Business Cases (OBCs) for Service change; a Laboratory Information Management System (LIMS); and a Managed Service Contract **Chief Executive**

Please find enclosed the key details from the three OBCs for the Kent and Medway Sustainability and Transformation Partnership (STP) Pathology Programme i.e.

- Service change
- Managed Service Contract
- LIMS

The OBCs were considered at the Finance and Performance Committee on 28th April 2020, and were supported for submission to the Trust Board for approval.

The full OBCs, plus the numerous appendices, have not been submitted to the Trust Board but have been made available to Trust Board members via the "documents" section of Admincontrol. The changes to the OBCs since the review by the Finance and Performance Committee have also been outlined in separate reports (which have also been made available to Trust Board members via the "documents" section of Admincontrol).

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]

Review and approval

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

Kent and Medway Pathology Programme

Outline Business Cases Board Cover Paper

REPORT TO:	**MTW TRUST BOARD**
DATE:	May 21sy 2020
REPORT TITLE:	**KENT AND MEDWAY PATHOLOGY PROGRAMME OUTLINE BUSINESS CASES (OBC)**
BOARD SPONSOR:	**Miles Scott, CEO and Kent and Medway Pathology SRO**
PAPER AUTHOR:	**AMANDA PRICE AND ADA FOREMAN PROGRAMME LEAD AND PROGRAMME FINANCE LEAD**
PURPOSE:	**Approval**
ACCOMPANYING PAPERS:	Core pack: Service change slides Laboratory Information Management System (LIMS) OBC slides Managed Service Contract (MSC) OBC slides Available on request: Service change OBC Service change OBC appendix pack Service change post OBC checklist changes LIMS OBC LIMS Comprehensive Investment Appraisal (CIA) LIMS post OBC checklist changes MSC OBC MSC CIA MSC post OBC checklist changes

Background

The Strategic Outline Case (SOC) for a single pathology service for Kent and Medway was approved by the four acute hospital Trust Boards and the STP Board in April 2019.

Over the past twelve months, three OBCs have been developed; for service change, LIMS and Managed Equipment Services (MES) (MSC).

The three OBCs stand alone but are inter-dependent. The LIMS case results in a reduced cost pressure and the MES (MSC) case results in direct savings. The savings from MSC will offset the LIMS investment required. A single LIMS and MSC will provide a common platform enabling a single operating model, which in turn enables the delivery of a safe, high quality service.

A number of iterative recommendations were made during the service change OBC development:

- That the present service site configuration of three hubs and four essential service laboratories (ESL) remain; with a potential move to two hubs in the future should there be sufficient evidence to do so. During the qualitative evaluation; there was

insufficient evidence to warrant a move to two hubs. This recommendation was taken to Trust Boards in summer 2019.

- That the commercial options of outsourcing and working with a major strategic partnership are not progressed beyond OBC. There was little appetite for either of these commercial models from pathology services or from CEOs. In addition, we have been unable to locate a successful outsourced or strategic partnership that would warrant such a move.
- That there will be a single pathology service for Kent and Medway with a single management structure rather than a looser network of separate services. This is the end state which will evolve over a period of time.
- That procurement of a single LIMS is a clinical priority with two of the three services urgently needing to replace their systems and the other needing to replace their system during the lifetime of the programme.
- That the lessons learnt from North Kent Pathology Services (NKPS) and Trust Board recommendations arising from the SOC underpin the OBCs and are referenced at each stage of the programme (see Appendix 1).
- That there will be no planned redundancies associated with the change.

The three outline business cases for the Kent and Medway Pathology Programme were approved by the Programme Board and Gateway Review comprising acute Trust CEOs and DoFs in March 2020. They are now due for Trust Board and CCG approval before being submitted to NHSE&I.

Executive Summary

The three OBCs stand alone but are inter-dependent. The LIMS case results in a reduced cost pressure and the MES (MSC) case results in direct savings. LIMS and MSC provide a common platform enabling a single operating model.

The service change OBC outlines the principles of a single operating model with standardised ways of working enabling higher quality, efficiency, workforce savings and innovation. It is not a traditional OBC with costed options; but rather an exploration of the range of opportunity from workforce optimisation through an illustrative set of internal and external benchmarks. The CEOs and DOFs have committed to a single management through a managed transition starting with the appointment of a single pathology lead director who will then appoint their senior team over time.

Changes to workforce will be incremental rather than a 'big bang' approach. The approach will be one of productivity rather than cost cutting i.e. doing more for the same investment not the same for less. Depending on the organisational form, TUPE will potentially not be required; but will be fully explored at FBC.

A new governance and legal steering group will build on the Heads of Terms (see Appendix 2) to work through the complexities of setting up what is likely to be a contractual joint venture.

The LIMS OBC identifies two preferred options for taking through the first two stages of procurement; when a single option will be landed. The two options proposed in the OBC are a single LIMS hosted by one Trust on behalf of the others (capital option) and a single LIMS hosted remotely (revenue option). The capital option is a marginally lower cost over the lifetime of the project; but can only progress if funding from the centre can be sourced. In the LIMS business case, do nothing is not an option, as two of the pathology services' LIMS are outdated and unsupported, posing a clinical risk in the near future. A single LIMS also affords significant qualitative improvements in quality and productivity.

The MSC business case is, at its simplest, a joint procurement demonstrating benefit by contract size of purchasing together. However, the benefits are much more than financial as working on common platforms enables standardisation of operating procedures and workflows.

Changes on this scale are not without risk, although the pace of the programme will help to minimise issues. Risks associated with the change, and mitigations to minimise, are outlined in the OBCs in the economic cases and associated appendices. For LIMS and MES (MSC), more detailed implementation risks will be identified once the supplier is known as implementation is a shared risk. The main mitigation strategy is the timing of the various changes; the pathology community have identified that the changes need to be implemented in a linear fashion with LIMS first followed by MES with the main service changes made once these two enabling changes are fully implemented.

The OBCs have been modelled prudently so as to not reflect any service change savings until year 8. However, during the development of the FBC it is anticipated that some savings may be deliverable earlier.

The core programme team completed a comprehensive NHSE&I OBC checklist for each OBC before Trust Board submissions and found there were no material changes required. The OBCs have been updated to ensure they are compliant with the checklist.

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The table below shows the phasing of the rollout of LIMS, MES and service change. The phasing is such that there is time to embed changes safely and learn from them; and to avoid implementing two major system changes simultaneously. This is the current timeline as of May 2020 based on extending the programme in light of Covid-19 related delays.

	LIMS	**MES**		**Contract**	**Service Change**
MTW	Aug-23	May-24	ESL 1	10%	Sep-27
		Feb-25	Hub 1	30%	
EKHUFT	Jan-24	Nov-25	ESL 2	40%	Sep-27
		Aug-26	ESL3	70%	
		Aug-26	Hub 2		
NKPS	Jan-24	May-27	ESL 4	80%	Sep-27
		Aug-27	Hub 3	100%	

Programme Impact

Quality

- Harmonisation and standardisation of processes and quality management enabling a truly equitable, quality and safe service to all users and patients across Kent and Medway
- Access to pathology records across the county enabling improved patient care, length of stay and time to reach diagnosis in some patients.
- Opportunity to progress digital strategy initiatives, e.g. digital pathology, unified order comms.
- Turnaround time improvements for tests referred across Trusts enabling improved patient care, length of stay and time to reach diagnosis in some patients.
- Enabling staff to work across sites, enhancing workforce sustainability, service resilience and individual career development.

Financial

Overall benefit to MTW of £2.374m to £2.974m over the 13 years of the programme depending on the final LIMS option selected; compared to do nothing. Had the Trust planned to invest in a replacement for LIMS which is a priority the savings would be higher. NB – this is a conservative figure which will be further developed at FBC.

Funding the programme to full business case this year will cost MTW £72.5k (pending agreement on funding Covid-19 related costs) which is already in the Trust budget baseline.
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Overall Financial Impact for MTW

Impact on MTW of LIMS Option 5 (MSC option)

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Y 6 to 13	TOTAL
	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	to 32/33	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
PMO	**94**	**114**	**104**	**32**	**32**	**32**	65	**475**
Send aways	(18)	(61)	(74)	(74)	(74)	(74)	(537)	**(912)**
LIMS		564	552	645	783	405	3,311	**6,260**
MES		(161)	(198)	(188)	(208)	(308)	(5,210)	**(6,274)**
	76	**456**	**383**	**415**	**534**	**55**	**(2,370)**	**(451)**
Service Change	**0**	64	0	0	0	0	(2,586)	**(2,522)**
	76	**520**	**383**	**415**	**534**	**55**	**(4,957)**	**(2,974)**
FUNDED BY:								
STP Programme funding	72.5	72.5	72.5	72.5	72.5	72.5	580	**1,015**
Transition funds	0	447	311	343	461	(17)	(1,545)	**0**
Surplus	3						(3,992)	**(3,989)**
	76	**520**	**383**	**415**	**534**	**55**	**(4,957)**	**(2,974)**

Impact on MTW of LIMS Option 4 (Capital option)

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Y 6 to 13	TOTAL
	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	to 32/33	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
PMO	**94**	**114**	**104**	**32**	**32**	**32**	**65**	**475**
Send aways	(18)	**(61)**	**(74)**	**(74)**	**(74)**	**(74)**	**(537)**	**(912)**
LIMS		333	549	700	731	589	**3,957**	**6,859**
MES	0	(161)	(198)	(188)	(208)	(308)	(5,210)	**(6,274)**
	76	**225**	**380**	**470**	**482**	**240**	**(1,724)**	**149**
Service Change	0	64	0	0	0	0	(2,586)	**(2,522)**
	76	**289**	**380**	**470**	**482**	**240**	**(4,311)**	**(2,374)**
FUNDED BY:								
STP Programme funding	72.5	72.5	72.5	72.5	72.5	72.5	580	**1,015**

Transition funds	0	217	308	397	410	167	(1,499)	**0**
Surplus	3						(3,392)	**(3,389)**
	76	**289**	**380**	**470**	**482**	**240**	**(4,311)**	**(2,374)**

The above table represents MTW element only of the programme which equates to 32.5% of the total cost as per the agreed financial principles agreed in 2018. This contribution will be reviewed and set as part of the development of the management case which will describe the operation of the Network following verification of the baseline.

Key

PMO	These are programme team costs each year to support the implementation of the programme.
Send Aways	These are the assumed savings identified from the current tests sent to non-Kent and Medway labs. The savings are delivered from three work streams 1) repatriating tests back to a Kent and Medway lab 2) procuring under robust SLA arrangements services currently provided by other NHS labs 3) tendering for a single provider for tests that cannot be undertaken by Kent and Medway labs.
LIMS	These are the investment costs required for the single Kent and Medway LIMS including internal implementation costs. This enables the service change.
MES	These are the net savings from the contract extensions and implementation of a single Managed Equipment Service net of bespoke implementation costs. This enables the service change.
Service Change	This is the project delivering the Single Pathology network which will include a single Target Operating Model and sustainable workforce following the implementation of the enablers. Savings are anticipated from service efficiencies in staffing from Q3 2026/27.
STP programme funding	Each Trust currently has a recurrent budget for contributing to the pathology programme costs
Transition funds	The K&M CCG have agreed in principle to support via 'a bridging facility' the impact of the costs incurred in the early years, repayable from savings as they are delivered in later years.
Surplus	This is the net effect of the programme to the current total cost of pathology services of EKHUFT.

- Potential improvements to the base case:
  - Earlier service change
  - Greater service change
  - Lower cost for LIMS
  - Capitalisation or part capitalisation of LIMS
  - Central funding for LIMS and/or transformation
  - Lower prices for new MSC contract

The financial impact across Kent and Medway through the life of the programme can be seen in Appendix 3.

Comparison to the SOC

In the SOC, the Trusts wished to secure £5.6m of cost reduction, net of individual Trust efficiency requirements, after investment over five years. This was more than the £4.8m proposed by NHSI when pathology networks were recommended in 2017.

The investment would be initially to create the single service, standardise the service around productivity, repatriate out of county testing, reduce unwarranted demand variation and invest in new LIMS and MSC schemes. The investment required as outlined in the SOC was thought to be around £3.2 - £4m for a new LIMS system (approximately a cost of £150k pa capital charge); and the combination of the above changes would generate savings of around £4.5 - 5m before the cost of the LIMS.

Appendix 1

Lessons learnt and Trust Board recommendations – addressed at OBC

	Recommendation	Action taken
Strategy	More radical options Clearer vision Patient voice Case for change for mortuary and phlebotomy	Option appraisal Refreshed clinical vision PPE group Mortuary and phlebotomy recommendation
Governance	Identical systems, processes and operating arrangements Clinical governance practices aligned	MSC and LIMS single service Clinical sub-group examining the creation of a single quality management system
Clinical Quality and Safety	Quality and quality assurance systems Clear Quality and Safety success criteria Independent sign off of Quality Readiness Test catalogues Resilience	Quality leads developing QMS for service change OBC
Workforce	Recruit ‘at risk’ in anticipation of staff turnover. Transition cover Retention incentive Listen and feed back to staff Strong OD plan KMMS links	Transition workforce in OBCs Staff comms and engagement plan in operation OD plan in service change OBC Connections made with KMMS
IT	Clinical safety officer GP systems fully understood, databases cleansed and full engagement	Appointed LIMS implementation plan
Comms and engagement	Stakeholder mapping and comms plan Dedicated communication lead	Reviewed for OBC Comms lead secured

Programme management	Contingency Programme resourcing plan Project management methodology	Added to MSC and LIMS OBC Budget for 20/21 Refreshed programme and project structure

Lessons learnt and Trust Board recommendations – to be addressed at FBC/implementation

	Recommendation
Strategy	More radical options Clearer vision Patient voice Case for change for mortuary and phlebotomy
Governance	Identical systems, processes and operating arrangements Clinical governance practices aligned
Clinical Quality and Safety	Standardising SOPs Clear Quality and Safety success criteria Independent sign off of Quality Readiness Resilience
Operations	Logistics and primary care interfaces

Workforce	QIA on workforce structure Recruit ‘at risk’ in anticipation of staff turnover. Logistics impact on workforce
IT	Business intelligence function Order comms
Comms and engagement	GP and singe commissioner engagement
Programme management	Contingency Programme resourcing plan Project management methodology

Appendix 2
Pathology Network Principles – Head of Terms

- The Programme Board will operate as the Pathology Network Operations Board and will be accountable for the delivery of the service transformation. The Board have devolved rights to agree exceptional costs up to £100k per issue where required to ensure business continuity which will be underwritten as per the financial principle s for cost/gain share which will also apply to risk sharing.
- There will be no material change to contracting arrangements i.e. KMPT, KCHFT, MCH and Kent and Medway CCG will continue to contract services under the same arrangements for the period of this service transition to 2032/33.
- The financial principles for cost/gain share are for the service development by gross cost of the partners MTW 32.5%, EKHUFT 37% and NKPS 30.5%. The Current JV arrangement for NKPS will determine contribution split between DGT and MFT. The network will underwrite the impact of agreed changes so as to ensure that all parties are affected as per this principle.
- All Organisations have the same 'voting' rights
- All parties will contribute to capital requirements when required on the same basis as the cost/gain share and the accounting/CRL will be managed via the System control total and NHSI/E transfer of CRL.
- Procurement support will be provided to each project within the programme as part of 'business as usual' and will be spread fairly among the parties.
- Any specialist advice or cost pressure will be raised initially with the Programme Director and where applicable a case made to the Programme Board for additional funding when all other options within the Network have been exhausted.
- Where a single contract is to be entered into, which is hosted by one of the partner organisations, a legally binding 'back to back' arrangement will be entered into by all the parties at the same time for the same T&Cs.
- While the programme is being implemented all parties are expected to uplift their baseline for inflation with a consistent approach.
- The parties will enter into a comprehensive Head of Terms as part of the formation of the single service for pathology service in Kent and Medway.

Definitions

- Organisation: - EKHUFT, MTW and NKPS (legal entity DGT). The network members who deliver the service.
- Parties – EKHUFT, MTW, DGT and MFT who will be the new partners of the single service when that model is implemented.

Sign off of Pathology Network Heads of Terms	Date of Board meeting	Board minute reference
East Kent Hospitals University NHS Foundation Trust		
Dartford and Gravesham NHS Trust		
Kent and Medway CCG		
Kent and Medway Partnership NHS Trust		
Kent Community NHS Foundation Trust		
Maidstone and Tunbridge Wells NHS Trust		
Medway NHS Foundation Trust		

Appendix 3

LIMS capital option 4 – impact across Kent and Medway

LIMS Option 1 do minimum	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13 to Q3 only	Total
	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Kent and Medway pathology cost Baseline	74,385	74,319	74,319	74,319	74,319	74,319	74,319	74,319	74,319	74,319	74,319	74,319	74,319	55,739	**1,021,952**
MINIMUM INVESTMENT LIMS	**-**	**1,048**	**1,658**	**3,181**	**2,820**	**2,776**	**2,727**	**2,705**	**2,656**	**2,581**	**2,514**	**1,856**	**1,814**	**867**	**29,202**
Baseline with Do minimum LIMS	**74,385**	**75,367**	**75,977**	**77,500**	**77,139**	**77,095**	**77,046**	**77,024**	**76,975**	**76,900**	**76,833**	**76,175**	**76,133**	**56,606**	**1,051,154**
Cost PMO	**289**	**352**	**320**	**100**	**100**	**100**	**100**	**100**	**0**	**0**	**0**	**0**	**0**	**0**	**1,461**
(Saving) 'send away' CIP	**(181)**	**(270)**	**(307)**	**(307)**	**(307)**	**(307)**	**(307)**	**(307)**	**(307)**	**(307)**	**(307)**	**(307)**	**(307)**	**(77)**	**(3,905)**
(Saving)/cost Service Change - LOW		**197**	**0**	**0**	**0**	**0**	**0**	**(637)**	**(1,274)**	**(1,274)**	**(1,274)**	**(1,274)**	**(1,274)**	**(956)**	**(7,766)**
(Saving)/cost from **Option 4** LIMS capital	**0**	**(22)**	**31**	**(1,026)**	**(569)**	**(962)**	**(944)**	**(950)**	**(942)**	**(878)**	**(859)**	**(514)**	**(504)**	**55**	**(8,084)**
(Saving)/cost from MSC	**0**	**(497)**	**(611)**	**(580)**	**(639)**	**(949)**	**(1,299)**	**(1,866)**	**(2,239)**	**(2,239)**	**(2,239)**	**(2,239)**	**(2,239)**	**(1,679)**	**(19,315)**

TOTAL SAVINGS	**108**	**(240)**	**(567)**	**(1,813)**	**(1,415)**	**(2,118)**	**(2,450)**	**(3,660)**	**(4,762)**	**(4,698)**	**(4,679)**	**(4,334)**	**(4,324)**	**(2,656)**	**(37,608)**
NET SAVINGS	**108**	**808**	**1,092**	**1,368**	**1,405**	**658**	**276**	**(955)**	**(2,106)**	**(2,117)**	**(2,166)**	**(2,478)**	**(2,510)**	**(1,790)**	**(8,406)**
NEW COST BASELINE	**74,493**	**75,127**	**75,410**	**75,687**	**75,724**	**74,977**	**74,595**	**73,364**	**72,213**	**72,202**	**72,153**	**71,841**	**71,809**	**53,949**	**1,013,546**
NET IMPACT COST/(SAVING)															
MTW	76	289	380	470	482	240	115	(285)	(658)	(662)	(678)	(779)	(790)	(575)	(2,374)
EKHUFT	18	288	395	497	511	234	92	(366)	(793)	(798)	(816)	(932)	(944)	(669)	(3,282)
NKPS	14	231	316	400	412	185	69	(305)	(654)	(657)	(672)	(767)	(777)	(546)	(2,750)
	108	**808**	**1,092**	**1,368**	**1,405**	**658**	**276**	**(955)**	**(2,106)**	**(2,117)**	**(2,166)**	**(2,478)**	**(2,510)**	**(1,790)**	**(8,406)**

LIMS option 5 – revenue – impact across Kent and Medway

LIMS Option 1 do minimum	**Year 0**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Year 7**	**Year 8**	**Year 9**	**Year 10**	**Year 11**	**Year 12**	**Year 13 to Q3 only**	**Total**
	2019/20	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2029/30**	**2030/31**	**2031/32**	**2032/33**	
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Kent and Medway pathology cost Baseline	74,385	74,319	74,319	74,319	74,319	74,319	74,319	74,319	74,319	74,319	74,319	74,319	74,319	55,739	**1,021,952**
MINIMUM INVESTMENT LIMS	**-**	1,048	1,658	3,181	2,820	2,776	2,727	2,705	2,656	2,581	2,514	1,856	1,814	867	**29,202**
Baseline with Do minimum LIMS	**74,385**	**75,367**	**75,977**	**77,500**	**77,139**	**77,095**	**77,046**	**77,024**	**76,975**	**76,900**	**76,833**	**76,175**	**76,133**	**56,606**	**1,051,154**
Cost PMO	**289**	**352**	**320**	**100**	**100**	**100**	**100**	**100**	**0**	**0**	**0**	**0**	**0**	**0**	**1,461**

(Saving) 'send away' CIP	(181)	(270)	(307)	(307)	(307)	(307)	(307)	(307)	(307)	(307)	(307)	(307)	(307)	(77)	(3,905)
(Saving)/cost Service Change - LOW		197	0	0	0	0	0	(637)	(1,274)	(1,274)	(1,274)	(1,274)	(1,274)	(956)	(7,766)
(Saving)/cost from Option 5 LIMS - revenue	0	688	41	(1,195)	(410)	(1,529)	(1,478)	(1,457)	(1,408)	(1,306)	(1,239)	(592)	(550)	505	(9,931)
(Saving)/cost from MSC	0	(497)	(611)	(580)	(639)	(949)	(1,299)	(1,866)	(2,239)	(2,239)	(2,239)	(2,239)	(2,239)	(1,679)	(19,315)
TOTAL SAVINGS	108	470	(557)	(1,982)	(1,256)	(2,685)	(2,984)	(4,167)	(5,228)	(5,126)	(5,059)	(4,412)	(4,370)	(2,206)	(39,455)
NET SAVINGS	108	1,518	1,101	1,199	1,564	91	(258)	(1,462)	(2,572)	(2,545)	(2,545)	(2,556)	(2,556)	(1,339)	(10,253)
NEW COST BASELINE	74,493	75,837	75,420	75,518	75,883	74,410	74,061	72,857	71,747	71,774	71,774	71,763	71,763	54,400	1,011,699
NET IMPACT COST/(SAVING)															
MTW	76	520	383	415	534	55	(58)	(449)	(810)	(801)	(801)	(804)	(804)	(429)	(2,974)
EKHUFT	18	552	399	436	571	24	(106)	(553)	(966)	(956)	(956)	(960)	(960)	(500)	(3,957)
NKPS	14	447	318	348	459	12	(94)	(460)	(796)	(788)	(788)	(792)	(792)	(410)	(3,323)
TOTAL	108	1,518	1,101	1,199	1,564	91	(258)	(1,462)	(2,572)	(2,545)	(2,545)	(2,556)	(2,556)	(1,339)	(10,253)
Cumulative	108	1,626	2,727	3,926	5,490	5,581	5,323	3,861	1,289	(1,256)	(3,802)	(6,358)	(8,914)	(10,253)	
RoI from Do minimum															
RoI Ratio per year	0%	-1%	1%	3%	2%	3%	4%	5%	7%	7%	7%	6%	6%	4%	0.01
RoI Ratio cumulative	0%	0%	0%	1%	1%	1%	2%	2%	3%	3%	3%	4%	4%	4%	

Overall programme impact

TOTAL PROGRAMME		Option 4		Option 5
		£m		**£m**
REVENUE IMPACT				
PMO		1.5		1.5
LIMS 'do minimum'	29.2		29	
LIMS saving	(8.1)		(9.9)	
Option LIMS investment		21.1		19.3
MSC saving		(19.3)		(19.3)
Send Away saving		(3.9)		(3.9)
Service change saving		(7.8)		(7.8)
Total		**(8.4)**		**(10.3)**
CAPITAL IMPACT		**12.0**		**-**

	31/32	
ANNUAL	Option 4	Option 5
	£m	£m
SOC Target	5.6	5.6
MSC + send away	(2.5)	(2.5)
Service change	(1.3)	(1.3)
	(3.8)	(3.8)
	68%	68%
BAU Investment LIMS	1.8	1.8
LIMS	(0.5)	(0.5)
Net saving	(2.5)	(2.6)
	0	0

Transforming health and social care in Kent and Medway

Kent and Medway Pathology Programme Service change Outline Business Case

To be read in conjunction with accompanying papers:

Service Change OBC Service Change appendices

Transforming health and social care in Kent and Medway is a partnership of all the NHS organisations in Kent and Medway, Kent County Council and Medway Council. We are working together to develop and deliver the Sustainability and Transformation Plan for our area.

1. Service Change - case for change

- Do nothing…
  - Unsustainable workforce
  - Quality and patient safety risks
  - Minimal productivity gains
  - Unable to modernise with new technology and innovation
- Case for change…Working together enables
  - Quality and patient safety
  - Single LIMS and MSC with better price for both procuring together
  - Harmonisation and standardisation of testing
  - Further optimisation and consolidation of lab repertoires
  - Increased repatriation of tests and better deal for send away tests
  - Better efficiency and productivity
  - Critical mass for digital innovation
  - Attract, develop and sustain a flexible workforce

2. Service change – 5 case model

- Strategic case
- Economic case
- Commercial case
- Financial case
- Management case

3. Service change - The Strategic Case

- Case for change updated from SOC to reflect NHS Long Term Plan, digital strategy and innovations
- Goal reviewed and tweaked; education strategy included and section on quality management system
- Learning from Kent and Medway previous planned and actual reconfiguration; and from more advanced networks
- Narrative on range of strategic partner opportunities
- Qualitative benefits and range of opportunity from workforce model
- Interdependencies between the three business cases

4. Service Change - The Economic Case

- Options evaluation:
  - Service site configuration
  - Inclusion or exclusion of phlebotomy and mortuary in scope
    - Mortuary as is and to be debated in future if appropriate
    - Phlebotomy as is and to be debated in future if appropriate

- Economic viability:
  - Workforce models – range of potential opportunity to define at FBC to meet target operating model (TOM) – £1.3m = 5% of the pay bill
  - Strategic partner/s contribution or cost – consultancy secured for FBC; to work up for implementation at FBC

5. Service Change - The Economic Case – Economic viability

- Workforce
  - Range of workforce options in OBC
    - current staffing model
    - LTS evaluation
    - internal views on staffing required to meet current service and quality demand
    - Internal views on impact of future changes
    - External benchmarking with more advanced networks
    - Internal comparators
  - Lower benchmark of £1.3m illustrated in overall financial impact – for further exploration at FBC

6. Service Change – The Commercial Case

- Pathology entity form – single service with single management
- NHS owned and managed – outsourcing and major strategic partner eliminated as commercial options
- Referred diagnostics tender for new contract
- OBC describes range and form of potential strategic partner/s
- Consultancy support for FBC phase
- SLAs for services from host Trust/s

7. Service Change – The Commercial Case – Strategic partnership

- Magrath Consulting leading FBC development
- FBC to outline degree and breadth of strategic partner support in pathology service
- Initial meetings held with:
  - NHS pathology provider networks
  - Public/private partnership pathology providers
  - Private pathology provider
  - MSC providers
  - Education/research institutions

  to explore range of partnership options from buddying, consultancy to direct provision of pathology services.

8. Service Change - The Financial Case

- Current cost
- Range of workforce models with range of opportunities
  - Incremental changes possible in first five years
- CIP plan for referred diagnostics and repatriation of tests
- FBC and Implementation costs – programme and project costs
- SLA costs for services as in NHSI return

9. Service Change – The Management Case

- High level timeline and resource requirements for FBC, procurement and implementation
- Details project management, risk management and benefits realisation arrangements for FBC and implementation
- Governance arrangements for pathology service
- Benefits will be subject to the approved gainshare agreement
- Management structure tba in FBC
- Staff communications, engagement and OD plan for FBC and implementation

10. Service Change - In summary:

- The OBC outlines the range of opportunity from service and workforce redesign
- The FBC will outline the planned operational and workforce model with actual indicative savings

Transforming health and social care in Kent and Medway

Pathology Managed Service Contract

Outline Business Case for Trust Boards May 2020

Transforming health and social care in Kent and Medway is a partnership of all the NHS organisations in Kent and Medway, Kent County Council and Medway Council. We are working together to develop and deliver the Sustainability and Transformation Plan for our area.

Summary for Trust Board - MSC

- High level timeline for LIMS and MSC on slide 2
- Background for MSC slides 3 to 4
- Cost/savings of MSC on slide 5
- OBC approvals timeline on slide 6
- Overview of the MSC 5 case OBC slide 7 to 24
- Recommendations for Trust Boards
- Appendix – pre-analytics (to be explored at FBC)

High level timeline – LIMS and MSC

OBC approval at Trust Boards Mar/April 2020

LIMS Tender Jan-June 2020

LIMS FBC August 2020 Contract Award Q3 20/21

LIMS Implementation planning Q2 20/21-Q1 22/23

LIMS Implementation Q2-Q3 22/23 All stable May 23

MSC Baselining activity Jan-June 2020 (June-Dec

MSC Spec development Q2-3 20/21 FBC August 2020 review

MSC Procurement 2021 Contract Award 2022

MSC Implementation from Q1 23/24 to Q3 26/27

Background

- The Managed Service Contract is a key enabler of the Pathology Programme service change
- It covers analytic equipment and associated consumables, maintenance and support
- Additional value added services can be included e.g.
  - pre-analytics – *see appendix slide 20*
  - phlebotomy
  - specimen reception
  - business intelligence
  - reporting and management tools
  - quality control
  - innovation testing

Background (continued)

- benchmarking
- leadership consultancy
- education and training
- logistics
- middleware to unify systems

- Pathology Services current contracts are with different suppliers
- A single managed service enables standardisation, taking advantage of new technologies, lean processes and smarter working
- Savings can be made through a single contract

Financial implications of the MSC

- The following table compares the net cost of current MSC against the transitional Pay cost and the phases cost of the new MSC contract (non-pay), delivering projected savings of £22.4m over 13 years (after allowing for a contingency of £9.4m):

Preferred option (inflated)	19/20 £k	20/21 £k	21/22 £k	22/23 £k	23/24 £k	24/25 £k	25/26 £k	26/27 £k	27/28 £k	28/29 £k	29/30 £k	30/31 £k	31/32 £k	32/33 £k	Total £k
Current budget	0	14,220	14,476	14,751	15,046	15,347	15,654	15,967	16,286	16,612	16,944	17,283	17,629	13,486	203,701
Pay	0	(55)	(47)	(117)	(138)	(141)	(144)	(73)	0	0	0	0	0	0	(715)
Non-Pay	0	(13,668)	(13,808)	(14,038)	(14,238)	(14,187)	(14,086)	(13,802)	(13,722)	(13,996)	(14,277)	(14,562)	(14,853)	(11,363)	(180,600)
EBITDA	**0**	**497**	**621**	**596**	**670**	**1,019**	**1,424**	**2,092**	**2,564**	**2,616**	**2,667**	**2,721**	**2,776**	**2,123**	**22,386**
Depn/interest	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net saving/(cost)	**0**	**497**	**621**	**596**	**670**	**1,019**	**1,424**	**2,092**	**2,564**	**2,616**	**2,667**	**2,721**	**2,776**	**2,123**	**22,386**

- Based on the previously gain share arrangement the allocation of the MSC benefit by organisation is identified in the following table:

Organisation	Gross Cost £000	Cost share	Share of MSC benefit £000
MTW	24,140	32.5%	7,271
EKHUFT	27,624	37.2%	8,321
NKPS	22,556	30.3%	6,794
Total	**74,319**	**100.0%**	**22,386**

OBC development and approval to date

The OBC

- The OBC follows the HM Treasury Green Book 5 case model, comprising:
  - **Strategic case:** This sets out the strategic context and the case for change, together with the supporting investment objectives for the scheme.
  - **Economic case:** This demonstrates that the organisation has selected the choice for investment which best meets the existing and future needs of the service and optimises value for money (VFM).
  - **Commercial case:** This outlines the content and structure of the proposed procurement arrangements and contractual terms.
  - **Financial case:** This confirms funding arrangements and affordability and explains any impact on the balance sheet of the organisation.
  - **Management case:** This demonstrates that the scheme is achievable and can be delivered successfully to cost, time and quality.

The Strategic Case

- Networked working requires standardisation and connectivity
- Demand for, and complexity of, pathology is increasing
- Current contracts are with different suppliers in each pathology service
- A single pathology service can procure as one with the benefit of economies of scale
- Digital technology is a key enabler of the NHS Long Term Plan
- Drive for efficiency requires processes to be learner and work to be smarter
- Pathology networks required by NHSI&E by 2021

The Economic Case

- Longlist

Option	Constituent elements and description
1. Do Nothing	Continue with current configuration of equipment/reagents and consumables – the baseline option for the economic appraisal
2. Do minimal	Continue with current third-party suppliers of equipment/reagents and consumables but change the automated systems only
3.Procurement of multiple providers managed under a single umbrella management contract	Procurement for multiple providers not under a single laboratory services supplier but managed by a lead provider
4a. Consolidated Procurement single supplier (Revenue solution)	Procurement for a single laboratory services supplier based on a managed service
4b. LS consolidated Procurement single supplier (capital service)	Procurement for a single laboratory services supplier based on a capital solution
5. LS solution profiled based on end of current contracts	Procurement of multiple providers phased based on the end dates for current contracts

The Economic Case

- Shortlist – from operations group based on evaluation against programme objectives

1. Do nothing/do minimum	Continue to procure separately and with different suppliers
3. Procurement of multiple providers managed under a single umbrella management contract	Procurement for multiple providers not under a single laboratory services supplier but managed by a lead provider
4a. LS consolidated Procurement single supplier (Revenue solution)	Procurement for a single laboratory services supplier based on a capital purchase
4b. LS consolidated Procurement single supplier (capital service)	Procurement for a single laboratory services supplier based on a managed service solution

Economic case continued

- Risks and benefits workshop held in October 2019 with GMs, CDs, pathology finance leads and interested clinical leads/service leads
- Selection of preferred option
- Sense check through finance group

Benefits – vary by option but broadly:

Benefit criteria	Definition /description (for the qualitative benefits assessment)
Support better quality of clinical Care	• Supports the clinical pathway, providing consistent quality of results • Consolidated reference ranges • Interface to chosen LIMS via HL7 through middleware solution • Interface capability with various GP Order comms currently used • Pass through numbering capability • Rules based Clinical validation through middleware • Ability to access and communicate across the different sites.
Business continuity	• Full back up and disaster recovery models • Product road map to include molecular and other specialist services. • Improved TATs • Automated solutions where possible utilising equipment across disciplines where appropriate • More effective use of resources
Operational and financial efficiency	• Ability to deliver described savings as a result of more effective use of resources • Cost per reportable pricing
Long term sustainability	• A “future proof” system able to support changes in local and national demand and scaleable to manage variation in demand • UK accredited service Compliant with ISO 15189 and CE marked products where available • Lean process flow • Reduced manual handling requirements • Reduction in waste and carbon footprint • Able to meet the defined KPIs
Improve staff experience	• Innovative solution providing an environment for ongoing training and development • Quality of working conditions • Facilitates aid the retention and recruitment of high-quality staff Empower staff to deliver positive patient experience

Risks

No	Objective	1. Do nothing/do minimum	Option 3 Multiple providers with Umbrella contract	Option 4a LS consolidated Procurement single supplier (Revenue)	Option 4b LS consolidated Procurement single supplier (Capital)
1	Clinical service. Ensuring an effective, integrated and efficient service	**Risk that integration will not be possible** **Risk that current configuration minimises the ability to deliver future service efficiencies** **Decreasing ability of the solution to respond to clinical safety requirements**	Risk that integration will not be possible other than for automated tests Risk that current configuration minimises the ability to deliver future service efficiencies Decreasing ability of the solution to respond to clinical safety requirements	Risk that the solution may not realise full integration until future move are complete as a result of estates and LIMS constraints Risk that full efficiencies may not be realised until future moves due to estates /geographical constraints	Risk that the solution may not realise full integration until future move are complete as a result of estates and LIMS constraints Risk that full efficiencies may not be realised until future moves due to estates /geographical constraints
2	Patient experience. Delivering improved quality and outcomes for patients	Harmonisation of testing may be delayed and therefore the risk of different results will remain Duplication of testing may occur with the risk of different reference ranges causing delays or incorrect treatment.	Harmonisation of testing may be delayed and therefore the risk of different results will remain Duplication of testing may occur with the risk of different reference ranges causing delays or incorrect treatment.	Risk of a Major change for the staff when the LIMS build is being done could result in TAT delays Risk that some third party suppliers may not be the best solution Risk that the change may result in different reference ranges and interpretation issues for patient management e.g. tumour markers which require on trend analysis	Risk of a Major change for the staff when the LIMS build is being done could result in TAT delays Risk that some third party suppliers may not be the best solution Risk that the change may result in different reference ranges and interpretation issues for patient management e.g. tumour markers which require on trend analysis

Risks (continued)

3	Operational a Financial efficiency. Ensuring a value for money service	Risk that multiple procurements will not make economies of scale savings Risk that VAT will not be reclaimable on some contracts	Risk that any procurement will take too long to complete or be fragmented thereby not delivering VFM/ cost reduction to required timescales Risk that VAT will not be reclaimable on some contracts	Risk that financial benefit may be lower than expected due to estates constraints or implementation timescales Risk that VAT will not be reclaimable Risk that a single procurement becomes too complex and will be challenged	Risk that financial benefit may be lower than expected due to estates constraints or implementation timescales Risk that a single procurement becomes too complex and will be challenged VAT will be not claimable on capital items Insufficient cashflow for up front capital costs. Insufficient capital or Capital Resource Limits to support a capital scheme On balance sheet assets attract additional depreciation and capital charges
4	Long term sustainability of the service including ensuring a service that is flexible and adaptable to change	Risk of preventing integration or standardisation Overall solution is fragmented where services are procured piecemeal Unable to deploy new solutions – delay to upgrading or modernising the MSC solution	Poorly defined umbrella contract means risk that cost savings will not be realised and the new services will be delayed Overall solution is fragmented where services are procured piecemeal Unable to deploy new solutions – delay to upgrading or modernising the MSC solution	Risk that the whole solution cannot be supported by a single supplier Risk that new solutions and technology becoming available will not be offered as part of the contract Contract has insufficient flexibility to respond to technology changes	Risk that the whole solution cannot be supported by a single supplier Risk that partners will be unable to afford new solutions and technology holding back the scope of the MSC services Contract has insufficient flexibility to respond to technology changes As partners own the capital equipment they will bear obsolescence and replacement risk. Partners bear equipment capacity risk

Risks (continued)

5	Staff experience Delivering an improved environment for staff	Risk that turnover of staff will increase due to dissatisfaction with current providers Risk that training and R&D will be reduced as a result of not being able to reinvest in the service Suboptimal skill mix hindering staff development and ability to work at the 'top of their licence' Poor retention or recruitment due to dated processes Unable to move to a single multiskilled workforce	Risk that turnover of staff will increase due to dissatisfaction with current providers Risk that training and R&D will be reduced as a result of not being able to reinvest in the service Suboptimal skill mix hindering staff development and ability to work at the 'top of their licence' Poor retention or recruitment due to dated processes Unable to move to a single multiskilled workforce	Risk that the implementation will be delayed due to the amount of change being asked of the staff. Extensive staff training programme for new equipment. Potential that substantial change demands causes some staff to leave	Risk that the implementation will be delayed due to the amount of change being asked of the staff. Extensive staff training programme for new equipment Potential that substantial change demands causes some staff to leave

The Commercial Case

- Pre-engagement meetings and visits through Spring and Summer 2019
- Procurement through Black Country Framework:
  - Strategy (Structure of Procurement Guidance Document)
  - Specification, Key Performance Indicators and Evaluation Criteria
  - Pre-Market Engagement, Procurement Activity & Supplier Responses
  - Supplier Completed Responses
  - Clarification Questions (from evaluation workshops)
  - Contractual Documentation
  - Procurement Outcome
  - Final Due Diligence Exercises
- Single contract hosted by one Trust

Financial Case - Current MSC baseline costs vs indicative bids

Current MSC baseline costs (£m)	
Entity	**£m**
NKPS	3.2
EKHUFT	4.8
MTW	5.1
EK cell path	0.6
EK other	0.5
Total	**14.2**

Anonymised indicative MSC bids (£m)	
Supplier	**£m**
A	13.2
B	12.2
C	9.6
D	9.9

- All 4 bids are from recognised and credible pathology service providers
- Supplier A, B and D already have MSC contracts with Kent Trusts.
- Suppliers C has limited knowledge of Kent pathology and as such their bid includes numerous assumptions as well as a number of cost exclusions (thereby being understated).
- Current range in bids is **£3.6m.** This range is too high to represents price differential and as such more likely represents difference in each suppliers interpretation of the specification.

Commentary on initial bids and impact on OBC

- Supplier A and Bs knowledge of Kent pathology services means their proposals have less uncertainty and are felt to be more appropriate cost estimates
- Bids from suppliers C and D are understated and exclude costs such that indicative savings of circa 25% from baseline seem unrealistic
- Knowledge of Supplier A is that they historically overestimate initial bids
- Knowledge of Supplier B is that their bids are normal reasonable estimates
- Triangulation with network business cases - procured prices for NWLP which were modelled confidentially and represent a strong data point. Sense-checked with other networks but difficult to compare like for like
- Accordingly, it is felt that the likely range of cost for the MSC service is in the region of **£10.5m to £12.5m/year**
- The range of annual savings expected based on current information is £**0.7m** with contingency to £**1.7m** without any contingency allowance
- The requirement is to use the bids to populate the OBC. The wide range means further work is required with bidders to help them refine their cost estimates
- Activity
  - Errors in baseline activity which went to suppliers
  - Now collating 18/19 data to test how far submitted data is from there
  - 10% contingency included until activity baseline is agreed
- The 10% contingency provides allowance for activity risk above. At FBC, the project will separately identify and manage the two core activity risks being 1) managing future activity growth and 2) risks relating to inaccurate activity figures

Assumptions following check and challenges

- Economic costs stated at 19/20 cost base
- Net Present Values derived over 10 years (the likely MSC contract length) discounted at standard NHS rate of 3.5%
- Modelling period 13 years
- Capital equipment borne by the supplier and incorporated into the MSC contract value
- Preferred option based on 3 Hubs and 4 ESLs
- Baseline MSC costs provided by finance leads in each NHS organisation - £14.2m
- New MSC costs estimated from request for information (RFI) and cross checked with procured prices by London network
- The MSC OBC does not included any potential staff changes as these are dealt with in the main Service Change OBC.
- Revenue contingency of 10% of estimated new MSC charge included in financial projections

Assumptions - continued

- Growth - The MSC OBC represents a comparison of future MSC costs with a new consolidated solution against the current baseline position. As the impact of future growth will be the same for both the do nothing and the preferred option accordingly the MSC financial projections have **not** specifically modelled growth
- Implementation. As a basic principle the financial analysis is predicated on:
- Extensions to current MSC contract 2 for EKHUFT and 1 at MTW
- Savings from extensions based on negotiations assuming IFRS16 go-live 1.4.20 but as of 26.3.20 this has been delayed a year.
- LIMS “goes 1st “
- MSC “goes 2nd “
- MSC roll out over 36-month period
- Cut over from MSC old prices to new MSC prices pro rata

Assumptions - continued

- Economic sensitivity:
  - Capital costs +10%
  - Transitional costs + 50%
  - New MSC cost +10%
  - Activity is found to be understated by 10%

Key cost and benefit sharing principle

- STP Pathology Consolidation proposal, including the deployment of the MSC, should not financially disadvantage any individual organisation.
- The MSC OBC V4 is projected to generate savings of £22.4m (V4 OBC) over 13 years (after including a contingency cost allowance of £9.4m) which it is proposed be shared based on gross pathology costs following STP financial sharing principles.

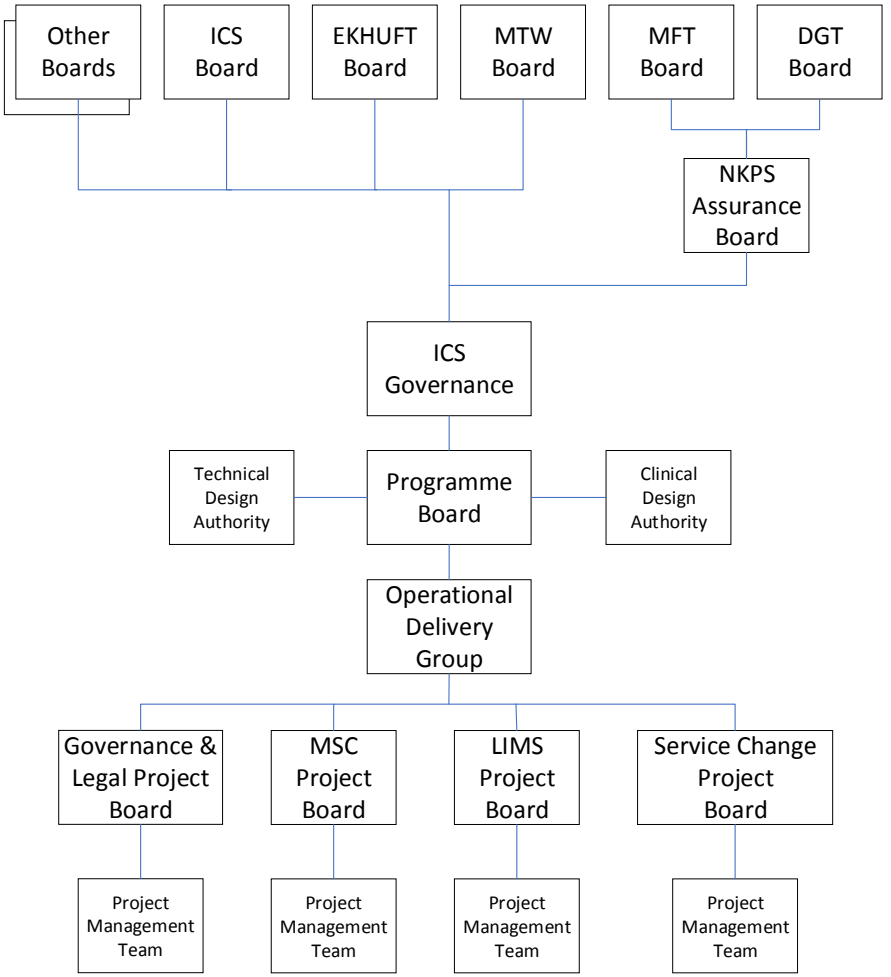
Comprehensive Investment Appraisal

- The Comprehensive Investment Appraisal (CIA) is a DOH Model used to support economic appraisals in business cases.
- The CIA supercedes the previous Generic Economic Model (GEM) which is now discontinued
- The economic appraisal considers the costs, benefits and risks of each option in comparison with a baseline option.
- This work has been completed and detailed in the Economic Case of the MSC OBC The CIA has been populated with our economic evaluation, benefits and unmometisable risk
- The MSC OBC includes a contingency of 10% (c£0.9m p.a.) to cover monetisable risk
- Currently it is not possible to easily model this contingency in the risk section of the CIA
- Instead, we have included the contingency within the financial tabs rather than the risk section i.e. it is included in the CIA
- The results of the CIA mirrors with the Economic Evaluation supporting the conclusion that the preferred option 3 remains the preferred option

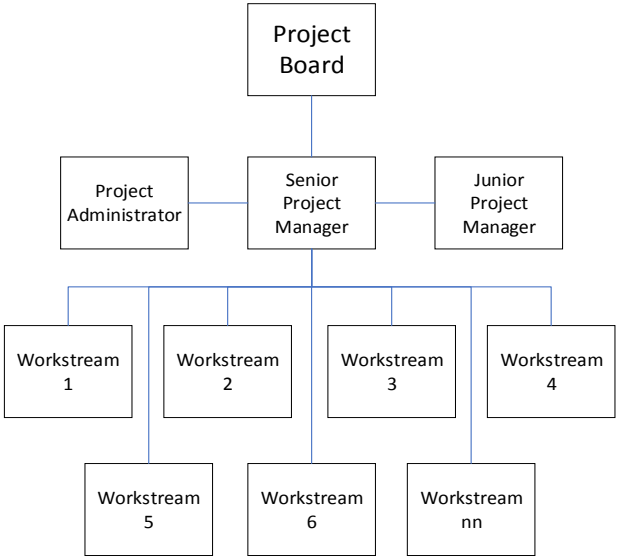
The Management Case

- Outlines high level timeline and resource requirements for FBC, procurement and implementation
- Phasing with LIMS
  - LIMS is the priority over MSC due to clinical risk so MSC timetable reflects requirement to implement LIMS first
  - Undertaking the two procurements in and to avoid duplicating demands on BMS time for procurement and implementation
  - The rollout programme has been extended to allow a year per hub of prep and implementation; and 9 months per ESL
- EKHUFT and MTW MSC contracts expire early 2020 so need to negotiate interim contract extension with current suppliers to secure savings from 2020/21. Assumptions on savings from the extended contracts in OBC and financial assumptions paper to be worked up for FBC.
- Resources required for project manager, project support, specialist procurement expertise and pathology cover
- Procurement support from existing resources and Black Country
- Benefits will be subject to the approved gainshare agreement

The Management Case



- Project to be manged within the Pathology Programme alongside Service Change and MSC Projects.
- Shared Programme Management governance arrangements with Clinical Design and Technical Design Authorities providing advice and guidance.



- Focused, discrete Project Management arrangements – led by PRINCE2 qualified Senior Project Manager supporting multiple work streams.

Recommendations and next steps

Trust Boards are asked to:

- Approve the preferred option - **Option 3:**Procurement of multiple providers managed under a single umbrella management contract
- Approve in principle that the final consolidated MSC contract should to be held by one Trust on behalf of all
- To note the approval by Directors of Finance for total transitional funding for 20/21 for the MSC project of £55k (now central)
- Approve that the MSC proposal proceeds to FBC stage

Appendix – Pre-analytics (to be explored at FBC)

- *MSC solutions as considered in the OBC typically focus on the analytical aspect of sample and the creation of a pathology result. Other than Order Communications, it is recognised that the sample pathway from GP to analyser is a largely manual process (i.e. the collection of sample, packaging, transport and sorting for analysis) and accordingly there is limited data available about this process. Typically, it is projected that this phase is where around 65% of all errors occur.*
- *Pre-analytics represents a solution that addresses the gaps in data in the front end of the sample journey and, in particular, deploys equipment solutions to automate and optimise the sample journey right the way through to specimen reception.*
- *Pre-laboratory and pre-analytics streamline the process from point of blood draw through to specimen reception enabling a full audit trail of the sample tube with recording of collection, transport time and temperature during transport as well as automated specimen reception. The process works by samples being place into radio-frequency identification (RFID) chipped racks. On arrival at specimen reception the racks are place on RFID encoders which have a bi-directional link the LIMS which thereby enable the solution to perform automated specimen reception.*
- *At this OBC stage pre-analytics has been identified as an area to explore with potential bidders during the procurement phase to allow the project to undertake a cost/benefit analysis for consideration of pre-analytics in the FBC. Currently the implications of pre-analytics have been excluded as a costed solution from both the MSC OBC and Service Change OBC.*

Transforming health and social care in Kent and Medway

Pathology LIMS

Outline Business Case for Trust Boards March 2020

Transforming health and social care in Kent and Medway is a partnership of all the NHS organisations in Kent and Medway, Kent County Council and Medway Council. We are working together to develop and deliver the Sustainability and Transformation Plan for our area.

Summary for Trust Boards - LIMS

- High level timeline for LIMS and MSC on slide 2
- Cost/savings compared to Do Minimum for LIMS and MSC on slide 5
- Benefits table – highlighting benefits across all three business cases in LIMS OBC appendix B
- Lessons learnt from NKPS in sections 1.6.3 and 6.5 and appendix I in LIMS OBC

High Level Timeline – LIMS and MSC

OBC approval at Trust Boards May/June 2020

LIMS Tender April-August 2020

LIMS FBC Dec 2020 Contract Award Q4 20/21

LIMS Implementation planning Q4 20/21-Q4 22/23

LIMS Implementation Q4 22/23-Q1 23/24 All stable Nov 23

MSC Baselining activity Jan-June 2020

MSC Spec development Q2-3 20/21 FBC August 2020

MSC Procurement 2021 Contract Award 2022

MSC Implementation from Q1 23/24 to Q4 26/27

Why ‘do minimum’ and not ‘Do Nothing’

The OBC considers option 1 as the ‘Do Minimum’ option because, over the proposed 10-year contract length, doing nothing is not considered realistic. This is because of the probability that the legacy LIMS must be replaced within this period, due to:

- The likelihood that the incumbent supplier – which is the same for all Trusts – will give notice on their support agreements as they are currently developing and marketing the next generation product and would wish to migrate Trusts to this.
- Since the current LIMS were designed and implemented, standards across all aspects of pathology have evolved and new standards and mandated requirements for LIMS have emerged such as SNOMED-CT, FHIR and COSD. The legacy LIMS are not totally compliant with these.

Background

- A single shared LIMS for Kent & Medway is a key enabler of the Pathology Programme service change.
- The scope includes all aspects that the four legacy LIMS currently accommodate.
- The Legacy, non-integrated, LIMS have exceeded their useful life and need upgrading to a new, modern product.
- Tangible qualitative benefits can be achieved through standardisation and the rationalisation to a single shared LIMS will provide the best foundation for standardisation and wider service changes.

Cost/savings compared to Do Minimum for LIMS and MSC

- The impact of LIMS option 4 and MSC compared to LIMS 'Do minimum' as the baseline is a saving of £37.6m. The total cost is therefore reduced from £29.2m to a saving of £8.406m;-

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13 Q1 Only	Total
	19/20	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	
Option 4	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
LIMS Option 1 – Do Minimum															
Total Investment	0	1,048	1,658	3,181	2,820	2,776	2,727	2,705	2,656	2,581	2,514	1,856	1,814	867	29,202
Savings	0	(240)	(567)	(1,813)	(1,415)	(2,118)	(2,450)	(3,660)	(4,762)	(4,698)	(4,679)	(4,334)	(4,324)	(2,656)	(37,608)
Net Cost / (Saving)	0	808	1,092	1,368	1,405	658	276	(955)	(2,106)	(2,117)	(2,166)	(2,478)	(2,510)	(1,790)	(8,406)
MTW	76	289	380	470	482	240	115	(285)	(658)	(662)	(678)	(779)	(790)	(575)	(2,374)
EKHUFT	18	288	395	497	511	234	92	(366)	(793)	(798)	(816)	(932)	(944)	(669)	(3,282)
NKPS	14	231	316	400	412	185	69	(305)	(654)	(657)	(672)	(767)	(777)	(546)	(2,750)
Total by organisation	30	808	1,092	1,368	1,405	658	276	(955)	(2,106)	(2,117)	(2,166)	(2,478)	(2,510)	(1,790)	(8,406)

NB. All parties need to confirm that the assumption that the MSC savings will be delivered within specific Organisations in years 1 to 4 from contract extensions and these savings will be distributed in accordance with the gain share arrangement of the pathology programme is to be applied

Table taken from section 1.1.3 of the LIMS OBC

Cost/savings compared to Do Minimum for LIMS and MSC

- The impact of LIMS option 5 and MSC compared to LIMS 'do minimum' as the baseline is a saving of £39.46m. The total cost is therefore reduced from £29.2m to a saving of £10.25m;-

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13 Q1 Only	Total
	19/20	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	
Option 5	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
LIMS Option 1 – Do Minimum															
Total Investment	0	1,048	1,658	3,181	2,820	2,776	2,727	2,705	2,656	2,581	2,514	1,856	1,814	867	29,202
Savings	-	470	(557)	(1,982)	(1,256)	(2,685)	(2,984)	(4,167)	(5,228)	(5,126)	(5,059)	(4,412)	(4,370)	(2,206)	(39,455)
Net Cost / (Saving)		1,518	1,101	1,199	1,564	91	(258)	(1,462)	(2,572)	(2,545)	(2,545)	(2,556)	(2,556)	(1,339)	(10,253)
MTW	76	520	383	415	534	55	(58)	(449)	(810)	(801)	(801)	(804)	(804)	(429)	(2,974)
EKHUFT	18	552	399	436	571	24	(106)	(553)	(966)	(956)	(956)	(960)	(960)	(500)	(3,957)
NKPS	14	447	318	348	459	12	(94)	(460)	(796)	(788)	(788)	(792)	(792)	(410)	(3,323)
Total by organis'n	108	1,518	1,101	1,199	1,564	91	(258)	(1,462)	(2,572)	(2,545)	(2,545)	(2,556)	(2,556)	(1,339)	(10,253)

NB. All parties need to confirm that the assumption that the MSC savings will be delivered within specific Organisations in years 1 to 4 from contract extensions and these savings will be distributed in accordance with the gain share arrangement of the pathology programme is to be applied.

Table taken from section 1.1.3 of the LIMS OBC

Summary impact and capital contribution

	Baseline	Do Minimum	Option 4	Saving	Option 5	Saving
Pay	4,028	4,425	4,323	(103)	7,766	3,340
Non pay	7,261	19,778	21,161	1,383	27,645	7,867
Capital	0	16,288	12,048	(4,239)	0	(16,288)
Savings	0		(5,861)	(5,861)	(5,861)	(5,861)
Total	11,289	40,491	31,671	(8,820)	29,550	(10,942)

The table above summarises the variation between the options by expenditure type

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Total
	19/20	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	
Option 4	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
MTW	0	1,825	991	690	164	2	235	2	2	2	1	3,913
EKHUFT	0	2,088	1,134	790	188	2	269	2	2	2	1	4,478
NKPS	0	1,705	926	645	153	2	220	2	2	2	1	3,657
Total Investment	0	5,618	3,051	2,125	505	7	724	5	6	6	3	12,048
Option 5	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Total Investment	0	0	0	0	0	0	0	0	0	0	0	0

The table above provides the capital investment requirement by organisation for the two options.

Tables taken from section 1.5.1 of the LIMS OBC

The OBC

- The OBC follows the HM Treasury Green Book 5 case model, comprising:
  - **Strategic case:** This sets out the strategic context and the case for change, together with the supporting investment objectives for the scheme.
  - **Economic case:** This demonstrates that the organisation has selected the choice for investment which best meets the existing and future needs of the service and optimises value for money (VFM).
  - **Commercial case:** This outlines the content and structure of the proposed procurement arrangements and contractual terms.
  - **Financial case:** This confirms funding arrangements and affordability and explains any impact on the balance sheet of the organisation.
  - **Management case:** This demonstrates that the scheme is achievable and can be delivered successfully to cost, time and quality.

OBC Development and Approvals to Date

SOC Approval April 2019

Technical specification (OBS) October

Project team and Programme Board Nov

Check and challenge Nov 19

Senior peer review Nov 19

2nd Check and challenge Dec 19

Project Team and Programme Board Dec 19

Clarification questions gateway January

Revised model Programme Board in Feb

Final Gateway review for the programme

STP DOFs System support for early years March

The Strategic Case

- A Pathology network requires standardisation and connectivity.
- Demand for, and complexity of, pathology is increasing.
- The four current LIMS contracts are with the same supplier for each pathology service, but the systems are disparate.
- A single pathology service can procure together with the benefit of economies of scale.
- The single shared LIMS is a key enabler of the NHS Long Term Plan.
- Drive for efficiency requires processes to be leaner and work to be smarter, which will be achieved in part through standardisation.
- Pathology networks required by NHSI&E by 2021.

The Economic Case

- A shortlist of options was developed and a means to appraise them was agreed.
- The appraisal initially consisted of a qualitative element forming 60% of the total assessment score and a financial element forming 40%. The financial appraisal was later changed to an economic appraisal using the Comprehensive Investment Appraisal (CIA) tool.
- The qualitative appraisal criteria as well as the risks and perceived benefits associated with option were discussed in detail at 1:1 meetings with the CDs and General Managers; the Information Sub-Group and the Project Team.
- The appraisal approach and the criteria, risks and benefits were formally approved by the Programme Board following the initial discussions.

Economic Case – Continued

- Shortlist of Options

Table summarised from information in section 3.4 of the LIMS OBC

Option	Constituent elements and description
1. Do Minimum	Continue with current legacy LIMS, replace hardware as and when required (2 Trusts overdue and one approaching end of life) with the likelihood that Trusts would ultimately replace whole LIMS platform within the next 10 years.
2. Keep existing LIMS but integrate through a new common Trust Integration Engine (TIE) and new enterprise Master Patient index (eMPI).	As per option 1 but LIMS would be integrated with the ability to share results and patient level data. There would be a means to ensure high-quality patient demographic data and identify linked patients across the county, i.e. the same person appearing on different LIMS to form a more holistic view of patients' records.
3. Each Trust buys the same LIMS and Integrate them via new TIE and eMPI.	Similar to option 2 but each Trust would benefit from a new, modern LIMS. With this option, all LIMS would remain separate instances with multiple contracts held by the individual Trusts. Standardisation would be achieved by a programme-level implementation team ensuring a common system configuration at all labs.
4. One Trust buys new LIMS and hardware on behalf of all Trusts and installs on site.	A single shared LIMS for all labs. Standardisation achieved through agreed harmonisation of test catalogues, tests, panels and methods detailed within a single Quality Management System. One Trust will physically host the LIMS on behalf of the Network.
5. One Trust enters a Managed Service Contract for a new remotely hosted (in the cloud) LIMS solution on behalf of all Trusts.	As per option 4 however the LIMS would be hosted remotely by the supplier and the responsibilities for the management and maintenance of the system hardware lies 100% with the supplier or their third-party hosting partner.

Options 4 and 5 are effectively the same, the key difference is the delivery solution, i.e. on-site capital or off-site managed service.

Economic Case – Continued

- Cash-releasing and non-cash-releasing benefits for all options were identified. Detailed information regarding the relevance of each benefit to the options can be found in appendix B of the LIMS OBC:

Benefit Description	Measures	Option 1	Option 2	Option 3	Option 4	Option 5	Benefit Type
Service Change	• Total pay budget per annum across all pathology services	X	X	✓	✓	✓	CRB
	• Seamless processes deployed	X	X	✓	✓	✓	
	• Harmonised workflows, catalogues, methods and QMS	X	X	✓	✓	✓	
Increased operational Efficiency	• Improved TATs	X	X	✓	✓	✓	NCRB
	• Reduction in duplicate testing	X	X	✓	✓	✓	
	• Reduced inter-lab administration	X	X	✓	✓	✓	
	• Local system maintenance tasks passed to supplier	X	X	X	X	✓	
	• Reduced system password re-sets (self-service)	X	X	✓	✓	✓	

Economic Case – Continued

Benefit Description	Measures	Option 1	Option 2	Option 3	Option 4	Option 5	Benefit Type
Increased clinical effectiveness	• Ability to see all results	X	✓	✓	✓	✓	NCRB
	• Less time required by clinicians and healthcare professions chasing results	X	X	✓	✓	✓	
	• Reduction in clinical incidents	X	X	✓	✓	✓	
	• Improved decision support	X	X	✓	✓	✓	
	• Reduction in clinical admin time	X	X	✓	✓	✓	
	• Improved ward efficiency	X	X	✓	✓	✓	
	• Increased number of patient records with NHS No.s on LIMS	X	X	✓	✓	✓	
	• Removal of paper results	X	X	✓	✓	✓	
Increased cost efficiency	• Reduction in LIMS support & maintenance costs	X	X	X	✓	✓	CRB
	• Reduction in stationery costs (printed results)	X	X	✓	✓	✓	

Table taken from section 3.5.1 of the LIMS OBC

Economic Case – Continued

- Some identified risks apply to all options and some relate to specific options, e.g. risks associated with disparate LIMS apply to options 1,2 and 3 to some extent, whereas risks associated to a single shared LIMS will relate to options 4 and 5. e.g:
  - Risk C12*: [There is a risk that] the managed service contract option criteria is determined as a lease that therefore is 'on balance sheet'.* This risk relates only to Option 5
  - Risk C13: *[There is a risk that] a catastrophic system failure of a single shared LIMS will impact the whole county, not just one laboratory/service.* This risk relates only to Options 4 and 5
- Detailed information regarding the relevance of each risk to the various options can be found in appendix C of the LIMS OBC:

Economic Case – Continued

Risk Description		Risk Impact	Mitigation
A - Design & Development Risks			
A1	Legacy LIMS are not compliant with the mandated requirement for LIMS to use SNOMED-CT and the FHIR interoperability standard.	The Network would not be able to take advantage of the benefits offered by FHIR as integrated systems start to use this standard more. Without the adoption of SNOMED-CT, the future recording of encoded clinical data within healthcare systems will not be possible as downstream systems move to fully adopt this standard. This may lead to sub-optimal patient care and data reporting.	Mitigation is dependent on whether the system supports these standards. Legacy LIMS do not
A2	The harmonisation of tests, methods and the quality management system to form a common approach to the delivery of pathology services in Kent will be challenging to achieve and may not be fully possible.	The Network will not be able to achieve its stated objectives and realise the anticipated benefits	Without a single shared LIMS or an identical LIMS deployed separately it may not be possible to harmonise fully
A3	To create an effective Pathology network, decisions and work must be made and completed at a County-wide (programme) level. These dependencies may impact on progress and therefore costs of local LIMS implementation projects.	The Network will not be able to achieve its stated objectives and realise the anticipated benefits and costs may increase due to additional time required to achieve standardisation	Ensure excellent programme and project management is in place and effective governance and clinical leadership at Network level
A4	As the new LIMS instances will be disparate, even slightly different configurations may have unintended consequences post implementation given the desire for maximum standardisation.	The Network will not be able to achieve its stated objectives and realise the anticipated benefits and costs may increase due to additional time required to achieve standardisation	Ensure excellent programme and project management is in place and effective governance and clinical leadership at Network level
A5	Implementing a common pathology catalogue across multiple LIMS will be challenging	The Network will not be able to achieve its stated objectives and realise the anticipated benefits and costs may increase due to additional time required to achieve standardisation	Ensure excellent programme and project management is in place and effective governance and clinical leadership at Network level
A6	Inadequate identification of local requirements prior to system going live	System does not match users' expectations, resulting in users not making full use of system and so full benefits not being realised	Ensure requirements are comprehensively documented, reviewed and approved. Medium risk as systems will be procured against well developed user statement of requirement.

Economic Case – Continued

Risk Description		Risk Impact	Mitigation
A - Design & Development Risks			
A7	Insufficient attention paid to redesigning working practices in advance of deployment	Extra costs incurred in attending to process redesign, business change and/or benefits associated with new service are not fully realised	Ensure change management is planned, appropriately resourced and carried out
A8	Integration between the systems does not deliver the end users needs	Benefits are delayed or not realised	Ensure that the system specification is built to meet end user needs, look for contractual cover
A9	Trust makes changes to specification	Additional investment required to design, develop and deploy changes	Ensure that major changes planned (Service reconfiguration & commissioning intentions) are taken into account before implementation to reduce impact.
B - Deployment Risks			
B1	Introducing a new LIMS would require the re-implementation of the existing (or new/alternative) GP Order Comms Systems	It might take longer than estimated and cost more to reconnect the new LIMS to existing order comms solutions	Ensure that an effective plan is developed and agreed by SMEs and ensure adequate resources are available
B2	Implementing a new LIMS will require significant data cleansing and data migration	It might take longer than estimated and cost more to complete the data migration work	Ensure that an effective plan is developed and agreed by SMEs and ensure adequate resources are available
B3	Unexpected difficulties encountered integrating new systems with local applications	Extra costs incurred and/or go live date, and so kick-in of benefits, delayed	Establish specific lead for integration. Regular and close management of interface development and testing
B4	3rd Party applications unable to interface with preferred supplier	Solution may not be able to provide the required functionality as originally specified.	Provide detailed interface specification documentation to all suppliers prior to start of project.
B5	Cost estimate for commissioning new system & interfaces underestimated.	Extra costs incurred and/or go live date, and so kick-in of benefits, delayed	Ensure estimates are robust and based on quality data. Include contingency or estimate for worst case. Ensure costs is signed off by service provider responsible for system

Economic Case – Continued

Risk Description		Risk Impact	Mitigation
C - Operational Risks			
C1	As it does not meaningfully support the 5 objectives of the STP Pathology Programme, change may be enforced by central government, removing autonomy.	The ultimate outcome may not be desirable to the Kent Trusts, e.g. outsourcing or another NHS Pathology service taking over	Ensure autonomy by acting proactively to develop a meaningful, efficient and effective pathology network through a single harmonised service, built around a common LIMS
C2	Existing aging hardware might not be replaced by the Trusts, which may cause a significant downtime period if the equipment cannot be quickly repaired (Trusts on best of endeavours arrangements with current LIMS suppliers)	potential clinical risk as tests will need to be processed manually and results provided outside of the LIMS. Depending on length of downtime significant effort may be required to add data onto the recovered LIMS	replace aging hardware ahead of any of the 5 options being implemented
C3	The existing Apex and Telepath systems may no longer be compliant with MHRA Blood Transfusion standards or may be become non-compliant so perpetuating use long term may invoke MHRA sanctions.	Services may be forced to change LIMS in order to maintain accreditation	Investigate MHRA position on existing LIMS functionality. Consider changing LIMS sooner for options 1 and 2
C4	The ability to manage samples across sites, e.g. sample tracking will be more difficult and less efficient with multiple LIMS	Less efficient service - reduced benefits profile and less able to reduce overall turnaround times	a single shared LIMS will fully mitigate this. Disparate LIMS will maintain the status quo.
C5	Annual support costs will remain separate to each Trust and may increase substantially above the cost of supporting a modern LIMS through a single contract.	cost pressure on pathology services / Trusts	a single shared LIMS will fully mitigate this. Disparate LIMS will maintain the status quo.
C6	Predatory competitor organisations may be able to supply a more holistic technology enabled service at a lower cost and may erode the market share held by the Trusts in Kent and Medway	Services may be outsourced and Trusts will lose autonomy / control	Ensure autonomy by acting proactively to develop a meaningful, efficient and effective pathology network through a single harmonised service, built around a common LIMS
C7	Trusts would be reliant on the Host Trust to effectively manage and maintain the hardware on behalf of all.	All of the risk will be borne by the host Trust but failure to maintain systems effectively will impact all Trusts	ensure that an effective SLA is agreed with the host Trust.

Economic Case – Continued

Risk Description		Risk Impact	Mitigation
C - Operational Risks			
C8	Trusts would be dependent on supplier management of the servers/data centres, security, Disaster Recovery, backups, system upgrades and patches.	All of the risk will be borne by the supplier but failure to maintain systems effectively will impact all Trusts	ensure that an effective SLA is agreed with the supplier and enforced by the host Trust.
C9	There may be network latency issues with a remotely hosted (cloud-based) system. This may impact performance e.g. causes issues for the Tracked Analysers management system	reduced operational efficiency	ensure that network infrastructure is up to the requirement
C10	System/services unable to respond to unforeseen increased activity/throughput	Extra investment required in order to rectify inadequacies	Ensure contract caters for CCNs in a controlled framework. Risk mitigated if contract has framework for CCNs, including charging mechanism.
C11	System cannot readily respond to legislative and regulatory changes during the lifetime of the service - e.g. changes to statutory reporting requirements	Additional investment required to design, develop and deploy service enhancements	Ensure project and contracts with third parties are supportive of legislative changes
C12	The managed service contract option critertia is determined as a lease that therefore is 'on balance sheet'.	Impacts against Host Capital Resource Limit (CRL)	CRL adjustment required by the Host Trust
C13	A catastrophic system failure of a single shared LIMS will impact the whole county, not just one laboratory/service	All laboratories may need to implement business continuity plans	Ensure that the system infrastructure, if hosted on-premise, is as robust as possible and auto-failover resilience is designed-in. Undertake periodical testing of the resilience
D - Termination Risks			
D1	The supplier may move towards removing support for the current LIMS, forcing labs to upgrade to re-tender and the eventual implementation of more expensive options than a single LIMS across Kent.	forced migration to new LIMS platform without many of the benefits achievable via a network approach being realisable unless harmonisation is delivered at the time of replacement	Ensure benefits are achieved by acting proactively to develop a meaningful, efficient and effective pathology network through a single harmonised service, built around a common LIMS before suppliers give notice
D2	Implementing a new LIMS will require historical data to be retained in a read-only database, accessible to service users.	service users will need to access separate systems for historical data, this could impact patient experience through minor delays in accessing information	Consider developing a single historical database for all Trust data or implement a results viewer and feed data through that

Table summarised from Appendix C of the LIMS OBC

Economic Case – Continued

- Identification of the preferred options was achieved using qualitative appraisal and value for money (cost of quality) assessment.
- The Qualitative Appraisal was undertaken by a panel formed from:
  - ICT Director for EKHUFT
  - Director of IT for MTW
  - Director of IT Transformation for MFT
  - Associate Director of Digital Transformation for DGT
  - Clinical Director of Pathology for EKHUFT
  - Clinical Director of Pathology for MTW
  - Clinical Director of Pathology for NKPS
  - MTW Pathology General Manager
  - EKHUFT Pathology General Manager
  - NKPS Pathology General Manager

Note, The DGT Associate Director of Digital Transformation did not participate in the scoring and the NKPS Pathology General Manager was unable to attend the event.

Economic Case – Continued

- Qualitative Option Appraisal Criteria used by the panel:
  - The degree to which the option supports the five objectives of the Kent & Medway STP Pathology Programme.
  - The degree to which the option enables a safe, modern and equitable pathology service to be provided to all patients living in Kent and Medway.
  - The degree to which the option enables collaboration of colleagues from across the Network.
  - The degree to which the option enables the ability to reconfigure laboratories across the Network.
  - The degree to which the option provides the required LIMS functionality AND enables the adoption of future technologies.
  - The degree to which the option provides a good balance between risk and benefit.
  - The degree to which the option enables business intelligence / management reporting requirements are met, including transparency of measurement methods and units across Kent and Medway Trusts.

Economic Case – Continued

- The panel members appraised each option using the agreed criteria and the identified risks and benefits.
- A score of between 1 and 5 was applied to each option against each criterion.
- The scores for each option were totalled and compared to the maximum possible to obtain a percentage compliance to the criteria.
- Options 1 and 2 scored significantly lower than options 3,4 and 5. This was due to these options effectively representing the status quo, which therefore would prevent the creation of a single Pathology service.
- Qualitative Assessment Outcome – Options 4 and 5 scored equally.

Evaluation Results	**Option 1**	**Option 2**	**Option 3**	**Option 4**	**Option 5**
Qualitative appraisal (%)	23	36	56	84	85
Ranking	**5**	**4**	**3**	**1**	**1**

Table taken from section 3.8.2 of the LIMS OBC

Economic Case – Continued

- **Economic Appraisal**– using the CIA tool, the economic appraisal derived the following results:

Evaluation Results	Option 1	Option 2	Option 3	Option 4	Option 5
Economic appraisals	3	5	4	2	1
Benefits appraisal	3	3	3	1	1
Risk appraisal	4	5	3	1	2
Overall Ranking	=3	5	=3	=1	=1

- **Total Appraisal Results** – comparing the assessment rankings identified options 4 and 5 were effectively joint first. It was recommended that both options 4 and 5 should be taken forward to the procurement stage:

Evaluation Results	Option 1	Option 2	Option 3	Option 4	Option 5
Economic appraisal ranking	3	5	3	1	1
Qualitative appraisal ranking	5	4	3	1	1
Overall Ranking	4	5	3	=1	=1

Tables taken from sections 3.9.4 and 3.9.5 of the LIMS OBC

The Commercial Case

Milestone Activity	Week No.
LIMS Strategy document and mandatory questions released to suppliers (stage 1)	1
Bidders short-listed – stage 1 completed	3
Initial Proposal (IP) Response Documents published including OBS and Service Level Agreement (SLA) (stage 2)	3
Completed IP Response Documents returned with completed OBS by bidders	10
IP Response and OBS evaluation complete – stage 2 completed	15
On-site system demonstrations (stage 3)	17
Scoring of on-site demonstrations – stage 3 completed	18
Visits to suppliers' reference customers complete (Stage 4)	21
Scoring of reference site visits complete – stage 4 completed	22
Submission of supplier's Best and Final Offer (BAFO) (stage 5)	24
BAFO evaluation conclusion – stage 5 completed (FBC can now be finalised)	27
FBC complete including peer review	32
FBC Governance complete (Including Trust Boards' approval)	45
Contract Award	49

Table taken table 32 in section 4.6 of the LIMS OBC

- Procurement will be through mini-competition process run by QE Procurement, supported by the Procurement Team at EKHUFT and NHS Commercial Solutions.

The Financial Case

- Assumptions used:
  - Base year (Year 0) is 2019/20.
  - Contract duration and anticipated system life is 10 years.
  - All system capital VAT is non-reclaimable.
  - Discount factor is 0.035 (3.5%).
  - Effect of inflation has been excluded.
  - Contingency has been added based on a financial impact assessment of identified risks using the Treasury green book approach. As well as a 10% optimism bias.
  - Scheme will be funded internally. If Public Dividend Capital (PDC) funds become available a bid will be submitted.
  - The Managed Service Contract term of 10 years for Option 5 is assumed to commence from the date of the first cutover to the new LIMS. However, there may be a cash impact caused by any payments to the supplier during the implementation stage. This option assumes the contract will be ‘off balance sheet’ under IFRS16 which will need to be confirmed via the auditors of the Host when the terms and conditions of the service contract are known.
  - Estimated sunk costs for the unamortized value, at the point of go-live, of any replacement servers for existing LIMS has been included.

The Financial Case - Continued

- Current costs associated with maintaining and supporting LIMS (pay and non-pay) across the four Trusts is £859k per annum.
- Capital requirement for option 4 is £12.048m (comparable to other nwrks) and for option 5 is £0:

Option 4: I & E

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13 Q1 Only	Total
	19/20	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	
Option 4	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Capital Cash Phasing															
Capital	0	5,618	3,051	2,125	505	7	724	5	6	6	3	0	0	0	12,048
Summary I&E Impact															
Pay	365	299	406	337	204	204	204	204	204	204	204	204	204	153	3,394
Non-pay	548	973	1,298	1,298	1,281	870	870	870	870	870	870	870	870	653	13,011
Contingency	0	10	18	17	10	11	8	9	10	11	8	0	0	0	113
Sunk Costs	0	161	224	278	254	0	0	0	0	0	0	0	0	0	917
Depreciation including Capital Contingency	0	337	358	769	1,221	1,210	1,208	1,209	1,210	1,209	1,206	939	939	235	12,048
Dividend	0	92	232	303	314	278	251	221	179	137	95	58	25	4	2,189
Total	913	1,873	2,537	3,002	3,283	2,572	2,540	2,513	2,472	2,431	2,382	2,070	2,038	1,044	31,671
Funded By															
Existing*	913	847	847	847	847	847	847	847	847	847	847	847	847	212	11,289
New Investment	0	1,026	1,690	2,155	2,436	1,725	1,693	1,666	1,625	1,584	1,535	1,223	1,191	832	20,382
Grand Total	913	1,873	2,537	3,002	3,283	2,572	2,540	2,513	2,472	2,431	2,382	2,070	2,038	1,044	31,671

Table taken from section 1.1.2 of the LIMS OBC

The Financial Case - Continued

- Option 4 continued
  - Capital and Revenue Cost Breakdown by Trust:

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13 Q1 Only	Total
	19/20	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	
Option 4	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Capital Investment															
MTW	0	1,825	991	690	164	2	235	2	2	2	1	0	0	0	3,913
EKHUFT	0	2,088	1,134	790	188	2	269	2	2	2	1	0	0	0	4,478
NKPS	0	1,705	926	645	153	2	220	2	2	2	1	0	0	0	3,657
Total Investment	0	5,618	3,051	2,125	505	7	724	5	6	6	3	0	0	0	12,048
Revenue Investment															
MTW	0	333	549	700	791	560	550	541	528	514	499	397	387	270	6,620
EKHUFT	0	381	628	801	905	641	629	619	604	589	571	455	443	309	7,576
NKPS	0	312	513	654	739	524	514	506	493	481	466	371	361	253	6,186
Total I&E Impact	0	1,026	1,690	2,155	2,436	1,725	1,693	1,666	1,625	1,584	1,535	1,223	1,191	832	20,382

Note: Revenue investment includes capital charges

Table taken from section 1.5.1 of the LIMS OBC

The Financial Case - Continued

- Option 5 I&E:

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Total
	19/20	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	
Option 5	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Capital Cash Phasing															
Capital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Summary I&E Impact															
Pay	365	648	1,742	1,563	707	209	210	210	210	206	206	204	204	153	6,836
Non-pay	548	1,763	563	976	2,199	1,788	1,788	1,788	1,788	1,788	1,788	1,788	1,788	1,341	21,698
Contingency	0	10	17	15	8	8	8	8	8	8	8	0	0	0	99
Sunk Costs	0	161	224	278	254										917
Depreciation including Capital Contingency	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dividend	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	913	2,583	2,546	2,833	3,168	2,005	2,006	2,006	2,006	2,003	2,003	1,992	1,992	1,494	29,550
Funded By															
Existing*	913	847	847	847	847	847	847	847	847	847	847	847	847	212	11,289
New Investment	0	1,736	1,699	1,986	2,321	1,158	1,159	1,159	1,159	1,156	1,156	1,145	1,145	1,282	18,261
Grand Total	913	2,583	2,546	2,833	3,168	2,005	2,006	2,006	2,006	2,003	2,003	1,992	1,992	1,494	29,550

Table taken from section 1.1.2 of the LIMS OBC

The Financial Case - Continued

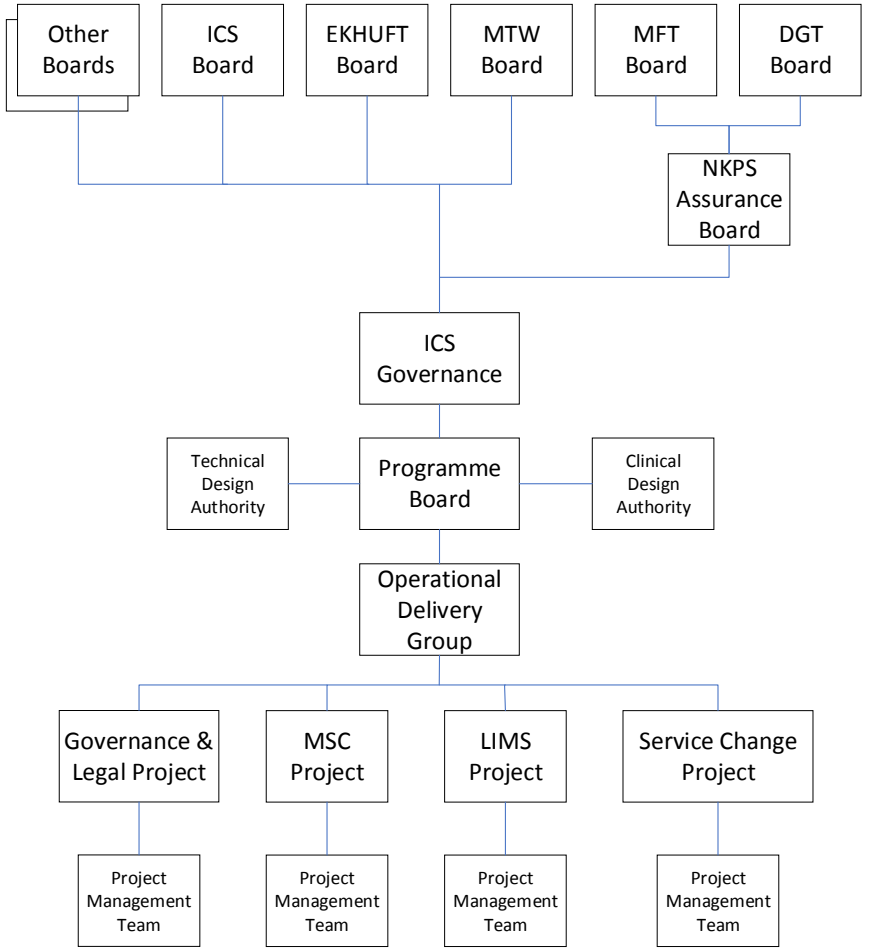
- Option 5 continued
  - Capital and Revenue Cost Breakdown by Trust:

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13 Q1 Only	Total
	19/20	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	
Option 5	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Capital Investment															
Total Investment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Revenue Investment															
MTW	0	564	552	645	754	376	376	376	376	375	375	372	372	416	5,931
EKHUFT	0	645	632	738	863	430	431	431	431	429	429	426	426	477	6,787
NKPS	0	527	516	603	704	351	352	352	352	351	351	348	348	389	5,542
Total I&E Impact	0	1,736	1,699	1,986	2,321	1,158	1,159	1,159	1,159	1,156	1,156	1,145	1,145	1,282	18,261

Note: Revenue investment includes capital charges

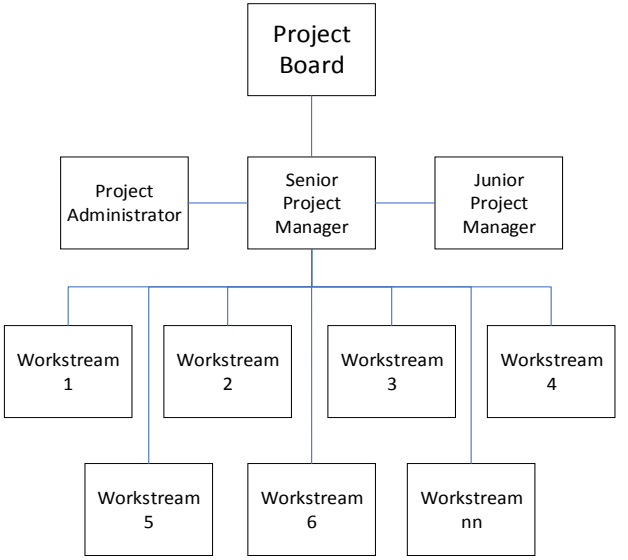
Table taken from section 1.5.1 of the LIMS OBC

The Management Case



Figures taken from section 1.6.2 of the LIMS OBC

- Project to be manged within the Pathology Programme alongside Service Change and MSC Projects.
- Shared Programme Management governance arrangements with Clinical Design and Technical Design Authorities providing advice and guidance.



Focused, discrete Project Management arrangements – led by PRINCE2 qualified Senior Project Manager supporting multiple work streams.

The Management Case - Continued

Milestone Activity	Month No.	Estimated Date	Year
Approval to proceed	-2	10/20	Q3 Yr 1
Project Team Recruitment complete (identification of candidates may start pre-approval)	1	12/20	Q3 Yr 1
Initiation complete	2	01/21	Q4 Yr 1
Data migration work starts	7	06/21	Q1 Yr 2
High-level Service Design (standardisation and harmonisation) complete	7	06/21	Q1 Yr 2
As-Is process mapping complete	7	06/21	Q1 Yr 2
Server and third-party software install complete	7	06/21	Q1 Yr 2
Analyser and Integration high level design complete	7	06/21	Q1 Yr 2
Technical system build complete	9	08/21	Q2 Yr 2
High level system design complete	9	08/21	Q2 Yr 2
To-Be process mapping complete	11	10/21	Q3 Yr 2
Test Strategy complete	11	10/21	Q3 Yr 2
SOPs revised / drafted	13	12/21	Q3 Yr 2
Test Script development complete	14	01/22	Q4 Yr 2
Data migration and testing complete (minus delta load)	14	01/22	Q4 Yr 2
Validation testing complete	16	03/22	Q4 Yr 2
User Acceptance Testing starts (3 rounds – all Trusts)	17	04/22	Q1 Yr 3
User Training (Trust 1) starts	23	10/22	Q3 Yr 3
User Acceptance Testing complete	25	12/22	Q3 Yr 3
User Training (Trust 1) complete	25	12/22	Q5 Yr 3
Cutover (Trust 1)	26	01/23	Q4 Yr 3
User Training (Trusts 2 and 3) starts	28	03/23	Q4 Yr 3
User Training (Trusts 2 and 3) complete	30	05/23	Q1 Yr 4
Trust 1 Stabilisation period complete	30	05/23	Q1 Yr 4
Cutover (Trusts 2 and 3)	31	06/23	Q1 Yr 4
Trusts 2 and 3 Stabilisation period complete	35	10/23	Q3 Yr 4
Project Closure commences	36	11/23	Q3 Yr 4

Table based on table 43 in section 6.4.3 of the LIMS OBC, with indicative dates added

- Estimated key milestone dates that the financial model is based on.
- Dates are applicable to both option 4 and 5:

3. LIMS - Issues for including a capital option

The Trusts have confirmed that no internal capital is available but wish to continue to explore a capital option and seek central funding therefore include in the tender.

The project teams understanding of the current status of central funding is

- The HLSI is fully committed and year 3 is revenue, (this to be verified)
- The digital aspirant programme has been approached for a view - however it should be noted that it is likely to require matched local funding.

The implementation timeline is currently based on a managed service option only being tendered, if the tender is now to include a capital option, it will increase the tender timeline by 4 months due to the need for additional tender documents and an extended evaluation process. This additional time cannot be recovered by the implementation stage.

The inclusion of a capital option raises the following issues/risk for the tender;-

- Many schedules will need to be duplicated and others added mainly to reflect the difference in the responsibilities of the supplier between a capital and a managed service option.
- There is an increased risk of challenge from unsuccessful suppliers as some suppliers may not be able to offer all variants.
- The evaluation criteria will be more complex and the evaluation process will take longer.
- EKHUFT as host will take on more responsibility as host of a capital solution therefore they may no longer wish to Host and may incur other costs they will seek to recover. Currently the option in the OBC has a modest hosting charge.

The Recommendation

- To take both option 4 and option 5 in to the procurement stage, with a final recommendation to be identified during procurement, based on assessment of suppliers' capabilities to deliver a remotely-hosted solution and the availability of capital.
- To proceed to FBC stage

Annual approval of the Sustainable Development Management Plan (SDMP)	**Chief Executive / Director of Estates & Facilities**

The enclosed report contains the annual Sustainability Development Management Plan (SDMP) which is required to be approved by the Trust Board annually. The Annual Energy Report 2019/20 is enclosed for review.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting – 19/05/20

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

Review and approval

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

Maidstone and Tunbridge Wells NHS Trust

Sustainable Development Management Plan

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1. Vision, Strategy and Scope

1.1. Sustainability Vision

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

1.2. Sustainability Strategy

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

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

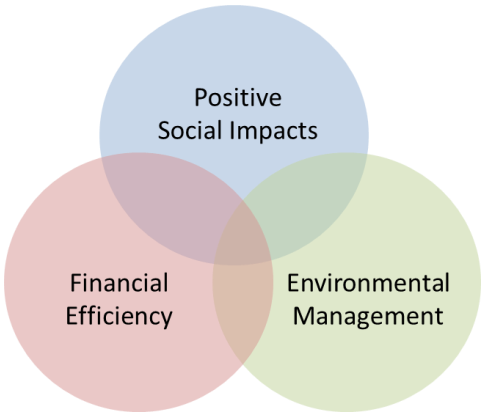


Figure 1: Components of Sustainability

The Trust has developed a Sustainability Strategy that will be implemented through a Sustainable Development Management Plan (SDMP) that comprises of 6 key areas of focus:

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

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

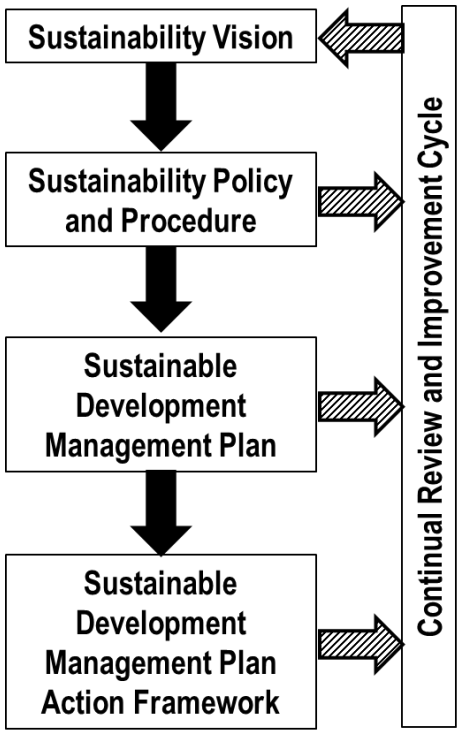


Figure 2: Relationship of the components of the Sustainability Strategy

1.3. Scope

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

2. Drivers for Change

The need for an SDMP is driven by different factors, both internal and external to the NHS and the Trust.

The Kent and Medway Sustainability and Transformation Plan (STP), driven by central Government, is reviewing the services that are being provided by each Trust and the ways that they support and interact with each other to ensure they are as sustainable and efficient as possible and to remove duplication and inefficiency.

The Trusts themselves are also required to review *how* they are delivering the services to ensure that they are operating in the most efficient and sustainable manner possible

2.1. Financial

- **Operational Budget Constraints**
  The challenge to the health and care system is clear. Kent, like the rest of England, has an ageing population that will put increasing demands on the system, and will require long-term complex care. This, along with unhealthy lifestyle behaviours and

the rising cost of technology means that nationally the NHS faces a £30bn funding gap by 2021.

- **Energy Costs**
  The costs of energy are set to remain volatile in the short term and are predicted to rise in the medium to long term. The wholesale energy price is dependent upon many natural and geopolitical variables, none of which are within the immediate control of the Trust.
  In 2018/19 the Trust spent a total of £4,913,861 on the procurement of Gas, Electricity, Biomass and CRC Compliance

- **Water Costs**
  In 2018/19 the Trust spent a total of £871,493on Water Supply, Sewerage and Effluent Treatment.

- **Material and Services Costs**
  The increase in the cost of materials and services, whilst being limited through effective procurement strategies, will continue to increase in line with inflation. External factors, such as Brexit, have potential to adjust the trajectory of increase to an unknown extent.

2.2. Legislation and Performance Targets

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

- **NHS Carbon Reduction Target**
  As the largest public sector emitter of carbon emissions, the health system has a duty to respond to meet the targets which are entrenched in law. Contributing to the Climate Change Act target with a 34% reduction in carbon emissions by 2020 against a 1990 baseline is a key measure of the NHS's ambition across the country.
- **Public Services (Social Value) Act 2012**
  The Public Services (Social Value Act) was passed at the end of February 2012 and came into force in January 2013. Under the Act, for the first time, all public bodies in England and Wales are required to consider how the services they commission and procure might improve the economic, social and environmental well-being of the area.

- **Modern Slavery Act 2015**
  The Modern Slavery Act 2015 is designed to tackle slavery in the UK. The Transparency in Supply Chain Provisions require commercial organisations to publish an annual statement regarding slavery within their supply chain if they have an annual turnover above a threshold (£36 million). However, the Department of Health has confirmed that publicly-funded NHS activities were not intended to be within the scope of the Act, and therefore the £36 million threshold only applies to profit-making activities.

2.3. Demands upon Services

Using resident populations for the districts of Maidstone, Sevenoaks, Tonbridge & Malling and Tunbridge Wells, the following changes are predicted over the next 20 years:

- The overall population of the four districts is expected to increase, with the highest increases in Maidstone for 65 years or over (11% increase) and Tonbridge & Malling for people aged over 85 years (26%).

- The under-five population will remain fairly constant with an increase of less than 4% over 20 years.

- The population aged 5-19 will increase by just over 12.5% across that period. The under 15 population will increase by 12% over his period. The number of people aged between 16 and 64 years will increase by 11% across that period.
- The population of 65+ is set to increase by 58.93% from 2015 to 2035 increasing from 101,000 to 152,600 people and during the same period, within this the population of 85+ group is predicted to increase by 127.3% during the same period, from 12,100 to 27,500 people.

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

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

- The prevalence of multi-morbidity increases substantially with age

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

3. Specific Areas of Focus

3.1. Corporate Vison and Governance

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

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

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

3.2. Leadership, Engagement, Partnership and Development

The Trust aspires will be a demonstrable leader within the provision of sustainable healthcare and is committed to engaging and partnering at all levels, both locally, regionally

and nationally to deliver this ambition. The Trust will ensure that the SDMP is adopted by Heads of Department and Senior Management Team members and is cascaded through the lines of control

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

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

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

3.3. Healthy, Sustainable and Resilient Communities

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

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

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

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

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

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

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

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

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

3.4. Sustainable Clinical Care Models

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

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

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

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

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

3.5. Commissioning and Procurement

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

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

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

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

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

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

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

3.6. Operational Management and Decarbonisation

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

The Trust will monitor and report upon its energy and water usage and its Scope 1 and Scope 2 emissions on an annual basis and will set internal targets with the aim of reducing the carbon emissions associated with its activities by 28% by 2020 against a 2013 baseline in line with the NHS Carbon Reduction Target of 80% by 2050.

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

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

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

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

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

4. Objectives and Progress

The Trust has established 20 clear objectives through which the Sustainability vision is achievable. The objectives are listed below along with the current progress as of March 2018.

1 The Trust has a clear vision of its Sustainability Goals

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

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

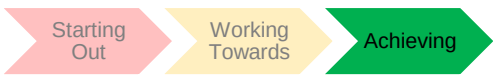
4 The Trusts approach to environmental and social responsibility is supported and owned by local people.

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

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

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

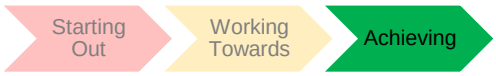
8 The Trust has a network of engaged and enthusiastic volunteers form the local community who capitalise on positive experiences and support the operations of the Hospital



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

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

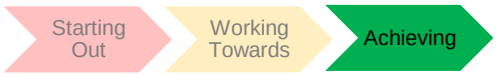
11 Adaptation plans are in place that link to business continuity and emergency planning processes



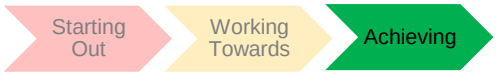
12 Transformation of the Trust services deliver improved health outcomes coupled with social and environmental benefits.

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

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

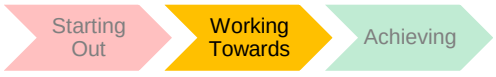


15 Materials are controlled, issued, reused and replaced in an efficient manner that minimises loss and the generation of waste

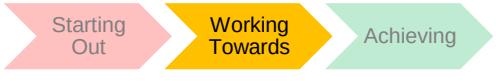


16 The Trust operates an environment where non-essential energy use is eliminated

17 The Trust delivers efficient low carbon transport services



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



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

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

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

5. Numerical Scope 1 and 2 Emissions Target

The Trust recognises that there is a concerted effort within the NHS to decarbonise the operational footprint of the wider supply chain and stakeholders, and the Trust is fully supportive of these efforts and is committed to undertaking activities to support them.

The specific numerical target of the SDMP is to reduce scope 1 and 2 carbon emissions by 28% by 2020/21 against a 2013/14 baseline in line with the NHS Carbon Reduction Target of 80% by 2050. It is a great achievement to note that the Trust is now operating ahead of the target and has exceeded its target a year early

Scope 1 (direct emissions) emissions are those from natural gas and liquid fuels procured by the Trust and consumed in boilers, generators and vehicles.
Scope 2 (energy indirect) emissions are those from electricity procured by the Trust and supplied via the national grid.

Figure 3 shows the Trust annual electrical consumption in 2019/20 versus 2018/19

Figure 4 shows the Trust annual gas consumption in 2019/20 versus 2018/19

Figure 5 shows the Trust annual carbon emissions per site in 2019/20 versus 2018/19

The graph in figure 6 shows the baseline years scope 1 and 2 emissions in Tonnes of Carbon Dioxide equivalent (TCO2e) and the performance of subsequent years

Figures 7 and 8 show the total breakdown of fuel consumption in 2019/20 and the corresponding carbon composition for 2019/20

	MSH	TWH	Laundry	Accom	Other	Trust Total
This Year (MWh)	9,678	11,043	422	353	81	**21,576**
Last Year (MWh)	10,226	11,794	464	339	75	**22,899**
Variance (%)	-5.37	-6.36	-9.14	+3.76	+7.30	**-5.78**

Figure 3: Trust annual electrical consumption in 2019/20 versus 2018/19

	MSH	TWH	Laundry	Accom	Other	Trust Total
This Year (MWh)	18,398	8,573	5,249	94	764	**32,477**
Last Year (MWh)	17,709	8,336	5,568	90	152	**31,856**
Variance (%)	+3.89	+2.84	-5.74	+4.09	+7.37	**+1.95**

Figure 4: Trust annual gas consumption in 2019/20 versus 2018/19

	MSH	TWH	Laundry	Accom	Other	Trust Total
This Year (MTCO2e)	5,856	4,399	1,073	107	51	11,486
Last Year (MTCO2e)	6,153	4,872	1,156	113	49	12,342
Variance (%)	-4.82	-9.71	-7.18	-4.79	+2.81	-6.94

Figure 5: Trust annual carbon emissions per site in 2019/20 versus 2018/19

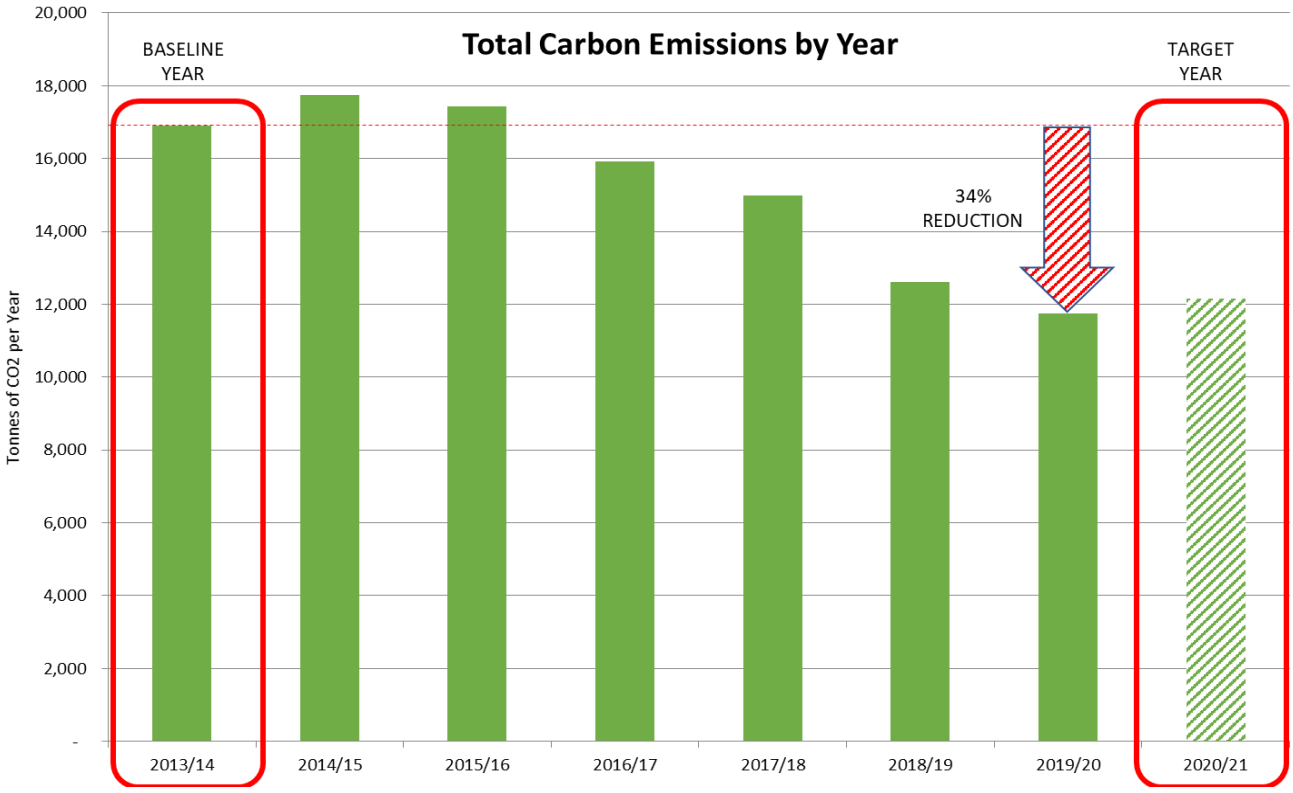


Figure 6: Trust progress towards target

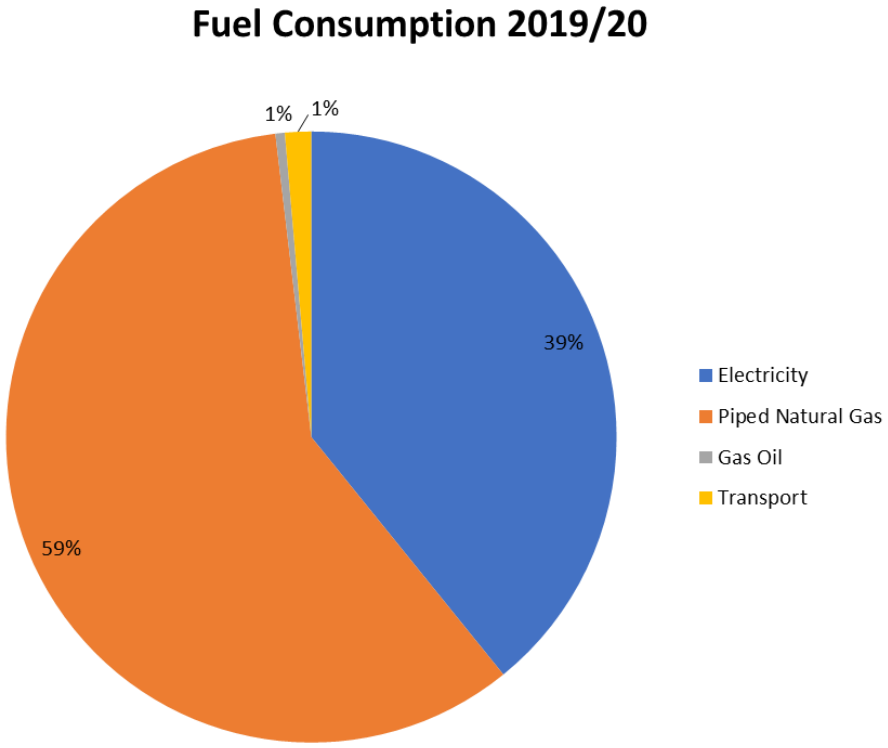


Figure 7: Breakdown of fuel consumption in 2018/19

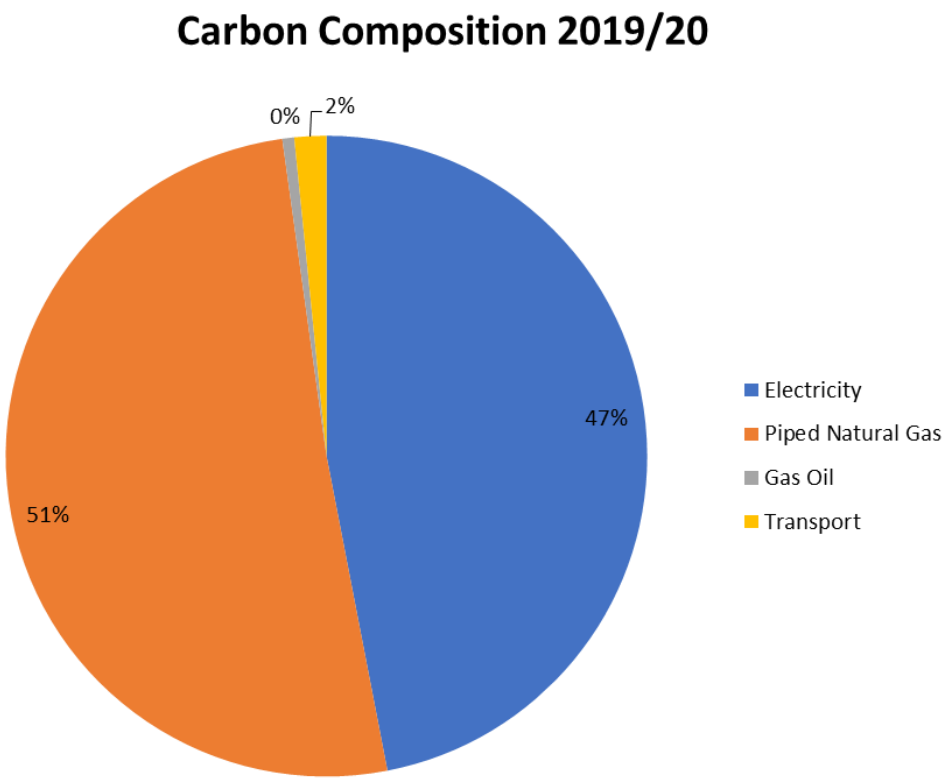


Figure 8: Breakdown of carbon composition for 2018/19

6. Sustainable Development Management Plan Action Framework

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

7. Review

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

8. Conclusion

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

ANNUAL ENERGY REPORT 2019 - 2020

Maidstone and Tunbridge Wells NHS Trust

Greener Edge Sustainability

Giving you a greener edge

www.greener-edge.co.uk

Electricity consumption per Site (MWh)

	MSH	TWH	Laundry	Accom	Other	Trust Total
This Year (MWh)	9,678	11,043	422	353	81	**21,576**
Last Year (MWh)	10,226	11,794	464	339	75	**22,899**
Variance (%)	-5.37	-6.36	-9.14	+3.76	+7.30	**-5.78**

Strong investment in LED technologies is continuing to paying dividends and reduce site electrical consumption

Greener Edge Sustainability

Gas consumption per Site (MWh)

	MSH	TWH	Laundry	Accom	Other	Trust Total
This Year (MWh)	18,398	8,573	5,249	94	764	**32,477**
Last Year (MWh)	17,709	8,336	5,568	90	152	**31,856**
Variance (%)	+3.89	+2.84	-5.74	+4.09	+7.37	**+1.95**

Analysis of Heating Degree Day Data (HDD 18.5 and 15.5) indicates that the 19/20 year was 6% cooler than the previous year. This supports the data set above where gas is used for heating in all sites except the Laundry where it is used for process

Greener Edge Sustainability

Carbon Production per Site from Electricity and Gas (MTCO2e)

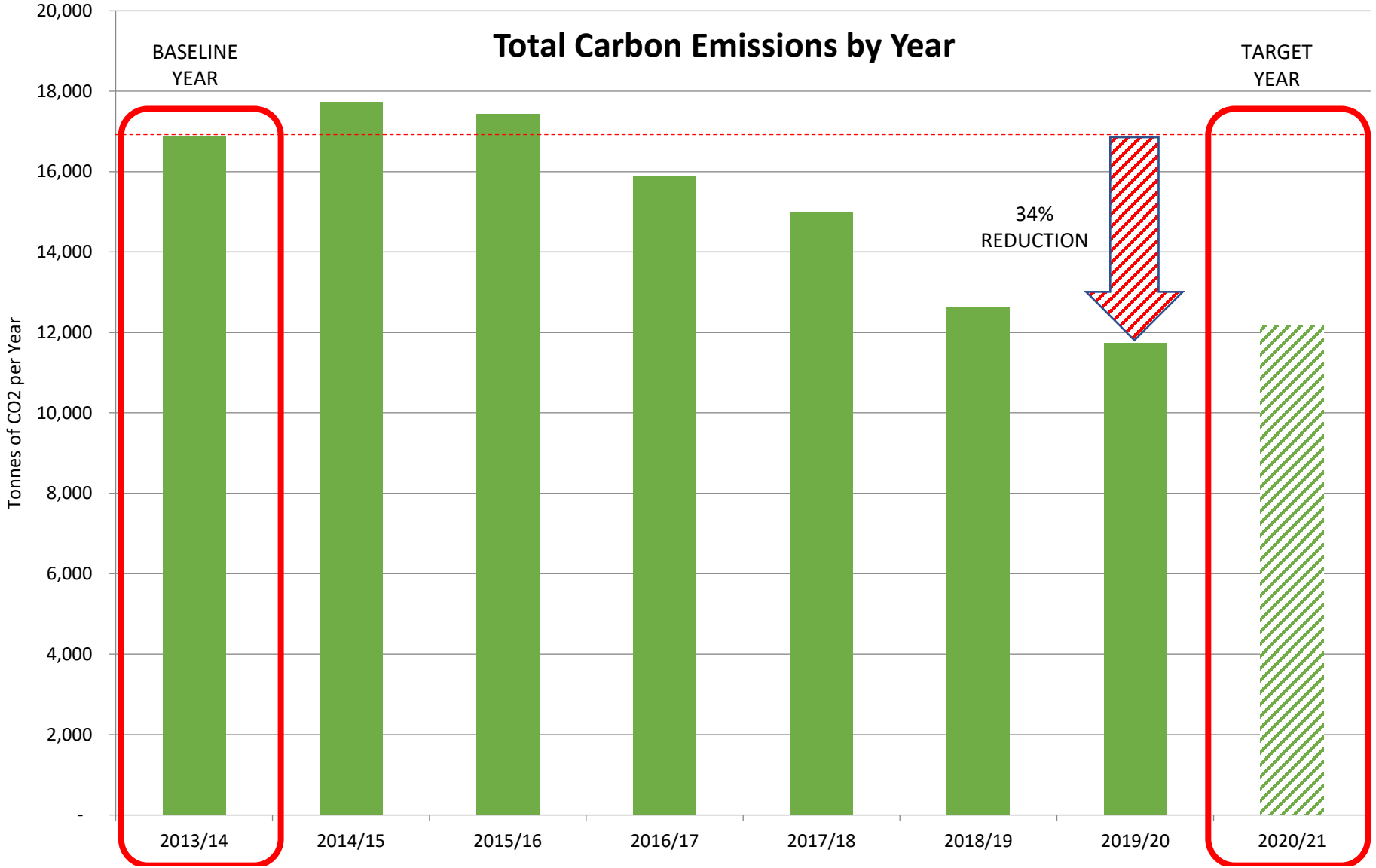
	MSH	TWH	Laundry	Accom	Other	Trust Total
This Year (MTCO2e)	5,856	4,399	1,073	107	51	11,486
Last Year (MTCO2e)	6,153	4,872	1,156	113	49	12,342
Variance (%)	-4.82	-9.71	-7.18	-4.79	+2.81	-6.94

This progress has been helped by the decarbonisation of the National Grid through the increase in renewables and the phase out of coal power stations

Greener Edge Sustainability

Trust progress towards Target

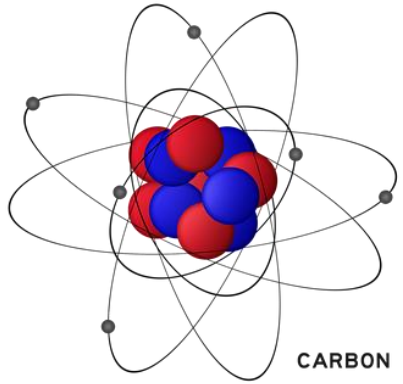
(28% reduction against Baseline by 2020/2021)



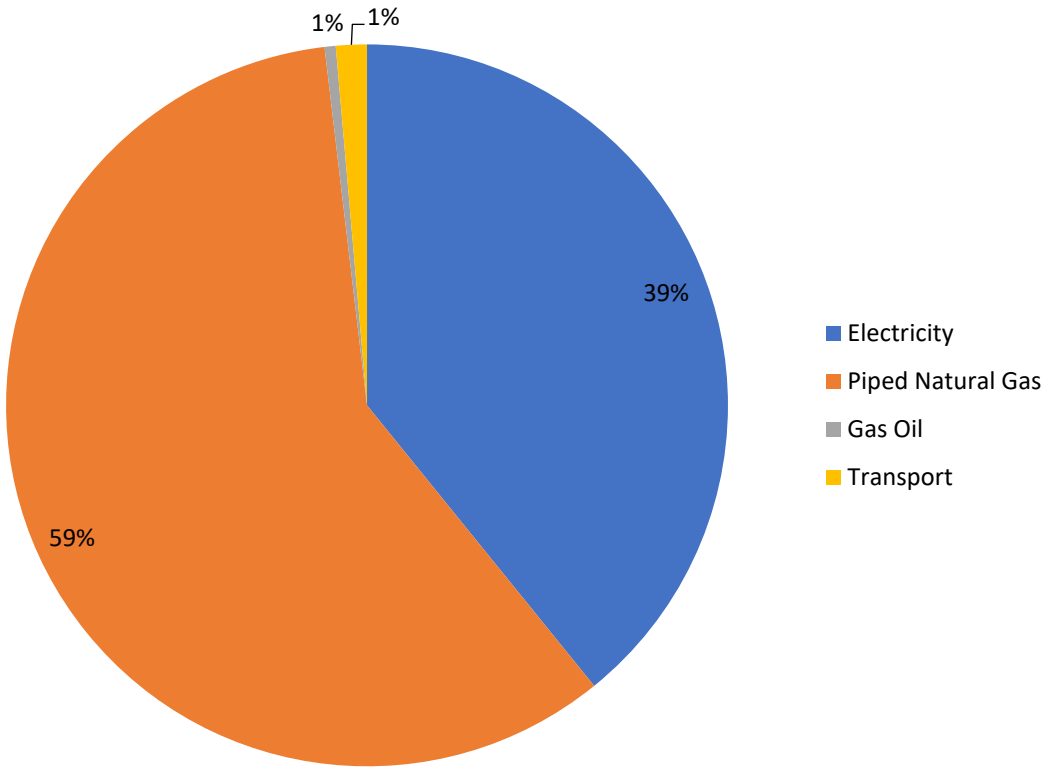
The Trust has exceeded the targeted emissions and now stands at a reduction of 34% against baseline

Greener Edge Sustainability

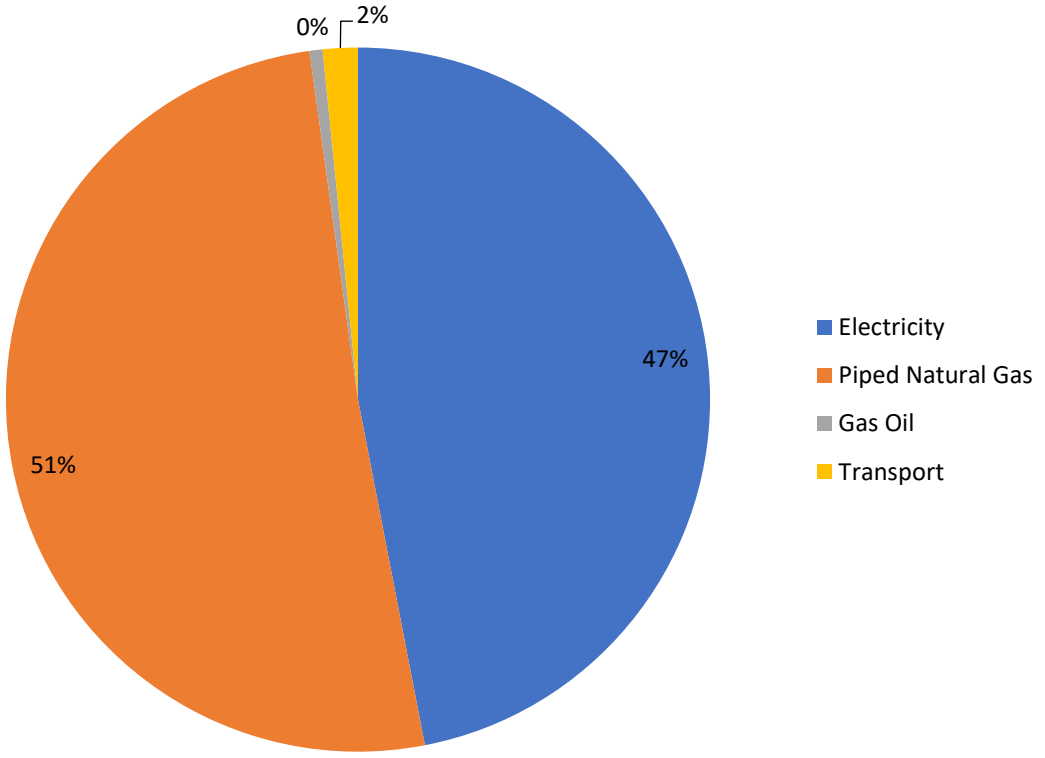
Scope 1 & 2 Carbon Composition



Fuel Consumption 2019/20



Carbon Composition 2019/20



The higher carbon intensity of Electricity is clearly evident.
The graph also suggests that the next area of focus for energy reductions should be gas consumption.

Greener Edge Sustainability

NHS Provider licence: Self-certification for 2019/20 **Trust Secretary**

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

NHS Trusts were required to undertake self-certification for the first time in May 2017 (covering 2016/17), and are now required to self-certify for 2019/20. Specifically, NHS Trusts are asked to self-certify that they have:

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

It is up to providers how they undertake their self-certification, but any process should ensure that the provider's Board understands clearly whether or not the provider can confirm compliance. NHSI provide templates which Trusts can (but are not obliged to) use.

NHS providers must self-certify against condition G6 by 31/05/20 and against condition FT4(8) by 30/06/20. Providers must then publish their G6 self-certification by 30/06/20 (the publication is itself a licence condition). NHS Trusts are not required to submit their self-certification declarations to NHSE/I unless specifically requested to do so. NHSE/I usually retains the option of contacting a select number of NHS Trusts to ask for evidence that they have self-certified, either by providing the completed or relevant board minutes and papers recording sign-off. However, although the timescale relating to self-certification has not been amended because of the COVID-19 pandemic, NHSE/I has confirmed that it does not intend to undertake any audits of compliance against the self-certification requirements of the provider licence, or to use their enforcement powers in the event of a breach in this financial year, where resource has been prioritised to address COVID-19.

The proposed self-certification, which uses the template provided by NHSE/I, is enclosed. The Trust Board is asked to review, and approve, the content. Ordinarily, the Board would receive the Annual Report, which contains the Annual Governance Statement (AGS), at the same meeting it considered the self-certification (under a separate agenda item), and the Annual Report and AGS would usually provide sufficient information and supporting evidence to enable the Board to self-certify that the Trust has been compliant with all relevant licence conditions. However, as the timetable for the Annual Accounts was delayed due to the COVID-19 pandemic, the Board will not see the draft Annual Report for 2019/20 until its meeting on 18/06/20. Ideally, the self-certification process would be deferred to that meeting, but as the self-certification timescale has not been changed, a draft version of the AGS has been included in this report, to support the proposal that the Trust Board self-certify that the Trust has been compliant with all relevant licence conditions.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Review and approval of the proposed self-certification for 2019/20

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

Worksheet "FT4 declaration"

Financial Year to which self-certification relates | **2019/20**

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	Refer to the content of the draft 2019/20 Annual Governance Statement for full details (see Appendix 1)
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	Refer to the content of the draft 2019/20 Annual Governance Statement for full details (see Appendix 1)
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	Refer to the content of the draft 2019/20 Annual Governance Statement for full details (see Appendix 1)
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	Refer to the content of the draft 2019/20 Annual Governance Statement for full details (see Appendix 1)

5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	Refer to the content of the draft 2019/20 Annual Governance Statement for full details (see Appendix 1)
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	Refer to the content of the draft 2019/20 Annual Governance Statement for full details (see Appendix 1)

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature	**Signature**
Name: Miles Scott	**Name:** David Highton

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A: N/A

Worksheet "G6 & CoS7" | **Financial Year to which self-certification relates** | 2019/20

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate	N/A

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account i particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	N/A

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available t it for the period of 12 months referred to in this certificate.	N/A

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

N/A

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Miles Scott	**Name**	David Highton
Capacity	Chief Executive	**Capacity**	Chair of the Trust Board
Date	21 May 2020	**Date**	21 May 2020

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

N/A

Annual Governance Statement (AGS) for 2019/20

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of Maidstone and Tunbridge Wells NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that Maidstone and Tunbridge Wells NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum[1].

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Maidstone and Tunbridge Wells NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Maidstone and Tunbridge Wells NHS Trust for the year ended 31st March 2020 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

The ways in which leadership is given to the risk management process

Risks are identified, analysed and controlled in accordance with the Trust's Risk Management Policy and Procedure. The overall Executive Lead for risk management is the Chief Nurse, who is supported in this role by a range of staff, including the Trust Secretary and Risk and Compliance Manager. A number of specific risk-related roles are also held by Trust Board Members, as follows:

- The Chief Nurse is the Senior Information Risk Owner (SIRO)
- The Medical Director is the Caldicott Guardian and the Responsible Officer (for Medical Revalidation)
- The Chief Executive is the Board Level Director (with fire safety responsibility)[2] and the Security Management Director[3]
- The Chief Operating Officer is the Accountable Emergency Officer for Emergency Preparedness, Resilience & Response (EPRR)[4]
- One of the Non-Executive Directors has been appointed as the Non-Executive Lead for Safeguarding and Resuscitation[5], and they have also been allocated the EPRR portfolio[6]
- The Chair of the Quality Committee is the Non-Executive Director with specific role/responsibilities for leading falls prevention[7], and also the Non-Executive lead on mortality and learning from deaths[8]

The Trust has a Risk Register and Board Assurance Framework (BAF) and in place, the operation of which are informed by accepted best practice[9]. The BAF is the document through which the Trust Board is apprised of the principal risks to the Trust meeting its key objectives, and to the

[1] See https://tinyurl.com/NHSAOM
[2] Required by "Firecode – fire safety in the NHS. Health Technical Memorandum 05-01: Managing healthcare fire safety"
[3] Required by the "Secretary of State Directions to NHS Bodies on Security Management Measures 2004 (amended 2006)"
[4] Required by The Health and Social Care Act 2012
[5] Health Services Circular 2000/028 states that "Chief executives should ensure that"…"a…NED…of the Trust is given designated responsibility on behalf of the Trust Board to ensure that a resuscitation policy is agreed, implemented, and regularly reviewed within the clinical governance framework"
[6] The Core Standards for Emergency Preparedness, Resilience and Response (EPRR) assess whether "The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation"
[7] The Falls and fragility fractures audit programme (FFFAP) pilot national audit of inpatient falls (2015) asks "Does your organisation have a Non-executive Director (or other Board member) who has specific roles/responsibilities for leading falls prevention (can be as part of a wider remit for patient safety)?"
[8] The CQC's "Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England" report states that "We also recommend that provider Boards strongly consider nominating a non-executive director to lead on mortality and learning from deaths"
[9] HM Treasury: Assurance frameworks

controls in place to manage those risks. In November 2019, the Trust Board approved a proposal that the 12 objectives within the BAF should be devolved for oversight by one or more Trust Board sub-committees, and that reports on the objectives be submitted to each sub-committee. The proposals noted that after each sub-committee had considered its objectives, the full BAF would then be considered by the Audit and Governance Committee and then be considered by the Trust Board, with the report presented by the Chair of the Audit and Governance Committee (supported by the Trust Secretary and relevant members of the Executive Team). That process was implemented throughout 2019/20, and culminated in the Chair of the Audit and Governance Committee presenting the BAF at the Trust Board meeting on 28/03/20.

As is the case every year, the BAF and Risk Register are subject to review by the Trust's Internal Audit function (which is provided by TIAA Ltd). The review for 2019/20, gave an overall assessment of "Reasonable Assurance", and the report's "overall conclusion" included the statements that "The Trust has an appropriately approved and up to date Risk Management Policy and Procedure …"; "There is an effective committee structure in place regarding risk management, and the BAF has been regularly presented to the Trust Board following review by the Audit and Governance Committee."; and "The Trust has clear risk management processes in place to support the identification and management of risks, with red rated risks within the Trust Risk Register being reviewed by the Trust Management Team on a quarterly basis.".

The ways in which staff are trained or equipped to manage risk in a way appropriate to their authority and duties (including the guidance provided to them and the ways in which the Trust seeks to learn from good practice)

The Trust has in place a range of systems to prevent, deter, manage and mitigate risks and measure the associated outcomes. In addition to the Trust's Risk Management Policy and Procedure, a comprehensive range of risk management policies and guidance is made available to staff. This includes the policies and procedures for risk assessment, incident reporting, managing complaints, investigation of incidents, health and safety, and 'being open' to staff and patients (to support the statutory Duty of Candour). Additional advice on good practice can be obtained from a range of professional and specialist staff. The remit of the Trust's Clinical Governance department includes patient safety/clinical risk management; clinical governance; clinical audit; complaints; the Patient Advice and Liaison Service (PALS); legal services; and research and development. The systems to oversee staff health and safety are managed via the Estates and Facilities department, but there is close liaison between the relevant staff. In addition, Directorates and sub-specialities have clinical governance and risk leads. There is a forum for clinical governance and risk management within each Directorate and within the majority of clinical sub-specialties.

Trust staff are involved in risk management processes in a variety of ways, including raising any concerns they may have (anonymously, if they so wish) via a range of methods, including via the Freedom to Speak Up Guardian; being aware of their responsibility to report and act upon any incidents that occur; being involved in risk assessments; and attending regular training updates.

The Trust's mandatory induction and ongoing training programme for all staff reflects the need for staff to have a sound basis in managing risks relating to Information Governance, Infection Prevention and Control, fire safety, Safeguarding, Health and Safety and Moving and Handling. Non-mandatory training is also available to staff on a wide range of issues relating to risk management, both general (e.g. risk assessment) and in response to specific risks (e.g. falls prevention), whilst in-house support and advice on risk management is also available (which includes advice relating to patient safety, health and safety, Emergency Planning & Response and information governance. Certain types of risk are also addressed via the engagement of external expertise. For example, the risk of fraud is managed and deterred via the appointment of a Local Counter Fraud Specialist (LCFS) and the Trust engages a Dangerous Goods Safety Advisor (DGSA) to advise on the safe management of healthcare waste.

The Trust's advisers on risk seek to learn from best practice from a variety of means, including continuing professional development and via networking with counterparts from other organisations.

The risk and control framework

The key elements of the Risk Management policy (including the way in which risk (or change in risk) is identified, evaluated, and controlled; and how risk appetites are determined)

Risks are identified, analysed and controlled in accordance with the Trust's Risk Management Policy and Procedure. Mitigations are aimed to be identified in advance (where appropriate), so that these can be applied should the identified risk materialise. Most risks are identified at local level and initially managed by department managers. Identified risks are added to the Risk Register and are then either managed locally or escalated through the Trust's management and/or committee structure. The Trust's competent persons (individuals with specialist skills, knowledge and qualifications that are assessed by external bodies who are able to advise managers and employees on all aspects of health, safety and risk) identify hazards within their area of expertise, and undertake Trust-wide risk assessments for hazards that affect multiple areas. Risks are identified, analysed and controlled in accordance with the Trust's Risk Assessment Policy and Procedure and guidance documents, which includes grading risks for their potential impact and likelihood of harm using a standard Risk Categorisation Matrix. The risk score determines the priority, response and level of management required to manage the risk. Risk appetite is the level of risk the Trust will accept for a particular type of risk. When a risk is assessed the uncontrolled risk score is determined, along with a target risk score, which indicates the risk rating that would be considered as satisfactory. This target risk score should be set as high as can be tolerated, and constitutes the risk appetite for that risk.

The key elements of the quality governance arrangements (including how the quality of performance information is assessed and how assurance is obtained routinely on compliance with Care Quality Commission (CQC) registration requirements)

The Trust's Quality Governance arrangements are overseen via the Quality Committee, which receives a report from each Divisional clinical governance committee whenever it meets in its 'main' form[10]. The Quality Committee then aims to seek and obtain assurance on the effectiveness of the Trust's structures, systems and processes to enable delivery of the Trust's objectives relating to quality of care (as well as oversee quality within the clinical divisions).

Clinical audit is supported by a central team, within the Clinical Governance department, and is primarily overseen by the Clinical Audit Overview Committee. The investigation of, and learning from, incidents are predominantly managed within Directorates and discussed at Divisional, Directorate and specialist clinical governance meetings. Serious Incidents (SIs) are discussed and monitored at a corporate level via the Learning and Improvement (SI) Panel, and an SI report is submitted to each 'main' Quality Committee.

Complaints are managed by the central complaints team in partnership with the relevant Directorates and Divisions. The rate of new complaints and percentage of complaints responded to within target are monitored monthly at the Trust Board, while detailed reports on Complaints and Patient Advice and Liaison Service (PALS) contacts are received by the 'main' Quality Committee.

Compliance with CQC registration requirements is ultimately assessed via inspections by the CQC, and the Trust was subject to such inspections in the latter part of 2017 (which resulted in an overall assessment of "Requires Improvement"). However, quarterly engagement events have taken place with the CQC during 2019/20. Although such engagement events do not affect the Trust's formal assessment rating, the CQC have provided positive feedback on the areas that have been visited during these events.

The Trust's preparations and planning for CQC inspections are fully integrated and embedded as part of the Trust's 'business as usual' quality improvement agenda. The Trust monitors compliance

[10] The Quality Committee meets monthly, with each alternate month being a 'main' meeting (which involves a broad membership and discussion of a wide range of subjects) or a 'deep dive' (which involves a smaller membership and discussion of a small number of targeted subjects)

with CQC registration requirements itself, primarily through a programme of in-house assurance visits/inspections. Such inspections, which are managed by the Clinical Governance and Corporate Nursing teams, include patient representatives and representatives from NHS Kent and Medway Clinical Commissioning Group, the main commissioner of the Trust's services. The outcomes of the inspections are used to identify areas for improvement, which are then acted upon. The Quality Improvement Committee, which meets monthly and is chaired by the Chief Nurse, provides the governance and oversight of this programme of work.

How risks to data security are being managed and controlled

Risks to data security are managed and controlled via a range of methods, and the Trust undertakes an assessment against the ten data and cyber security standards that were published jointly by the Department of Health and Social Care, NHS England (NHSE) and NHS Improvement (NHSI) in January 2018 (which were based on the standards recommended by the National Data Guardian, and confirmed by HM Government in July 2017). That assessment is primarily done via the Data Security and Protection Toolkit, and the Trust Board approved the submission against the latest assessment in March 2020, although the submission deadline for the Toolkit was extended to the end of September 2020 because of the COVID-19 period, so the Trust will make its formal submission at some point before the end of September 2020.

An Internal Audit assessment review on "Cyber Security Maturity" was also undertaken as part of the 2019/20 Internal Audit plan, which focused on the maturity in each of the ten data and cyber security standards referred to above. The report was issued in January 2020 and the key findings from the review were as follows:

- Management rated the Trust's dependency on Information technology as high and recognised that Cybercrime was a significant risk. Management considered that untreated cyber risks were at a high level. It was noted that the organisation had invested in improving cyber security measures in the last 12 months.
- The Trust had not experienced any cyber incidents within the last 12 months.
- Out of the ten areas reviewed, one was assessed at level 5 and three at level 4. There were two or more maturity steps between the aspirational level of maturity and the self-assessed level for "User Education and Awareness", "Incident Management" and "Home and Mobile Working", and these areas therefore require improvements to progress the maturity, counter measures and overall Cyber Assurance position.

Furthermore, in July 2019, the Trust achieved Cyber Essentials Plus accreditation, which is a government-backed, industry-supported scheme designed to help organisations protect themselves against common on-line threats (it is mandatory that all NHS organisations achieve Cyber Essentials Plus accreditation by 2021).

Brief description of the organisation's major risks (including how they are/will be managed and mitigated and how outcomes are/will be assessed)

In July 2016, the Trust Board approved the proposal to focus the BAF on a deliberately small number of higher-level objectives to act as proxy indicators (a 'litmus test') for broader performance. That approach has continued in subsequent years, and the objectives for 2019/20, which were approved by the Trust Board on 23/05/19, are as follows:

1. Reduce our falls rate while in hospital to 6 per 1'000 bed days
2. Reduce E. coli blood stream infections to 21.5 per 100'000 bed days by March 2020
3. Improve complaints performance to 75% across all divisions and directorates by March 2020
4. Improve our vacancy rate to 9% by March 2020
5. Achieve staff engagement score of ≥ 7.2 within 2019/20
6. Implement the planned surgical reconfiguration by the end of 2019/20
7. Build new AMU to enable a new Hyper Acute Stroke Unit (HASU) by winter 2019
8. Ensure that 85% or more of cancer patients are treated within 62 days
9. Ensure that 86.7% or more of patients wait no longer than 18 weeks from referral to treatment
10. Ensure that 91.67% or more of people presenting to our Accident and Emergency Departments wait no longer than 4 hours

11. Deliver a surplus of £6.9m in 2019/20 so that we can invest back into patient care
12. Ensure that our Hospital Standardised Mortality Ratio (HSMR) is <100

The main risks to the achievement of these key objectives (i.e. the issues that could prevent the objectives being achieved) are described within the BAF, and the Trust Board received formal update reports on the performance of each objective, and the management of risks to non-achievement at its meetings in June 2019, September 2019 and March 2020. A year-end BAF report regarding the achievement of the objectives was received by the Trust Board in April 2020.

In addition, a number of risks were rated as 'red' in 2019/20. Red-rated risks are reviewed and validated at the Executive Team Meeting (see below) each quarter. The underlying risks have been discussed at the Trust Board and its sub-committees throughout 2019/20, and include the cost pressures associated with the use of temporary staff; risk associated with failing to learn from incidents; the inability to fulfil the national standard of 20% of women being cared for by Continuity of Carer teams within the Maternity service; the backlog of typing orthopaedics outpatient clinic letters; and the effect of the COVID-19 (coronavirus) outbreak on the Trust's ability to carry out its functions. Each associated risk assessment describes the efforts being made and/or planned to manage and mitigate the risk, and the Trust's Risk and Compliance Manager oversees the regular reviews of the assessments with the relevant risk leads.

Are the Trust's services well-led (under NHS Improvement's well-led framework)?

The CQC inspection in 2017 that was referred to above rated the Trust as "Good" for the Well-led domain. It is likely that the Trust will be assessed again by the CQC during 2020/21.

The principal risks to compliance with the NHS provider licence, condition 4, and actions identified to mitigate these risks

In May 2019, the Trust Board completed the required self-certification (for 2018/19) that the Trust could meet the obligations set out in the NHS Provider Licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution); and that it complied with governance requirements (condition FT4(8)). The Trust Board confirmed full compliance, on the basis of the content of the Trust's Annual Report, and Annual Governance Statement for 2018/19. The Trust Board will be asked to undertake the required self-certification for 2019/20 at its meeting in May 2020, and it will again be proposed that full compliance be confirmed.

The key ways in which risk management is embedded in the activity of the organisation

As noted earlier in this Statement, risks are identified, analysed and controlled in accordance with the Trust's Risk Management Policy and Procedure, and a range of supporting systems and processes are in place to embed risk management activity. For example:

- The Trust's mandatory induction and ongoing training programme for all staff reflects the need for staff to have a sound basis in managing risks relating to Information Governance, Infection Prevention and Control, fire safety, Safeguarding, Health and Safety and Moving and Handling.
- Incident reporting is openly encouraged across the Trust, and lessons learned from incident investigations are disseminated and promoted (including via the "Governance Gazette" newsletter produced by the Clinical Governance department).
- The Trust's central communications programme aims to embed risk management via the promotion of a monthly "Safety moment" (which focused on a different theme each month) and "Take Five, Talk Five" programmes (which promotes clinical teams taking five minutes from their days to discuss a pertinent key issue).
- Risk is regularly discussed at a wide range of forums, including the Trust Board and its sub-committees (which sets the tone for discussions at Divisional-, Directorate- and departmental-levels forums)
- Risk management is incorporated into the Trust's planning arrangements and Quality Impact Assessment (QIA) process, which is overseen by the Project Management Office (PMO).

The key ways in which the Trust ensures that short, medium and long-term workforce strategies and staffing systems are in place (which assure the Trust Board that staffing processes are safe, sustainable and effective)

The Trust complies with the "Developing Workforce Safeguards"[11] recommendations via the following methods:

- A bi-annual review of safe staffing levels is led by the Chief Nurse, using a combination of historical data, professional judgement and reference to quality outcomes. The reviews follow the National Quality Board's 2016 guidance[12] cover the necessary three components (i.e. evidence-based tools, professional judgement and outcomes).
- The Trust has a workforce plan that is submitted to NHSE/NHSI along with the annual financial and activity plans. The Trust Board discusses all of these plans before submission
- The Executive Team Meeting received monthly updates throughout 2019/20 on progress against the Trust's nursing recruitment plan (which included the recruitment of significant numbers of overseas nursing staff)
- All service changes including those related to skill mix and the introduction of new roles are subject to a QIA process led by the Medical Director and Chief Nurse
- The Trust Board reviews workforce metrics on a monthly basis as part of its wider review of quality, safety, performance and finance metrics, to ensure that workforce challenges and risks are understood as part of the wider context of service delivery.
- Where there are critical service risks in relation to staffing and the safe delivery of care these, along with their associated mitigations are escalated to the Trust Board and external regulators as required.
- The Trust's Workforce Committee (a sub-committee of the Trust Board, which is chaired by a Non-Executive Director) meets every two months. The Committee's purpose (as stated it its Terms of Reference) is to provide assurance to the Board in the areas of workforce development, planning, performance and employee engagement. The Committee also works to assure the Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that is supporting business success.

Care Quality Commission (CQC) registration

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

Register of interests

The Trust has an established "Gifts, hospitality, sponsorship and interests policy and procedure". However, it has not yet implemented NHSE's "Managing Conflicts of Interest in the NHS" guidance and has not therefore published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff within the past twelve months, as required by the "Managing Conflicts of Interest in the NHS" guidance. The Trust's Audit and Governance Committee (which receives reports of declarations made under the "Gifts, hospitality, sponsorship and interests policy and procedure") has however been kept informed of the Trust's plans regarding the guidance, which the Trust intends to implement in full in 2020/21.

NHS Pension scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Obligations under equality, diversity and human rights legislation

[11] "Developing workforce safeguards - Supporting providers to deliver high quality care through safe and effective staffing" (NHS Improvement, October 2018)
[12] "Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time" (National Quality Board, July 2016)

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

Obligations under the Climate Change Act and the Adaptation Reporting requirements

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

A range of processes are applied to ensure that the Trust's resources are used economically, efficiently and effectively. The monitoring of this is primarily overseen by the Trust Board, Finance and Performance Committee and Audit and Governance Committee, although the Workforce Committee, Quality Committee and Remuneration and Appointments Committee have all participated in this oversight during 2019/20. The Trust also undertook detailed preparation for a forthcoming "Use of Resources" assessment during the year, while the Trust's annual Internal Audit plan for 2019/20 included a range of reviews relating to this area, including "Critical Financial Assurance – Financial Accounting and Non Pay" and "Payments for Additional Activity Undertaken by Trust Staff", which achieved overall assessment of "Reasonable Assurance". A further review of "Critical Financial Assurance – Payroll" was commissioned as part of the Internal Audit plan, but this was unable to be completed at the time of this Statement because of the COVID-19 period (during which Internal Audit staff were furloughed).

Information governance

The Trust had one Serious Incident Requiring Investigation involving personal data that met the criteria for reporting to the Information Commissioner's Office (i.e. a 'Level 2' severity incident) during 2019/20. The incident, which related to unauthorised access, was subject to an internal investigation and remedial action was taken. The Information Commissioner's Office was informed of the action taken by the Trust and the Information Commissioner's Office concluded that appropriate measures were taken in this instance.

Data quality and governance

The controls in place to ensure the accuracy of data (including the quality and accuracy of elective waiting time data)

The following processes are in place to assure the quality and accuracy of elective waiting time data (and to manage the risks to such quality and accuracy):

- The Trust has a "Patient Access to Treatment Policy and Procedure", which encompasses Standard Operational Procedures for waiting list management at all stages of a referral to treatment pathway. The Policy also states the responsibilities of key staff, including those for auditing data quality.
- The Trust also has an "Information Lifecycle Management Policy and Procedure", which describes the Trust's general approach to data quality
- There is a weekly validation process involving operational, management and information leads, to assure the quality of local and national waiting times reporting/data

The quality of performance information is primarily assessed via the Internal Audit programme, and in particular via the review of "Data Quality of Key Performance Indicators", which forms part of the Internal Audit plan each year. However, although the 2019/20 review started, it was unable to be completed at the time of this report because of the COVID-19 period (during which Internal Audit staff were furloughed). However, the "Data Quality of Key Performance Indicators" that was undertaken as part of the 2018/19 Internal Audit plan (which was issued in May 2019) gave an overall assessment of "Reasonable Assurance" to both of the indicators that were selected (62-day

Cancer waiting time target and 18 Weeks Referral to Treatment (RTT) Incomplete Pathway). The review also concluded that "The Trust has an appropriately approved and up to date Information Lifecycle Management Policy and Procedure in place."

In addition, the Trust's contract with the Clinical Commissioning Group (CCG) includes a requirement to have a Data Quality Improvement Plan (DQIP). The governance processes defined in the contract mean that any data quality issues relating to our RTT or cancer waiting times can be raised and resolved via that route. The Trust's commissioners receive copies of the Trust's performance reports, as well as information provided to them via NHSE/I, to support the performance management of the Trust's services (with the aim of ensuring the achievement of key targets such as the RTT and cancer waiting time standards). Any associated data quality issues are raised as part of this dialogue and are managed via the technical groups established under the contract and documented in the DQIP.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, the Audit and Governance Committee and the Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit Opinion for 2019/20 states that "My overall opinion is that Reasonable Assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk". The last sentence of the Opinion reflects the fact that some reviews undertaken by Internal Audit during 2019/20 resulted in a "limited assurance" conclusion. As is the case with all reviews with such a conclusion, the details have been, or will be, considered at the Audit and Governance Committee and actions to address the weaknesses identified in controls are monitored as part of the routine reports that Internal Audit submit to that Committee.

The Audit and Governance Committee approves the Internal Audit plan for the year and receives details of the findings from each of the Internal Audit reviews that are undertaken. Summary reports of relevant Internal Audit reviews are also submitted to the Trust Management Executive (TME), Finance and Performance Committee and 'main' Quality Committee during the year. Although a number of the Internal Audit reviews completed in 2019/20 resulted in an overall 'Reasonable assurance' assessment, one led to an assessment of 'Limited assurance'. This related to the implementation of the Trust's Electronic Patient Record (EPR), and actions to address the issues identified in the review will be taken during 2020/21 (which is the year in which the implementation is scheduled to occur).

The role of the Trust Board in maintaining and reviewing the effectiveness of the system of internal control

The Trust Board meets every month (with the exception of August) in public (a 'Part 1' meeting), although the Trust Board meeting in March 2020 was unable to be held in public following HM government's guidance on social distancing. The agenda and reports for the meeting which took place via a webconference was however made available via the Trust's website.

The agenda for Board meetings is mainly focused around the key aspects of operational performance; quality; planning and strategy; assurance and policy; and reports from its sub-committees. A separate ('Part 2') meeting is held on the same day as the meeting held in public, to consider confidential matters, in accordance with the Public Bodies (Admission to Meetings) Act 1960. A 12-month rolling forward programme of agenda items is actively managed to ensure the Board receives the information, and considers the matters it requires to perform its duties efficiently and effectively.

A key tenet of the information the Board receives at each meeting in public is an Integrated Performance Report, which contains up-to-date details of performance across a range of indicators. Some Board meetings also feature "patient experience" and "staff experience" items, which provide invaluable first-hand experience of being a patient of, and working at, the Trust.

The role of the Trust Board' sub-committees and other key forums in maintaining and reviewing the effectiveness of the system of internal control

The Trust Board operates with the following sub-committees (which are listed alphabetically):

- The Audit and Governance Committee. This supports the Trust Board by critically reviewing the governance and assurance processes on which the Board places reliance. This therefore incorporates reviewing Governance, Risk Management and Internal Control (including the BAF); oversight of the Internal and External Audit, and Counter Fraud functions. The Committee also undertakes detailed review of the Trust's Annual Report and Accounts, is the Trust's Auditor Panel (in accordance with Schedule 4, Paragraph 1, of the Local Audit and Accountability Act 2014). The Committee is chaired by a Non-Executive Director, and meets five times each year (including a specific meeting to review the Annual Report and Accounts prior to the Trust Board being asked to approve these). All other Non-Executives Directors (apart from the Chair of the Trust Board) are members.
- The Charitable Funds Committee. This aims to ensure that the Maidstone and Tunbridge Wells NHS Trust Charitable Fund is managed efficiently and effectively in accordance with the directions of the Charity Commission, relevant NHS legislation and the wishes of donors, which includes reviewing, and agreeing the Charitable Fund Annual Report and financial accounts, for approval by the Trust Board. The Committee is chaired by a Non-Executive Director, and meets three times per year.
- The Finance and Performance Committee. This aims to provide the Trust Board with: assurance on the effectiveness of financial management, treasury management, investment and capital expenditure and financial governance; an objective assessment of the financial position and standing of the Trust; and advice and recommendations on all key issues of financial management and financial performance. In addition, the Committee receives assurance on informatics (including Information Technology) strategies and plans, and on plans and proposals for major development and investment in Information Technology. The Committee is chaired by a Non-Executive Director, and meets monthly.
- The Patient Experience Committee. This aims to capture the patient and public perception of the services delivered by the Trust (although the role and functioning of the Committee is under review, and may change during 2020/21). The Committee is chaired by a Non-Executive Director, and meets quarterly, and in addition to Trust staff, its membership includes representatives from the Trust's catchment area, Healthwatch Kent, and from Leagues of Friends of Maidstone and Tunbridge Wells Hospitals.
- The Quality Committee. This aims to seek and obtain assurance on the effectiveness of the Trust's structures, systems and processes to enable delivery of the Trust's objectives relating to quality of care. The Committee is chaired by a Non-Executive Director and meets monthly. On alternate months, the Committee meets in the form of a 'deep dive', with a reduced membership, to enable a small number of subjects to be scrutinised in greater detail.
- The Remuneration and Appointments Committee. This reviews, on behalf of the Trust Board, the appointment of Executive Directors and other staff appointed on Very Senior Manager (VSM) contracts, to ensure such appointments have been undertaken in accordance with Trust Policies. It also reviews the remuneration, allowances and terms of service of such staff; reviews (with the Chief Executive), the performance of Executive Directors and other staff

appointed on VSM contracts; oversees appropriate contractual arrangements for such staff (including the proper calculation and scrutiny of termination payments, taking account of such national guidance, as appropriate); and considers and approves, on behalf of the Trust Board, proposals on issues which represent significant change. The Committee is chaired by the Chair of the Trust Board, and meets on an ad-hoc basis (although it met several times during 2019/20).

- The Workforce Committee. This aims to provide assurance to the Board in the areas of workforce development, planning, performance and employee engagement; and assure the Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that is supporting business success. The Committee is chaired by a Non-Executive Director and meets every two months.

Although not a Trust Board sub-committee, the Executive Team Meeting enables key clinical and managerial issues to be discussed, debated, developed, scrutinised, monitored and agreed and/or approved. The Executive Team Meeting meets every week, is chaired by the Chief Executive and its membership comprises all members of the Executive Team, the five Divisional Chiefs of Service and the Director of Estates and Facilities. The Executive Team Meeting is authorised to make decisions on any matter that is not reserved for the Trust Board or its sub-committees, and the key issues considered are reported to the Trust Board as part of the monthly report from the Chief Executive.

The TME, which meets quarterly, supports the delivery of robust risk management policies and processes and the identification and addressing of all key risk issues. The meeting is chaired by the Chief Executive and its membership comprises circa 50 senior clinical and managerial leaders from across the Trust.

In addition to the above committees, there are a range of other forums, structures and processes in place to oversee and manage any issues relevant to particular aspects of risk and governance. In this respect, the Trust has, for example, an Infection Prevention and Control Committee; a Health and Safety Committee; a Drugs, Therapeutics and Medicines Management Committee; an Information Governance Committee; and a Joint Safeguarding Committee.

The impact of the COVID-19 pandemic during 2019/20

The impact of the COVID-19 pandemic began to be felt materially by the Trust during March 2019/20, but was more significantly felt within 2020/21 (which is outside the scope of this Governance Statement). However, despite the unprecedented scale of the impact of COVID-19, the Trust's structure of governance allowed a prompt response to the significant change in circumstances. The Trust commenced its preparations for the impact in January 2020, and regular updates on progress with preparedness started to be considered by the Executive Team Meeting in early February 2020 (with weekly updates being considered from March 2020). A COVID-19 Incident Command Centre was established in March 2020, under the Trust's emergency planning and response framework, and with the Chief Operating Officer as the Strategic Commander. The Command Centre's role was to lead and coordinate the response to the COVID-19 pandemic at the Trust, including acting as the single point of contact for the escalation of issues; acting as the single point of contact for external agencies; being responsible for identifying and mitigating Trust-wide risks; and having decision making over all substantial issues, queries, operational changes and expenditure requests relating to the COVID-19 response.

All of the scheduled meetings of the Trust Board and its sub-committees in March 2020 proceeded, but were held via webconference, to follow HM government's guidance on social distancing.

As could be reasonably expected, the Trust's control environment needed to adapt to the COVID-19 circumstances, and at its meeting on 28/03/20, the Trust Board approved a proposal to temporarily extend the delegated expenditure limits for members of the Executive Team, to add resilience to the system in the event of certain members of the Executive Team being absent because of sickness or self-isolation (in the event of them, or a family member, having COVID-19 symptoms).

The Trust did not experience any notable business continuity issues. However, as it part of routine practice, once the COVID-19 period has ended, the Trust will undertake a debrief/'lessons learned' exercise, to identify what worked well, and more importantly, the areas of the Trust's business continuity plan and Major Incident plan that could be improved. It is expected that the outcome of that exercise will, in the first instance, be considered by the Executive Team Meeting in 2020/21.

The Internal Audit plan for 2019/20 was adversely affected by COVID-19, as a number of reviews that were scheduled to be completed in March 2020 were unable to be completed. The Head of Internal Audit's Opinion makes reference to this, but the overall opinion was not significantly affected. The overall review of effectiveness of the control environment as described in this Statement was also not significantly affected.

Significant internal control issues

The following significant internal control issues[13] have been identified in 2019/20:

1. Three "Never Events" were declared at the Trust in 2019/20, which related to a lumbar puncture being carried out the wrong baby; medication being given via the incorrect route; and an injection being administered to a patient's incorrect eye. The incidents were subject to scrutiny through the SI investigation process and the aim is to ensure that lessons were learnt to prevent recurrence.

Conclusion

The significant internal control issues identified in 2019/20 are described above, in the body of the Annual Governance Statement.

Miles Scott, Chief Executive

18th June 2020

[13] The Trust considered the following criteria when identifying if any significant internal control issues had occurred during 2019/20: Might the issue prejudice achievement of priorities? Could the issue undermine the integrity or reputation of the NHS? What view does the Audit and Governance Committee take on this point? What advice has internal or external audit given? Could delivery of the standards expected of the Accountable Officer be at risk? Has the issue made it harder to resist fraud or other misuse of resources? Did the issue divert resources from another significant aspect of the business? Could the issue have a material impact on the accounts? Might national or data security or integrity be put at risk? As was noted in the "COVID-19 related considerations for 2019/20 annual reports and accounts disclosures" guidance issued by NHS England/NHS Improvement on 22/04/20, it was not expected that the emergence of COVID-19 in 2019/20 would, in itself, be considered a significant internal control issue.

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from Workforce Committee, 30/04/20	Committee Chair (Non-Exec. Director)

The Workforce Committee met on 30th April 2020.

- **The key matters considered at the meeting were as follows:**
  - The **actions** from previous meetings were reviewed and it was agreed that the Chief Nurse and Deputy Medical Director should investigate the methods by which socially isolating and shielding staff can safely return to work, giving consideration to appropriate testing and the use of segregation,
  - The Committee reviewed the **Draft People and Organisational Development Strategy** and it was agreed that the strategy should **not be agreed**. Instead it was agreed that the strategy should be reviewed at future date once the concurrent pieces of work had been further developed to allow better alignment between the organisational development work across the Trust. It was also agreed that the Director of Workforce should liaise with the Chair & Vice chair of the Workforce Committee and Associate Director for Organisational Development to agree short term organisational development priorities and an action plan for achieving the priorities agreed.
  - The Director of Workforce reported the key **workforce implications of COVID-19** including details of the employment of bank and volunteer staff by the Trust, the breakdown of COVID-19 positive staff across the Trust and the psychological support services which had been implemented by Occupational Health. It was agreed that a plan of should be submitted in regards to the outcome of the investigation of the staff members from the same accommodation block that had tested positive for COVID-19. It was also agreed that an update on the Psychological Support Services which had been implemented across the Trust should be submitted to the May Committee meeting, which included details of the utilisation of the support services, additional support that would be required and any shortfall in resourcing for the services
  - The Associate Director for Organisational Development updated the Committee on the **Findings from the COVID-19 staff pulse survey (including action plan),** wherein it was agreed that the Associate Director for Organisational Development should consider and confirm the actions which would be taken to ensure that the next COVID-19 staff pulse survey was completed by those staff that did not complete the first survey. It was also agreed that an update on the Findings from the COVID-19 staff pulse survey should be submitted to the May Committee meeting, which should include the method and date for which the next survey will be carried out and the steps taken to reassure staff that actions had been taken in response to the findings from the first COVID-19 staff pulse survey
  - Under to **note the Committee forward programme** it was agreed that the Trust Secretary and Assistant Trust Secretary should Liaise with the Chair of the Workforce Committee and the Director of Workforce to discuss and amend the scheduling of reports for future workforce committees on the forward programme
  - Under **any other business** the Committee was notified that Richard Finn, Associate Non-Executive Director had been appointed as Vice Chair of the Workforce Committee

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

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

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

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

Summary report from Quality Committee, 06/05/20 (including approval of revised Terms of Reference)	**Committee Chair (Non-Executive Director)**

The Quality Committee met on 6th May (a 'main' meeting), via virtual means. The usual format was adapted due to the COVID-19 situation in that the meeting was scheduled for two hours, instead of three; some items were deferred to future meetings; the Divisional reporting template was adapted to focus on COVID-19-related issues; and Divisional representatives were offered the option of only joining the meeting to deliver their report (although most chose to stay for the entire meeting).

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

- The **progress with previous actions** was noted and two actions from the Quality Committee 'deep dive' meeting in February 2020 were closed. However the Deputy Director of Quality Governance agreed to arrange for a clinical audit of the new appendix to the "Blood glucose monitoring guideline" (which covered the administration of insulin & management of hyperglycaemia) to be done, to assess the effectiveness on diabetes care).
- The Committee agreed **revised Terms of Reference**, as part of the routine annual review. These are enclosed in Appendix 1, with the proposed changes shown as 'tracked', and the Trust Board is asked to approve the changes.
- The **"Safety Moment"** item, which was on safeguarding children, was noted.
- The issues raised from the **reports from the five clinical Divisions** included changes that had been made during the COVID-19 period; the current situation regarding screening patients for COVID-19 prior to admission; the availability & use of Personal Protective Equipment; the use of IT for virtual outpatient consultations; the increased ICU capacity that had been introduced; and the support available to staff who had worked on the frontline caring for COVID-19 patients. On the latter issue, the Medical Director agreed to follow-up the Chief of Service for Surgery's suggestion that professional psychological support be made available to such staff. The Chief Nurse also agreed to liaise with the Head of Occupational Health and Associate Director for Organisational Development regarding that suggestion. It was also agreed that the Deputy Director of Quality Governance should liaise with relevant staff from the clinical divisions to develop and confirm the divisional reporting template that should be used for future 'main' Quality Committee meetings.
- The Consultant in Palliative Medicine & Lead Nurse for Palliative and End of Life Care attended to give details of the **End of Life Care response to COVID-19**, which noted that the team had been able to maintain care provision to its core group of patients.
- An update was given on the **Quality Impact Assessments (QIAs) relating to COVID-19**.
- The Medical Director reported on the **output from the COVID-19 Ethics Committee and the COVID-19 Clinical Reference Group**, and it was noted that the role of the latter had now evolved into a forum to explore some of the issues relating to COVID-19 recovery.
- The Chief of Service, Medicine & Emergency Care gave the latest **update on mortality** and the Deputy Medical Director reported the **latest position on Serious Incidents (SIs)**
- Reports were received from the **Committee's sub-committees** (the Complaints, Legal, Incidents, PALS, Audit (CLIPA) group; the Infection Prevention and Control Committee; and the Drugs, and Therapeutics and Medicines Management Committee). For the latter, it was agreed that the Clinical Director for Pharmacy and Medicines Management should complete, & submit, a QIA for the arrangement to supply Controlled Drugs to care homes out of hours.
- Following a discussion, it was agreed that the 'main' Quality Committee should continue to be scheduled every two months, with a Quality Committee 'deep dive' meeting scheduled on the same frequency during the alternate months.

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

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

- Revised Terms of Reference were agreed & the Trust Board is asked to approve the changes

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

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
1. Information and assurance and 2. To approve revised Terms of Reference (see Appendix 1)

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

Appendix 1: Revised Terms of Reference for the Quality Committee (for approval)

QUALITY COMMITTEE - TERMS OF REFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

1. Purpose

The Quality Committee is constituted at the request of the Trust Board to:

a) Sseek and obtain assurance on the effectiveness of the Trust's structures, systems and processes to enable delivery of the Trust's objectives relating to quality of care
b) Oversee quality within the clinical divisions

2. Membership

- Non-Executive Director or Associate Non-Executive Director (Chair)*
- Non-Executive Director or Associate Non-Executive Director (Vice Chair)*
- One~~1~~ other Non-Executive Director or Associate Non-Executive Director*
- Chief Operating Officer*
- Chief Nurse*
- Medical Director*
- Deputy Medical Director*
- Director of Infection Prevention & Control (if not represented via another role within the membership)
- Deputy~~Associate~~ Director of~~,~~ Quality Governance*
- The Chiefs of Service for the five clinical divisions
- The Divisional Directors of Nursing & Quality (DDNQs) (or equivalent) for the five clinical divisions
- The Clinical Director of Pharmacy & Medicines Optimisation (as Chair of the Drugs, Therapeutics and Medicines Management Committee)

* Denotes those who constitute the membership of the 'deep dive' meeting (see below)

Members are expected to attend all relevant meetings, but will be required to attend at least four of the 'main' Quality Committee meetings per year (those who are also members of the 'deep dive' meeting will be required to attend at least three such meetings per year). Failure of a committee member to meet this obligation will be referred to the Chair of the Quality Committee for action.

3. Quorum

The 'main' meeting of the Committee will be quorate when the following members are present:

- The Chair or Vice Chair of the Quality Committee or one other Non-Executive Director or Associate Non-Executive Director[2]
- Two members of the Executive Team (i.e. Chief Operating Officer, Chief Nurse or Medical Director)
- Three clinical divisional representatives (i.e. either the Chief of Service, DDNQ (or equivalent) or an appropriate deputy for either)

The 'deep dive' meeting (see below) will be quorate when the following members are present:

- The Chair or Vice Chair of the Quality Committee or one other Non-Executive Director or Associate Non-Executive Director[1]
- Two members of the Executive Team (i.e. Chief Operating Officer, Chief Nurse or Medical Director)

4. Attendance

The following are invited to attend each 'main' meeting

[2] For the purposes of quorum, the Chair of the Trust Board will be regarded as a Non-Executive Director

- ~~Representatives from Internal Audit~~
- The Chief Nurse (or an appropriate deputy, as they determine) from ~~West~~ Kent and Medway Clinical Commissioning Group ~~(CCG) (or an appropriate deputy in their absence)~~

Other staff may be invited to attend, as required, to meet the Committee's purpose and duties.

All other Non-Executive Directors (including the Chair of the Trust Board), Associate Non-Executive Directors, and members of the Executive Team (i.e. apart from those listed in the "Membership") ~~will be~~are welcome~~invited~~ to attend all meetings of the Committee. The same applies to representatives from Internal Audit.

5. Frequency of Meetings

Meeting will be generally held every month, but will operate under two different formats. The meeting held on alternate months will generally be a 'deep dive' meeting, which will enable detailed scrutiny of a small number of issues/subjects. For clarity, the other meeting will be referred to as the 'main' Quality Committee.

Additional meetings will be scheduled as necessary at the request of the Chair.

6. Duties

6.1 To seek and obtain assurance on all aspects of the quality of care across the Trust, and if not assured, to oversee the appropriate action or escalate relevant issues to the Trust Board, for consideration

6.2 To oversee all aspects of quality within the clinical divisions, and to obtain assurance that an appropriate response is given

6.3 To seek and obtain assurance on the mitigations for significant risks relating to quality

6.4 To seek and obtain assurance that the Trust Risk Management Policy is implemented, in relation to quality issues

6.5 To seek and obtain assurance on compliance with relevant policies, procedures and clinical guidance

6.6 To receive details of the learning arising from complaints, claims, inquests, and Serious Incidents (SIs)

6.7 To seek and obtain assurance on the Trust's compliance with the Fundamental Standards (as defined by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and reflected in the Care Quality Commission's 5 domains)

7. Parent committees and reporting procedure

The Quality Committee is a sub-committee of the Trust Board. The Committee Chair will submit a written summary report ~~activities~~ to the next Trust Board meeting following each Quality Committee meeting.

Any relevant feedback and/or information from the Trust Board will be reported to the Quality Committee by the Committee Chair~~Executive and Non-Executive (including or Associate Non-Executive Directors) members to each meeting of the Committee~~, as they deem~~ed required by the Committee Chair~~necessary.

The Committee's relationship with the ~~Trust Clinical Governance and~~ Patient Experience Committees is covered separately, below.

8. Sub-committees and reporting procedure

The Committee has the following sub-committees.

1. The Cancer Services Divisional Clinical Governance Committee (or equivalent)

2. The Diagnostics & Clinical Support Divisional Clinical Governance Committee (or equivalent)
3. The Medicine & Emergency Care Divisional Clinical Governance Committee (or equivalent)
4. The Surgery Divisional Clinical Governance Committee (or equivalent)
5. The Women's, Children's & Sexual Health Divisional Clinical Governance Committee (or equivalent)
6. The Complaints, Legal, Incidents, PALS, Audit (CLIPA) group
7. The Infection Prevention and Control Committee
8. The Learning and Improvement (SI) Panel
9. The Joint Safeguarding ~~Adults~~ Committee
~~10. The Safeguarding Children Committee~~
~~11.~~10. The Drugs, Therapeutics and Medicines Management Committee

A report from the Clinical Governance Committees of the five clinical divisions will be submitted to each 'main' Quality Committee meeting, using a format approved by the Chair of the Quality Committee.

~~Unless specifically requested by the Quality Committee, the Chair of the Learning and Improvement (SI) Panel will only report SI-related issues to the 'main' Quality Committee by exception (as such issues would be included within the reports the Clinical Governance Committees of the five clinical divisions.~~

Reports from the Quality Committee's other sub-committees will be given after each sub-committtee meeting (either via submission of the minutes of the meeting, a written summary report or a verbal report from the Chair)~~The minutes of each Infection Prevention and Control Committee meeting will be submitted to the next 'main' Quality Committee meeting~~.

The Quality Committee may establish fixed-term 'Task & Finish' Groups to assist it in meeting its duties as it, or the Trust Board, sees fit.

10. Patient Experience Committee

The Quality Committee may commission the Patient Experience Committee to review a particular subject, and provide a report. Similarly, the Patient Experience Committee may request that the Quality Committee undertake a review of a particular subject, and provide a report.

~~The Patient Experience Committee should also receive a summary report of the work undertaken by the Quality Committee, for information/assurance (and to help prevent any unnecessary duplication of work). The summary report submitted from the Quality Committee to the Trust Board should be used for the purpose. Similarly, a~~A summary report of the Patient Experience Committee will be submitted to the Quality Committee (the summary report submitted from the Patient Experience Committee to the Trust Board should be used for the purpose).

11. Administration

The minutes of the Committee will be formally recorded and presented to the following meeting for agreement and the review of actions

The Trust Secretary will ensure that each meeting~~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

12. Emergency powers and urgent decisions

The powers and authority of the Quality Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least two of the Committee's members, one of whom should be a member of the Executive Team. The exercise of such powers by the Committee Chair shall be reported to the next meeting of the Quality Committee, for formal ratification.

13. Review of Terms of Reference

These Terms of Reference will be agreed by the Quality Committee and approved by the Trust Board. They will be reviewed annually or sooner if there is a significant change in the arrangements.

Review history

- Agreed by Quality and Safety Committee: 13 March 2013
- Approved by the Board: March 2013
- Agreed by the Quality & Safety Committee 'deep dive' meeting: 25th April 2014
- Terms of Reference (amended) agreed by the Quality & Safety Committee: 9th May 2014
- Approved by the Board: May 2014
- Terms of Reference (amended) agreed by the Quality & Safety Committee: 21st January 2015 (to remove reference to the Health & Safety Committee, which is a sub-committee of the Trust Management Executive)
- Revised Terms of Reference agreed by the Quality & Safety Committee, 13th May 2015
- Revised Terms of Reference approved by the Trust Board, 27th May 2015
- Revised Terms of Reference agreed by the Quality Committee, 6th January 2016
- Revised Terms of Reference approved by the Trust Board, 27th January 2016
- Revised Terms of Reference agreed by the Quality Committee, 11th January 2017
- Revised Terms of Reference approved by the Trust Board, 25th January 2017
- Terms of Reference approved by Trust Board, 18th October 2017 (to add Associate Non-Executive Directors to the membership)
- Revised Terms of Reference agreed by the Quality Committee, 10th January 2018
- Revised Terms of Reference approved by Trust Board, 25th January 2018
- Revised Terms of Reference agreed by the Quality Committee, 8th May 2019
- Revised Terms of Reference approved by Trust Board, 23rd May 2019
- Revised Terms of Reference agreed by the Quality Committee, 10th July 2019 (to add the Drugs, Therapeutics and Medicines Management Committee as sub-committee, and add the Clinical Director of Pharmacy & Medicines Optimisation as a member of the 'main' Quality Committee)
- Revised Terms of Reference approved by Trust Board, 25th July 2019
- Revised Terms of Reference agreed by the Quality Committee, 6th May 2020
- Revised Terms of Reference approved by the Trust Board, 21st May 2020

NHS Maidstone and Tunbridge Wells NHS Trust

Annual review of the Trust Board's Terms of Reference	**Chair of the Trust Board / Trust Secretary**

The Terms of Reference for the Trust Board are required to be reviewed and approved at least every 12 months. That review and approval last took place in March 2019 (the review item was deferred from the Trust Board meetings in March and April 2020 because those meetings were affected by the Trust's response to COVID-19).

The Terms of Reference have therefore been reviewed, and a small number of very minor amendments are proposed, which are shown as 'tracked' on the following pages. None of the proposed amendments are significant, and all can be categorised as 'housekeeping'.

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

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

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

Trust Board

Terms of Reference

NHS
Maidstone and Tunbridge Wells NHS Trust

Purpose and duties

1. The Trust exists to ~~'~~provide goods and services for any purposes related to the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and the promotion and protection of public health~~'~~.

2. The Trust has a Board of Directors which exercises all the powers of the Trust on its behalf, but the Trust Board may delegate any of those powers to a committee of Directors or to a Member of the Executive Team. The voting members of the Trust Board comprise a Chair (Non-Executive), five other Non-Executive Directors, the Chief Executive, and four specified Members of the Executive Team~~)~~. Other, non-voting members of the Trust Board attend Trust Board meetings~~,~~ and contribute to its deliberations and decision-making.

3. The Trust Board leads the Trust by undertaking three key roles:
   3.1. Formulating strategy;
   3.2. Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable;
   3.3. Shaping a positive culture for the Trust Board and the organisation.

4. The general duty of the Trust Board and of each individual Trust Board Member, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the patients and communities served and members of the organisation.

5. The practice and procedure of the meetings of the Trust Board – and of its sub-committees – are described in the Trust's Standing Orders.

<u>General responsibilities</u>

6. The general responsibilities of the Trust Board are:
   6.1. To work in partnership with all stakeholders and others to provide safe, accessible, effective and well governed services for the Trust's patients;
   6.2. To ensure that the Trust meets its obligations to the population served and its staff in a way that is wholly consistent with public sector values and probity;
   6.3. To exercise collective responsibility for adding value to the Trust by promoting its success through the direction and supervision of its affairs in a cost effective manner.

7. In fulfilling its duties, the Trust Board will work in a way that makes the best use of the skills of all Trust Board Members.

<u>Leadership</u>

8. The Trust Board provides active leadership to the organisation by:
   8.1. Ensuring there is a clear vision and strategy for the Trust that is implemented within a framework of prudent and effective controls which enable risks to be assessed and managed;
   8.2. Ensuring the Trust is an excellent employer by the development of a workforce strategy and its appropriate implementation and operation.

<u>Strategy</u>

9. The Trust Board:
   9.1. Sets and maintains the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;
   9.2. Monitors and reviews management performance to ensure the Trust's objectives are met;
   9.3. Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;

9.4. Develops and maintains an annual plan and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders;
9.5. Ensure that national policies and strategies are effectively addressed and implemented within the Trust.

Culture

10. The Trust Board is responsible for setting values, ensuring they are widely communicated and that the behaviour of the Trust Board is entirely consistent with those values.

11. A Code of Conduct has been developed to guide the operation of the Trust Board and the behaviour of Trust Board Members. This Code is incorporated within the Trust's Gifts, Hospitality, Sponsorship and Interests Policy and Procedure

Governance

12. The Trust Board:
    12.1. Ensures that the Trust has comprehensive governance arrangements in place that ensures that resources are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements;
    12.2. Ensures that the Trust complies with its governance and assurance obligations;
    12.3. Ensures compliance with the principles of corporate governance and with appropriate codes of conduct, accountability and openness applicable to Trusts;
    12.4. Reviews and ratifies Standing Orders, Reservation of Powers and Scheme of Delegation, and Standing Financial Instructions as a means of regulating the conduct and transactions of Trust business;
    12.5. Ensures that the statutory duties of the Trust are effectively discharged;
    12.6. Acts as the agent of the corporate trustee for the Maidstone and Tunbridge Wells NHS Trust Charitable Fund. This includes approving the Annual Report and Accounts of the Charitable Fund.

Risk Management

13. The Trust Board:
    13.1. Ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities;
    13.2. Ensures that there are sound processes and mechanisms in place to ensure effective patient and carer involvement with regard to the review of quality of services provided and the development of new services;
    13.3. Ensures there are appropriately constituted appointment arrangements for senior positions such as Consultant medical staff and Members of the Executive Team.

Ethics and integrity

14. The Trust Board:
    14.1. Ensures that high standards of corporate governance and personal integrity are maintained in the conduct of Trust business;
    14.2. Ensures that Trust Board Members and staff adhere to any codes of conduct adopted or introduced from time to time.

Sub-Committees

15. The Trust Board is responsible for maintaining sub-committees of the Board with delegated powers as prescribed by the Trust's Standing Orders and/or by the Board from time to time

Communication

16. The Trust Board:

16.1. Ensures an effective communication channel exists between the Trust, staff and the local community;
16.2. Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback;
16.3. Ensures that those Trust Board proceedings and outcomes that are not confidential are communicated publically, primarily via the Trust's website;
16.4. Approves the Trust's Annual Report and Annual Accounts.

Quality Success and Financial success

17. The Trust Board:
17.1. Ensures that the Trust operates effectively, efficiently, economically;
17.2. Ensures the continuing financial viability of the organisation;
17.3. Ensures the proper management of resources and that financial and quality of service responsibilities are achieved;
17.4. Ensure that the Trust achieves the targets and requirements of stakeholders within the available resources;
17.5. Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

Role of the Chair

18. The Chair of the Trust Board is responsible for leading the Trust Board and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole;

19. The Chair is responsible for the effective running of the Trust Board and for ensuring that the Board as a whole plays a full part in the development and determination of the Trust's strategy and overall objectives;

20. The Chair is the guardian of the Trust Board's decision-making processes and provides general leadership of the Board.

Role of the Chief Executive

21. The Chief Executive reports to the Chair of the Trust Board and to the Trust Board directly.
22. The Chief Executive is responsible to the Trust Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board;
23. The Chief Executive is responsible for implementing the decisions of the Trust Board and its committees, providing information and support to the Board

Membership of the Trust Board

24. The Trust Board will comprise the following persons:
24.1. The Chair of the Trust Board
24.2. Up to five~~5~~ Non-Executive Directors. One of these will be designated as Vice-Chair
24.3. The Chief Executive
24.4. The Deputy Chief Executive / Chief Finance Officer
24.5. The Medical Director
24.6. The Chief Nurse
24.7. The Chief Operating Officer

Non-voting Trust Board Members (as stated in the Trust's Standing Orders) will be invited to attend Trust Board meetings at the discretion at the Chair.

Quorum

25. The Board will be quorate when four Trust Board Members including at least the Chair (or Non-Executive Director nominated to act as Chair), one other Non-Executive Director, the

Chief Executive (or member of the Executive Team nominated to act as Chief Executive), and one other member of the Executive Team (voting member) are present[2].

26. An Officer in attendance for a voting member of the Executive Team but without formal acting up status may not count towards the quorum at Trust Board meetings

Attendance

27. The Trust Secretary will normally attend each meeting.

28. Other staff members and external experts may be attend Trust Board meetings to contribute to specific agenda items, at the discretion of the Chair

Frequency of meetings

29. The Trust Board will sit formally at least ten times each calendar year. Other meetings of the Board will be called as the need arises and at the discretion of the Chair.

Board development

30. The Chair, in consultation with the Trust Board will review the composition of the Board to ensure that it remains a "balanced board" where the skills and experience available are appropriate to the challenges and priorities faced;

31. Trust Board Members will participate in Board development activity designed to support shared learning and personal development.

Sub-committees and reporting procedure

32. The Trust Board has the following sub-committees
    32.1. The Quality Committee
    32.2. The Patient Experience Committee
    32.3. The Audit and Governance Committee
    32.4. The Finance and Performance Committee
    32.5. The Workforce Committee
    32.6. The Charitable Funds Committee
    32.7. The Remuneration and Appointments Committee

33. For the Quality Committee, Patient Experience Committee, Audit and Governance Committee, Finance and Performance Committee, Charitable Funds Committee, and Workforce Committee, a summary report from each meeting will be provided to the Trust Board (by the Chair of that meeting) in a timely manner

34. The Terms of Reference for each sub-committee will be approved by the Trust Board. The Terms of Reference will be reviewed annually, agreed by each sub-committee, and approved by the Trust Board.

Emergency powers and urgent decisions

35. The powers which the Board has reserved to itself within the Standing Orders Set may in emergency or for an urgent decision be exercised by the Chair of the Trust Board and Chief Executive after having consulted at least two Non-Executive Directors.

36. The exercise of such powers shall be reported (by the Chair of the Trust Board) to the next formal meeting of the Trust Board in public session ('Part 1') for formal ratification.

[2] This number is set to accord with the relevant section of the Standing Orders, which states that "No business shall be transacted at a Trust Board meeting unless at least one-third of the whole number of the Chair and members (including at least one Executive Director and one Non-Executive Director) is present"

Administration

37. The Trust Board shall be supported administratively by the Trust Secretary whose duties in this respect will include:
    37.1. Agreement of the agenda for Trust Board meetings with the Chair and Chief Executive;
    37.2. Collation of reports for Trust Board meetings;
    37.3. Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward on an action log;
    37.4. Advising the Trust Board on governance matters.

38. A full set of papers comprising the agenda, minutes and associated reports will be sent within the timescale set out in Standing Orders to all Trust Board Members and others as agreed with the Chair and Chief Executive.

Conflict with Standing Orders Set

39. In the event of a conflict between these Terms of Reference and the content of the Standing Orders Set, the content of the Standing Orders Set should take precedence.

Review

40. These Terms of Reference will be reviewed and approved at least every 12 months.

~~Approved by the Trust Board, 28th March 2019~~Approved by the Trust Board, 21st May 2020