NHS
Maidstone and Tunbridge Wells NHS Trust

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

25 June 2020, 09:45 to 12:00
Virtual meeting, via webconference

Agenda

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

06-8
To receive apologies for absence

David Highton

06-9
To declare interests relevant to agenda items

David Highton

06-10
To approve the minutes of the 'Part 1' Trust Board meetings of 21st May and 18th June 2020

David Highton

Board minutes 21.05.20 (Part 1).pdf (7 pages)

Board minutes 18.06.20 (Part 1).pdf (3 pages)

06-11
To note progress with previous actions

David Highton

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

06-12
Report from the Chair of the Trust Board

David Highton

Chair's report.pdf (1 pages)

06-13
Report from the Chief Executive

Miles Scott

Chief Executive's report June 2020 final.pdf (3 pages)

06-14
Integrated Performance Report (IPR) for May 2020, incorporating an update on the Trust's response to COVID-19 and review of the 'reset and recovery' project briefs

Miles Scott and colleagues

IPR month 2 (incl. PMRT).pdf (26 pages)

06-14.1
Update on progress with the Perinatal Mortality Review Tool (PMRT)

N.B. The report has been included within the IPR report for May 2020.

Claire O'Brien

06-14.2

Planned and actual ward staffing for May 2020

N.B. The report has been included within the IPR report for May 2020.

Claire O'Brien

06-14.3

Infection prevention and control board assurance framework

Sara Mumford

Infection Preventation and Control Board Assurance Framework.pdf (28 pages)

06-14.4

Board Checklist - workforce risk factors linked to COVID-19 and an update on BAME staff risk assessments

Simon Hart

Board Checklist - workforce risk factors linked to COVID-19 & BAME staff risk assessments update.pdf (19 pages)

Quality items

06-15

Quarterly mortality data

Peter Maskell

Quaterly Mortality Update, June 2020.pdf (9 pages)

Planning and strategy

06-16

Approval of Business Case for Point of Care Testing (POCT)

Sean Briggs

Approval of the Business Case for Point of Care Testing (POCT).pdf (31 pages)

Reports from Trust Board sub-committees

06-17

Workforce Committee, 15/05/20 (incl. quarterly report from the Guardian of Safe Working Hours)

Emma Pettitt-Mitchell

Summary of Workforce Cttee, 15.05.20 (Incl. Quarterly Report from Guardian of Safe Working Hours).pdf (5 pages)

06-18

Quality Committee, 02/06/20

Sarah Dunnett

Summary of Quality C'ttee, 02.06.20.pdf (1 pages)

06-19

Patient Experience Committee, 11/06/20

Maureen Choong

Patient Experience Cttee Trust Board Report, 11.06.20.pdf (2 pages)

06-20

Audit and Governance Committee 18/06/20

David Morgan

Summary of Audit and Governance Cttee, 18.06.20.pdf (1 pages)

06-21

Finance and Performance Committee, 23/06/20

N.B. The report will be issued after the meeting on 23/06/20

Neil Griffiths

06-22
To consider any other business

David Highton

06-23
To approve the motion (to enable the Board to convene its 'Part 2' meeting) that...

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

David Highton

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 21st MAY 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)
	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)
	Doug Ward	Director of Estates and Facilities (for item 05-10)	(DW)

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

05-1 To receive apologies for absence

Apologies were received from David Morgan (DM), Non-Executive Director.

05-2 To declare interests relevant to agenda items

No interests were declared.

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

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

05-4 To note progress with previous actions

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

- **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").** KR confirmed he had nothing else to add to the content of the 'actions log'. SO however noted that the development of the Integrated Performance Report (IPR), which would be discussed under item 05-8, was closely linked to the action. DH reported that the format and content of the IPR had again been discussed at the Non-Executive Directors meeting that had been held earlier that morning, and stated that he would relay the Non-Executive Directors' comments outside of the Trust Board meeting, as there was unlikely to be sufficient time to discuss such comments during item 05-8.
- **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").** AJ reported that he had a meeting scheduled with COB on 22/05/20 to discuss amendments to the objective.

05-5 Report from the Chair of the Trust Board

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

- DH, and the Non-Executive Directors as a whole, wanted to acknowledge the collaborative working across the system that had taken place during the COVID-19 period, and he was keen to ensure such collaboration, which reflected the direction of the NHS Long Term Plan, was fermented in the future. DH was aware that a similar desire was in place among the Non-Executive Directors at other organisations in the local system.
- An Advisory Appointments Committee panel had been held on 18/05/20, via virtual means, and had gone well. An appointment had been made and the details would be reported to the next Trust Board meeting.

05-6 Report from the Chief Executive

MS referred to the relevant attachment and highlighted that consideration was being given on how best to use the significant amount of charitable funds that had been received during the COVID-19 period, which included the Trust's share of the NHS Charities Together national fund, which was circa £100m.

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

MS firstly referred to the "Post-COVID-19 recovery" report that had been considered at the Finance and Performance Committee on 19/05/20, which had been made available to Trust Board members via the "documents" section on the Admincontrol meetings portal, and stated that he would be discussing the content of that report during item 05-7. MS then referred to the news story from that morning regarding the fee that overseas health workers had to pay to use the NHS and confirmed that the Trust already paid that fee for its overseas staff.

MS then asked SH to give details of the work being done regarding Black, Asian, and Minority Ethnic (BAME) staff. SH reported that the work was being led by the Head of Occupational Health, and had been discussed by the Trust's COVID-19 Ethics Committee. SH continued that all managers of BAME staff had been asked to complete a risk assessment by 04/06/20. SH also noted that a board assurance framework on the matter had been issued, and proposed this be considered at the Trust Board and Workforce Committee in June and July 2020 respectively.

DH asked what feedback had been given from BAME staff on the action taken by the Trust. SH reported that some concerns had been raised but reassurance that had been given. COB elaborated on the concerns, which were focused on the process of the aforementioned risk assessment, and the ability of line managers to consider the range of possibilities available. SDu asked whether the concerns reflected managers being busy, or being competent in discussing the issues. COB clarified that the concerns pertained to the fact that the risk assessment required line managers to discuss staff members' underlying health issues, which were not usually discussed. COB continued that the concerns therefore reflected the sensitive nature of the discussions, as well as the novel nature of the exercise. SDu asked whether any guidance or support had therefore been provided to managers. SH confirmed that the support required by managers had been considered.

MS then asked COB to give details of the Root Cause Analysis (RCA) approach that would be applied to staff who had tested positive for COVID-19. COB reported that she, SM and SH had met to consider the issue, and a discussion had then been held at the Executive Team Meeting on 19/05/20. COB explained that clusters of three or more staff who had tested positive for COVID-19 within a 14-day period would be subject to an RCA. SM then added further details of how the Infection Prevention and Control Team would support the process. RF asked whether the protocol covered the response to the outcome of the RCA. SM confirmed that each RCA had an action plan that was tailored to the specific issues that had been identified.

JW then noted that the person who had raised awareness of the fee that overseas health workers had to pay to use the NHS was a Syrian refugee who was now an NHS cleaner, and asked whether the Trust's payment of that fee for its overseas staff extended to such non-clinical support staff. MS agreed the issue should be investigated.

Action: Investigate whether the Trust's payment of the fee that overseas health workers had to pay to use the NHS extended to non-clinical support staff, such as cleaners (Chief Executive & Director of Workforce, May 2020 onwards)

DH then remarked that he presumed from the data within the site reports that had been issued that morning that the acuity of the Trust's COVID-19 patients had reduced markedly from that previously seen. PM replied that he was not aware that was the case and he would consider that outcome unlikely.

MS then referred to the "Post-COVID-19 recovery" report that had been considered at the Finance and Performance Committee on 19/05/20 and highlighted the following points:

- The volume of work involved in the Trust's 'reset and recovery' was significant, and it had therefore been agreed that the work should be delivered via the Trust's standard programme management approach, through the Divisions. The Divisions would therefore need to agree, and deliver on, specific objectives.
- Eight 'reset and recovery' priority areas had been identified - "Outpatients", "Elective care", "Acute & Urgent", "Social Distancing / Home Working", "Staff Welfare", "Patient and Staff Safety – RAG", "ICC" (i.e. the COVID-19 Incident Command Centre), and "Data?".
- Several organisational objective areas had also been identified - "Finance & Contacts", "Operational Performance", "Quality and CQC", "EPR", "Education / KMMS", "Strategy – Estates", "Strategy – Clinical", "OD / EPOC", "ICP / External", and "Workforce".
- The work also needed to incorporate Divisional objectives.
- The report contained details of the "Scope", "Objectives" and "Leadership" for the eight 'reset and recovery' priority areas.
- The same version of the report had been discussed at the Finance and Performance Committee and Executive Team Meeting on 19/05/20, so comments from those meetings had not been reflected in the report.

JW referred to the "…What to [sic] we keep…" section and suggested that the Trust also needed to keep the support of the local community that had been so evident during the past few weeks. MS agreed that needed to be captured. JW also noted that the economy was likely to enter a recession, and the NHS was often one of the economic anchors of local communities. MS again agreed that aspect needed to be incorporated within the document.

DH remarked that the interdependencies affecting the objectives also needed to be reflected. MS agreed and stated that he would expect the Trust Board to hold members of the Executive Team to account in recognising such interdependencies.

RF asked how the oversight of the programme was intended to work, and also remarked that the list of things in the "What did we change that we want to reverse?" and "What did we stop that should stay stopped?" sections was 'thin', and the programme therefore seemed to add a lot more to the Trust's workload. RF also commented that it did not appear as if much time had been given for 'headspace'. In addition, RF queried how the various worksteams would work together, to enable back-office areas, such as Human Resources, to influence the direction of each project. Finally, RF emphasised the significance of having some 'quick wins', to demonstrate that action was being taken.

MS replied that he wanted the programme oversight to take place via the existing management structure, so that plans would be monitored and any variance to such plans addressed. MS however added that it would be important to avoid constraining action by having too much corporate control. MS then stated that he had not presumed any influence into particular projects from particular departments, but each project brief should consider who needed to be involved, and such project briefs would then be discussed and critiqued. MS concluded his response to RF's points by confirming that there should be further reflection on the things that should cease, to enable the Trust's priorities to be clear.

RF then asked a further question on how the 'reset and recovery' work linked with the work taking place system-wide. MS acknowledged that the document needed to include details of how the

Trust would work within the wider system, the areas of work being led by other organisations, and how the Trust would engage with such organisations.

COB then pointed out that the importance of patient experience had not been fully reflected in the document, and noted that the opportunity should not be lost to engage with patients.

NG asked for a comment on the current thinking regarding system expectations on the 'new normal', including the "Second phase of NHS response to COVID19" letter that had been sent by the NHS Chief Executive and NHS Chief Operating Officer. MS noted that there was an expectation that all urgent and acute activity should be re-established first, and then more local services should be re-established. SO added details of the finance regime in 2020/21, which included expectations regarding activity, as well as the expected future arrangements.

DH acknowledged that several of the comments from the Non-Executive Directors pertained to the wider system and noted that although there was an Organisational Objective regarding "ICP / External", it would be sensible to cease the current development and production of the IPR. DH elaborated that the reporting to the Trust Board needed to reflect the 'new normal' and not just revert back to old methods. DH noted, for example, that some funding streams would, in future, flow on a system-wide basis. SO confirmed that capital expenditure had already been allocated on such a system-wide basis. KC then added to DH's comments by stating that she believed the issue was part of setting the context in which the Trust operated i.e. the Trust was part of a health and care ecosystem that would need to change rapidly and there was a need to understand how this would affect the Trust, and how such change could be influenced.

MS acknowledged the points and proposed that the project briefs for the 'reset and recovery' work be submitted to the Trust Board in June 2020, for review and scrutiny, as these would include the proposed Key Performance Indicators, and therefore describe how the reporting would work. This was agreed, although DH noted that he expected the situation to be subject to rapid change.

Action: Schedule a "Review of the 'reset and recovery' project briefs" item at the Trust Board meeting on 25/06/20 (Trust Secretary, May 2020 onwards)

KC then remarked that the issue was about recognising the Trust would be part of the economic and social regeneration of the region, as a major employer, as part of the supply chain in the region, and importantly, part of the public health agenda. JW also opined that the Trust needed to be flexible with its estate. MS agreed and confirmed such aspects needed to be reflected in an updated version of the document.

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

DH referred to the relevant attachment and noted that it mainly reflected the old i.e. pre-COVID-19 world, although he acknowledged the intention to develop the IPR. MS noted that major changes to the IPR should not be expected until the Trust Board meeting in July 2020, but DH stated that he would discuss that with MS outside of the meeting, as he believed some of the IPR's content should be removed for the Trust Board meeting in June 2020.

SB then referred to the relevant attachment and highlighted the current performance on the Emergency Department (ED) 4-hour and 62-day cancer waiting time targets, pointing out that if the latter was achieved for April 2020, it would have been achieved for nine months in succession. SB also noted that ED attendances had started to rise and then reported that the Trust's Referral to Treatment waiting time target performance had reduced by 20% during the COVID-19 period.

SDu acknowledged the recent increase in ED attendances but observed that the Trust's website and other communication made no reference to that change, nor to the gratitude the Trust had for the local community for staying away from the Trust in recent weeks. SB acknowledged the point and noted that it was intended for such communications to be covered via the "Acute & Urgent" workstream of the aforementioned 'reset and recovery' work.

COB then reported details of the latest position for patient falls, which had increased, and gave assurance that work was underway in response. COB also reported that pressure ulcers had

increased and would be the subject of the Quality Committee 'deep dive' meeting in June 2020. COB then continued and reported that the Trust's complaints and Serious Incident processes had restarted, while consideration was being given to re-starting the Friends and Family Test.

COB then referred to the planned and actual ward staffing for April 2020 and explained the work that would take place on the e-roster IT system.

DH referred to the increase in pressure ulcers and asked whether it was more difficult to turn patients during the COVID-19 period, and if so, whether that had been a factor in the increase. COB confirmed it had been more difficult to turn patients, as most patients required two members of staff to perform such manoeuvres. COB also noted that COVID-19 patients had been subject to prone positioning and PM added his perspective on that issue.

PM then reported the latest details on stroke care, which included the reasons for the continued low performance on the Best Practice Tariff.

SH reported the current status of the vacancy rate and staff sickness absence.

SO then reported the latest financial position, including how the block contract and 'top up' regime would work to bring the Trust back to a break-even position. SO added that the regime meant that the Trust was not currently focusing on Cost Improvement Programme delivery and 2020/21 therefore represented a real opportunity to achieve a strong financial footing for 2021/22. DH acknowledged SO's earlier confirmation that capital funding was now allocated at a system level, but noted that revenue funding was still based locally, so asked whether SO had any concerns that the Trust's plans would be constrained by a lack of capital funding. SO gave his perspective on the situation.

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

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

- The OBCs had already been considered by the Finance and Performance Committee, which had recommended they be approved by the Trust Board.
- A Strategic Outline Case had been approved circa one year ago, and the Trust Board was now being asked to approve the OBCs, to enable the Full Business Cases (FBCs) to be developed.
- The change was dependent on a common LIMS being in place across all Trusts (for which significant investment was required); and also on a common Managed Service Contract for equipment. The programme would therefore take a long time, as the LIMS and Managed Service Contract aspects would take considerable time to implement.
- Caution had been deliberately applied to the benefits of the service change, as these would not take effect until the LIMS and managed service contract were in place. However, a Target Operating Model would ensure such benefits were realised, and the FBC would fully quantify the expected benefits.
- Although the investment would be significant, such investment would be needed in any case, if the Trust wanted to upgrade its current LIMS, which was required, given its age.
- All four partner organisations would submit the OBCs to their Trust Boards, but Maidstone and Tunbridge Wells NHS Trust was the first to consider the OBCs. The Trust and East Kent Hospitals University NHS Foundation Trust were very keen for the wider service change to occur, but the Trust Boards at Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust (DGT) were nervous of the service change elements, given their experiences of the North Kent Pathology Service. It was therefore possible that DGT's Board may only want to proceed with the LIMS and Managed Service Contract aspects in the first instance, and if that was the case, careful consideration would be required.

NG then gave details of the discussion the Finance and Performance Committee had held on the OBCs in April 2020, which noted the work had been underway for a considerable length of time, but needed to properly quantify the benefits, as MS had stated.

Questions were invited. None were received. The Trust Board then approved the Kent and Medway STP Pathology Programme Outline Business Cases for Service change, a Laboratory Information Management System, and a Managed Service Contract, as submitted.

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

MS acknowledged that the Trust Board had not considered sustainability issues much over the past 12 months, but then deferred to DW. DW referred to the relevant attachment and highlighted that the Trust would see a reduction in carbon emissions over the coming year.

Questions were invited. None were received. The Trust Board then approved the Sustainable Development Management Plan as submitted. However, DH then asked whether the Trust Board wanted to consider a more detailed, forward-looking, report on sustainability issues at some point in the future. This was agreed. MS therefore stated that he would liaise with KR to schedule an item at an appropriate point.

Action: Liaise, to consider and propose the scheduling of an item to enable the Trust Board to have a more detailed, forward-looking discussion on sustainability issues (Chief Executive & Trust Secretary, May 2020 onwards)

Assurance and policy

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

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

- NHS Trusts were required to self-certify against the licence for providers of NHS services at this time each year, and the timescales had not been affected by the COVID-19 period.
- The evidence to support compliance against the licence conditions would usually be included in the Trust's Annual Report, and in particular the Annual Governance Statement, rather than in a separate report to the Trust Board. However, because the timetable for the Annual Accounts for 2019/20 had been deferred, the Annual Report for 2019/20 had not been submitted to that month's Trust Board meeting, as would usually be the case, as that Annual Report had not yet been considered by the Audit and Governance Committee. The draft Annual Governance Statement for 2019/20 had therefore been submitted to support the proposed self-certification, and supplement the various other sources of evidence that had been received by the Trust Board and its sub-committees throughout the year.
- The self-certification did not need to be submitted to NHS England (NHSE)/NHS Improvement (NHSI) but was required to be posted on the Trust's website.
- NHSE/I usually select a small number of NHS Trusts for a follow-up review of the evidence used to support their self-certification, but that aspect had been removed for the 2019/20 self-certification process, as a result of COVID-19.

Questions were invited. None were received. The Trust Board then approved the proposed self-certification for 2019/20 as submitted.

Reports from Trust Board sub-committees

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

The attachment that had been circulated was noted. EPM then reported that the Workforce Committee meeting on 15/05/20 had agreed to change the Committee's membership, to add the Chief Finance Officer and remove the Chief Operating Officer, and the Trust Board was therefore asked to approve that change. The Trust Board approved the change to the Workforce Committee's Terms of Reference as proposed. DH asked KR whether the Terms of Reference would be submitted to the Trust Board's meeting in June, but KR confirmed that the approval given at the meeting was sufficient, and the Terms of Reference did not therefore need to be submitted.

EPM then noted that the results of the 2019 NHS Staff Survey had been unable to be discussed in detail at the meeting on 15/05/20, so it was possible that an extraordinary meeting of the Workforce Committee would be held in June 2020.

05-13 Quality Committee, 06/05/20

SDu referred to the relevant attachment and proposed that given the earlier discussion, the Quality Committee 'deep dive' meeting undertake a review of complaints during the COVID-19 period. COB confirmed she was content with the proposal.

Action: Liaise with the Chief Nurse to schedule a "Review of complaints during the COVID-19 period" at a future Quality Committee 'deep dive' meeting (Trust Secretary, May 2020 onwards)

KR then pointed out that the Trust Board was asked to approve revised Terms of Reference for the Quality Committee. SDu confirmed that the Committee had agreed the proposed amendments. The revised Terms of Reference were then approved as submitted.

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

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

Other matters

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

KR referred to the relevant attachment and highlighted that only a few minor, 'housekeeping' changes had been proposed, as part of the routine annual review of the Terms of Reference. DH added that the proposed changes were shown as 'tracked' in the report.

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

05-16 To consider any other business

SDu remarked that the Trust's website only made reference to visitor restrictions, and contained no information about patients who had had their care and treatment delayed by the COVID-19 situation. SDu also noted that the website contained details of consultants who no longer worked at the Trust. MC echoed SDu's sentiments and also stated that much of the information on the "MyMTW" App, including the membership of the Trust Board, was out of date. MC added that if the use of the App was to continue, the information it contained should be updated. MS confirmed that AJ, as the relevant member of the Executive Team, would respond to the points raised.

Action: Arrange for the Trust's website and "MyMTW" App to be updated to reflect the latest available information (Director of Strategy, Planning and Partnerships, May 2020 onwards)

DH then noted that he and RF had had a recent discussion, and DH had circulated a blog by the Chief Executive of the NHS Confederation regarding integrated care. DH continued that it may be beneficial for the Trust Board to have a horizon-scanning session on that issue. RF elaborated that he believed the Trust Board needed to have a position on the matter that DH and MS could then relay to external agencies. DH noted that the Trust Board Seminar programme had not been re-introduced following COVID-19, but a development session could be scheduled, although he would expect some time would be needed to prepare for such a session. It was agreed that DH and MS would discuss the scheduling of that session outside of the meeting.

Action: Liaise to discuss and agree the scheduling of a Trust Board horizon-scanning session on integrated care (Chair of the Trust Board & Chief Executive, May 2020 onwards)

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

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

MINUTES OF THE EXTRAORDINARY TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 18th JUNE 2020, 12.15 P.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)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Jo Webber	Associate Non-Executive Director	(JW)
	Kevin Rowan	Trust Secretary	(KR)
Observing:	The meeting was livestreamed on the Trust's YouTube channel.		

DH introduced the meeting by explaining that finalisation of the Trust's Annual Report and Accounts for 2019/20 had been delayed by the COVID-19 pandemic, and it was therefore necessary to schedule an extraordinary Trust Board meeting to approve the documents.

06-1 To receive apologies for absence

No apologies were received. It was however noted that Amanjit Jhund (AJ), Director of Strategy, Planning & Partnerships would not be in attendance.

06-2 To declare interests relevant to agenda items

DM declared that his son worked at Grant Thornton UK LLP (the Trust's external auditors) as a trainee, although he did not work within the public sector audit team.

Reports from Trust Board sub-committees

06-3 Audit and Governance Committee, 26/05/20 & 18/06/20 (to include the Committee's 2019/20 Annual Report)

DM referred to the relevant attachment and the Audit and Governance Committee's meeting held earlier that morning, and highlighted the following points

- The external auditors had given an unqualified audit opinion.
- An "emphasis of matter" point had been raised by the external auditors, which related to the valuation of land and property, and in particular the Trust's valuer's material uncertainty in respect of the valuation of property, plant and equipment as a result of the COVID-19 pandemic.
- The external auditors had commended the Trust for submitting high quality working papers.
- There were no issues of concern raised in the Audit Findings Report.
- The Audit and Governance Committee meeting on 26/05/20 discussed risk management and agreed that every red-rated risk should be reviewed by either the Trust Board or a Trust Board sub-committee at least once per year.
- It was also agreed at the meeting on 26/05/20 to consider the introduction of a self-assessment prior to Internal Audit reviews, to enable a pre- and post-assessment to occur.

- The summary report contained two appendices: the Audit and Governance Committee's Annual Report for 2019/20 (which KR clarified had been approved by the Audit and Governance Committee, and was submitted to the Trust Board as part of the suite of assurance-related documents to support the Trust Board's review of the Annual Report and Accounts); and a "Benchmarking your 2018/19 Annual Report, Website and Social Media as at January 2020" report from Grant Thornton UK LLP, which identified that the Trust, like many others, did not optimise the use of its website and social media platforms in publicising its work.

DM then elaborated that the Audit and Governance Committee had agreed that the "Benchmarking your 2018/19 Annual Report, Website and Social Media as at January 2020" report should be considered by the Trust Board, as the issues raised on communications were beyond the Committee's remit. DM added that the Trust Board was therefore asked to consider whether any action was required.

MS stated that the Trust's communications function should be reviewed as a whole, and AJ had already commissioned such a review, through the Director of Emergency Planning & Communications. MS therefore proposed that the outcome of that review be considered in the first instance, although he clarified that the review was internal, and was not expected to result in any radical changes, although some areas would likely be strengthened. DM confirmed he was satisfied with the approach proposed by MS. DH noted the distinction between internal and external communications. MS acknowledged the point and confirmed the review would cover both.

DM then reported that the Audit and Governance Committee's meeting on 18/06/20 had, following a point raised by RF, discussed the Committee's role in the oversight of the Trust's governance, noting that much of the Committee's agenda was focused on audit. DM continued that it had been agreed that he and KR would give the matter some thought, but Trust Board members were welcome to give their opinion. DH commented that it was sensible for organisations to review the effectiveness of their governance arrangements periodically, but any such review should include the Trust Board and its sub-committees, and not therefore have too narrow a focus. The point was acknowledged.

Annual Report and Accounts

06-4 To approve the Trust's Annual Report, 2019/20 (incl. the Annual Governance Statement)

DM confirmed that the Audit and Governance Committee had agreed, at its meeting on 18/06/20, to recommend that the Trust Board approve the Annual Report for 2019/20. DH invited questions or comments. None were received.

The Trust's Annual Report for 2019/20 was approved as submitted.

06-5 To approve the Trust's Annual Accounts, 2019/20

DM confirmed that the Audit and Governance Committee had agreed, at its meeting on 18/06/20, to recommend that the Trust Board approve the Annual Accounts for 2019/20. DH invited questions or comments. None were received.

The Trust's Annual Accounts for 2019/20 were approved as submitted

06-6 To approve the Management Representation Letter, 2019/20

DM confirmed that the Audit and Governance Committee had agreed, at its meeting on 18/06/20, to recommend that the Trust Board approve the Management Representation Letter for 2019/20. DM also noted that the letter contained standard text, as provided by the Trust's external auditors. DH invited questions or comments. None were received.

The Management Representation Letter for 2019/20 was approved as submitted, and the authority to sign the letter on behalf of the Trust Board was delegated to SO.

DH then thanked the members of the Audit and Governance Committee for their diligence in reviewing the Annual Report and Accounts for 2019/20.

06-7 To consider any other business

There was no other business.

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]
05-16a	Arrange for the Trust's website and "MyMTW" App to be updated to reflect the latest available information	Director of Strategy, Planning and Partnerships	May 2020 onwards	A verbal report will be given at the meeting on 25/06/20.

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
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	June 2020	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. The BAF for 2020/21 is currently being developed, and will start to be submitted to various forums at the end of June 2020.
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	May 2020	The Director of Strategy Planning and Partnerships met with the Chief Nurse and agreed that the objective should be "Improve Friends and Family Score to 25% for inpatients (from the baseline of 16.7%), 25% for maternity (from the baseline of 10.6%), and 15% for the Emergency Department (from the baseline of 10%).

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
05-7a	Investigate whether the Trust's payment of the fee that overseas health workers had to pay to use the NHS extended to non-clinical support staff, such as cleaners	Chief Executive & Director of Workforce	May 2020	The action was superseded by events, as the Prime Minister announced on 21/05/20 that he had asked the Home Office and the Department for Health and Social Care to remove NHS and care workers from the NHS surcharge as soon as possible. This is understood to include all NHS workers, including clinical staff, porters and cleaners.
05-7b	Schedule a "Review of the 'reset and recovery' project briefs" item at the Trust Board meeting on 25/06/20	Trust Secretary	May 2020	The item was scheduled for the Trust Board meeting on 25/06/20
05-10	Liaise, to consider and propose the scheduling of an item to enable the Trust Board to have a more detailed, forward-looking discussion on sustainability issues	Chief Executive & Trust Secretary	June 2020	A meeting was held (on 04/06/20) between the Chief Executive, Chair of the Trust Board, Trust Secretary, and Director of Estates and Facilities, and it was agreed that the Trust Board Seminar in October 2020 should be focused on sustainability issues. A small working group will therefore be established to design the Seminar session.
05-13	Liaise with the Chief Nurse to schedule a "Review of complaints during the COVID-19 period" at a future Quality Committee 'deep dive' meeting	Trust Secretary	June 2020	It was instead agreed at the Quality Committee 'deep dive' meeting on 02/06/20 that the item should be scheduled for the 'main' Quality Committee on 08/07/20
05-16b	Liaise to discuss and agree the scheduling of a Trust Board horizon-scanning session on integrated care	Chair of the Trust Board & Chief Executive	June 2020	A meeting was held (on 04/06/20) between the Chief Executive, Chair of the Trust Board, and Trust Secretary, and it was agreed that a Trust Board Seminar should be scheduled in July 2020, to focus on the future of integrated care.

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

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

The last month has been a period of transition, with a welcome reduction in COVID-19-positive patients in our two hospitals to the lowest level since the beginning of the pandemic, and the initial steps taken in a recovery of services which were put on hold. We are very grateful and proud of the care to patients that has been given to our patients over the last three challenging months.

The complexity of restarting services while the virus is still present has meant a significant amount of planning within clinical teams to reset services in a sustainable way which takes advantages of new ways of delivering care. The Board are supportive of the executive and clinical teams as the recovery and reset process builds up over the coming weeks.

The Non-Executive Directors and I are also fully committed to the efforts the Trust must make to protect and support our Black, Asian, and Minority Ethnic (BAME) staff during the pandemic and beyond. We wish to support inclusion of all of our staff, particularly through our Culture & Ethnic Minorities Network, our LGBTQ+ Network and our Disabilities Network, and make sure that this is a key part of the Board agenda.

Consultant appointments

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

Date of AAC	Title	First name	Surname	Department	Potential / Actual Start date
18/05/2020	Dr	Kudzai	Mugweni	Paediatrics (Resident Paediatrician)	TBC
01/06/2020	Dr	Samantha	Anandappa	Diabetes & Endocrinology	TBC

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

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

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

Report from the Chief Executive **Chief Executive**

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

1. The numbers of patients we're caring for with coronavirus remains at a steady, low level. As a result we have put preparations in place to reinstate some of our non-urgent and routine services that were temporarily suspended during the pandemic. Our key focus is keeping our staff and patients safe so it's important that we implement robust measures that follow social distancing rules and strict infection prevention and control protocols.

   We have reviewed all patient pathways so that we can split them into Covid-19 positive and non-Covid-19 patients. This means we can care and treat them separately to prevent the spread of the virus. We have also carefully analysed our capacity to better understand how many patients we can safely see or treat at any one time in our hospitals and clinics. We know we will need to continue to work differently and with the independent sector to ensure our patients are seen and treated in a timely way. To keep everyone safe, we also know we won't be able to resume normal levels of activity yet for many of our services, and there will be instances where some of our non-urgent patients may have to wait a little longer to be seen.

   As a result, we are reviewing all our patients that are waiting for non-urgent and routine planned procedures or appointments so that we fully understand their care and treatment needs. We are carefully assessing them so that we identify those that may need to be seen more quickly.

   Where we can already put safety mitigations in place we have increased the number of patients we're seeing and treating and restarted some services. These include:

   - Urgent bowel screening and symptomatic endoscopy services
   - Paediatric planned surgery
   - Middle-ear and priority ear, nose and throat planned surgery as well as corrective squint and cataract surgery
   - Brachytherapy treatments for prostate and gynaecological cancers
   - Cardiology services for priority patients
   - Routine MRI using the mobile MRI unit

2. MTW is working with its partners across Kent and Medway to support Medway NHS Foundation Trust following their announcement that temporary changes to their acute stroke services will be made at the end of this month. The temporary emergency transfer of acute (urgent) stroke services out of Medway Hospital will take place from July 2020. Suspected stroke patients from Medway and Swale will be taken by ambulance directly to Maidstone Hospital or Darent Valley Hospital in Dartford (depending on which site is closest). This situation has arisen due to staff leaving the service and challenges in recruiting.

   MTW is working with Medway FT and Dartford and Gravesham NHS Trust to ensure that safety and quality standards are maintained for stroke patients. In response to coronavirus, Maidstone Hospital has additional bed capacity to care for patients from the Medway area as stable rehabilitation patients are currently being treated at a local private hospital.

3. We are carrying out risk assessments on all vulnerable and Black Asian and Minority Ethnic (BAME) staff as part of our ongoing welfare plans to keep our staff safe and in line with new health guidance on coronavirus. This is a continuous process to ensure assessments are undertaken where an individual's health circumstances change. Those identified as high risk, who are not already shielding, will be moved to lower risk areas, or asked work from home, with appropriate safety and support measures put in place.

4. Nearly 740 staff completed our second pulse (climate) survey, which took place between 26 May and 5 June, to assess how staff were feeling and identify any further actions the Trust could take to improve the workplace. Out of those who responded, 62% indicated there was an improvement in how they were feeling since the start of the pandemic. A small proportion of staff continued to have some concerns around feeling supported and this appears to be based on local or individual circumstances. Survey data will now be used to make further enhancements to staff welfare and wellbeing, with a focus on improving communications between line managers and their teams, particularly those that are working from home; developing tailored training and support for middle managers; and encouraging collaboration within services to generate and implement solutions to support the Trust's reset and recovery programme.

5. We have now rolled out antibody testing for patients and staff. Our phlebotomy team has already carried out tests on over 3,000 staff at our hospitals.

6. MTW recently saw an increase in staff testing positive for Covid-19 on one ward at Tunbridge Wells Hospital. Our absolute priority is keeping our patients and staff safe, and we have implemented a range of measures since the pandemic started that are continually reviewed and adapted in line with updated guidance. These include:

   - Complying with all guidance issued by Public Health England (PHE) and WHO Organization about the use of Personal Protective Equipment (PPE) and ensuring we always have an adequate supply of PPE stock levels
   - Introducing social distancing measures across all areas of our hospitals
   - Undertaking risk assessments for BAME and vulnerable members of staff
   - Visiting restrictions put in place at both of our hospital sites
   - Testing for staff and families since the end of March
   - Reviewing cases where staff in an area test positive for Covid-19

   Additional safety measures have also been introduced in the last two weeks. These are:

   - All staff working in clinical areas are now wearing masks throughout their shift and travelling around the hospital, not just in patient areas.
   - Tracking and tracing staff and patients who may have come into contact with those who have tested positive.

7. The Trust's charity has launched a number of fundraising efforts this month to help raise money for patient care and our staff. The 'Bake. Donate. Nominate.' challenge aims to raise £20,000 to support staff health and wellbeing. The fundraiser encourages people to bake and share their creation on social media, donate £5, then nominate five other people to do the same.

   Double Olympic gold medallist Dame Kelly Holmes launched our new 'Go the distance' fundraising event. The active fundraiser involves people walking, running or cycling either 5km, 10km, a half marathon or full marathon in a maximum of 30 days in return for sponsorship. Donations will also go towards supporting our staff.

8. The Kent Oncology Centre courtyard garden makeover was completed recently thanks to volunteers, Kent Fire and Rescue Service (KFRS) and South East Water. Water was donated by the utility company and KFRS helped transport it so that MTW volunteers could refill the courtyard pond after the garden underwent a dramatic transformation. Thank you to all involved for their help.

9. Thank you to BNP Paribas Tunbridge Wells who gave a generous donation of £10,000 to the Trust's charitable fund. The money will be used to enhance staff welfare and improve facilities for colleagues.

10. We marked Volunteers' Week this month by shining the spotlight on some of our amazing volunteers. We have almost 300 volunteers who work across 10 departments at MTW. They range in age from 18 to 96 and support both clinical and non-clinical teams and services in our hospitals. Thank you for everything our volunteers do.

11. New volunteer hubs have been set up at Maidstone and Tunbridge Wells hospitals to provide help and support to patients and staff during the pandemic. Located in the main entrances, the hubs are staffed by an army of volunteers and act as a central point for relatives, friends and carers to drop property off for delivery to patients; escort able-bodied and wheelchair-bound patients to their outpatient appointments; and provide people with directions around the sites.

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

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

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

Integrated Performance Report (IPR) for May 2020, incorporating an update on the Trust's response to COVID-19 and review of the 'reset and recovery' project briefs	**Chief Executive / Members of the Executive Team**

Enclosed is the IPR for month 2, 2020/21, which also includes an update on progress with the Perinatal Mortality Review Tool (PMRT); and the planned and actual ward staffing for May 2020.

Further details of performance under each of the Domains (Caring, Effective, Responsive, Safe and Well-led), as well as the detailed performance scorecard, have been made available in the "IPR Appendices" folder of the "Documents" section within the Admincontrol meetings portal (which is under the "Trust Board/Trust Board Meetings (Part 1)\2020\06b.25.06.20\" folder).

The project briefs (i.e. Project Initiation Documents (PIDs)) for the 'reset and recovery' programme are currently being developed by the various project leads, and are scheduled for review by Executive Team on 23/06/20. It is intended that the documents will be made available to Trust Board members after that review (and after any requested revisions have been made, if necessary), via the "'Reset and recovery' programme PIDs" folder of the "Documents" section within the Admincontrol meetings portal (which is under the "Trust Board/Trust Board Meetings (Part 1)\2020\06b.25.06.20\" folder).

Which Committees have reviewed the information prior to Board submission?

- Finance and Performance Committee, 23/06/20 (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

May 2020

MTW
exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells NHS Trust

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Appendices (Page 11 onwards)

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

MTW exceptional people, outstanding care

Executive Summary

Executive Summary

The Trust has achieved the National Cancer 62 Day FDT Standard of 85% for nine consecutive months at 86.4%. The 2 week wait cancer waiting time target remained above target for the eighth consecutive month with Breast Symptoms dipping below target at 91. 9%. In addition, May performance increased further to 98.15% for the A&E 4hr standard and the Trust remains one of the best performing Trusts in the UK. As expected due to the COVID-19 pandemic activity levels remained low in May for both elective and outpatient appointments , however the numbers have increased compared to April (+12% for elective and +7% for first outpatients). The low activity has adversely impacted the RTT performance in April and May and of the constitutional standards the RTT and Diagnostics standards are most at risk in future months due to the likely decrease in capacity (with the impact of social distancing and use of PPE) and the uncertainty as to the likely level of demand. Modelling the possible demand vs capacity is taking place as part of the Trust's Reset and Recovery Programme including some cancer and urgent activity continuing to be transferred and undertaken in the independent sector.

The rates of falls, pressure ulcers and infection control continue to be impacted by the COVID-19 pandemic due to the Trust continuing to have a lower level of occupied beddays and admissions, however the number of infection control issues and Falls have remained similar to those reported prior to the COVID-19 pandemic, despite the lower level of occupied beddays. The number of new complaints received continues to remain low, slight increase in May 2020.

Items for Escalation

- **Infection Control:** There were 2 cases of MRSA bacteraemia reported in May, which exceeds the trajectory. One case has been confirmed as unavoidable and the second is under investigation at this stage. There were 2 cases of C.Diff reported in May, but the Trust remains on trajectory. Cases of E.Coli decreased by 1 to 4 in May equating to a rate of 32.9 per 100,000 occupied beddays which is above the threshold.

- **Falls:** The level of Falls has increased in May to 97 equating to a Rate of 7.97 per 1,000 occupied bed days. The level of occupied beddays continues to be reduced in May due to COVID-19 which may have impacted the overall rate. The overall rate is therefore above the maximum trajectory year to date. 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 reduced slightly in May with 11 reported equating to a rate of 2.5 against a maximum limit of 1.3. Once again the level of admissions was reduced in May due to COVID-19 but was higher than in April 2020. The monitoring process for hospital acquired pressure ulcers has been adapted to triangulate pressure ulcer incidence in COVID positive patients. A deep dive of hospital acquired Pressure Ulcers was presented to the Deep Dive Quality Committee in June.

- **Stroke:** Due to a technical issue with the national reporting system the performance data for he Best Practice Indicators is currently unavailable.

- **A&E 4 hour Standard:** Performance in May improved further to 98.15% due to robust processes in place and excellent staff engagement as per the recent CQC report. While there have been lower attendance numbers, there have been considerable changes to working practices and patient pathways in response to the COVID-19 Pandemic. One of the key improvements is the assessment of all patients at the front door on both sites by the First Contact Practitioner to stream the patients effectively or redirect to MIUs. The Trust remains one of the best performing Trusts in the UK for the 4hr standard. The pandemic reduced A&E attendance to 55-60% of the normal levels in early April. They have since increased to around 65 to 70% of normal levels. Minor attendances have been reduced more than major attendances and ambulance arrivals are now around 15% lower than normal, whilst non ambulance attendances are 30-35% lower. Emergency Admissions are now around 20% to 25% lower than the normal levels, with the total bed occupancy increasing from around 42% in April to around 55% in May. June to date is around 66% occupancy.

Executive Summary Continued

- **Referral to Treatment (RTT) Incomplete Pathway:** As expected due to the COVID-19 pandemic activity levels continue to remain low for both elective and outpatient appointments which have adversely impacted the RTT performance. April 2020 performance was 68.9% and May performance deteriorated further to 61.5%.

- **Outpatient Activity Face to Face vs Virtual:** The level of virtual outpatient activity for first (new) appointments is showing an increasing trend week on week form around 7.5% prior to the COVID-19 Pandemic to a high of around 45% in May. For follow up appointments this has also seen an increasing trend but at an even higher level from around 8% prior to Covid to around 65% in May. The increased use of Virtual vs Face to Face outpatient appointments (where clinically appropriate) is part of the Trust's Reset and Recovery Programme.

- **Cancer 62 Day:** The Trust continues to report achievement of the 62 day standard with 86.4% for April 2020. This is the ninth consecutive month of achievement and a significant improvement over last year when only 64.5% of our patients were treated in 62 days. April is likely seeing the affect of Covid-19 with a reduced numbers of patients treated in the month**.** The current number of treatments is 80% of the average monthly totals from 2019-20.

- **Cancer 2weeks (2ww):** The Trust has maintained achievement of the 2ww standard from September 2019, reporting 93.4% for the start of the new year in April 2020. Breast Symptoms referrals were reduced to 27% of the average for last year and with the reduced numbers, Breast Symptoms did not achieve the target, reporting 91.9% for April 2020. The current un-validated position for May is 93.1%.

- **Cancer 2weeks (2ww) Referrals:** After the drop in referral numbers at the beginning of April due to COVID-19, the incoming referrals are increasing weekly and the numbers received are currently up to 75% of the average daily referrals from January / February 2020.

- **Diagnostics Waiting Times <6 weeks:** As expected performance for April and May have been adversely impacted by COVID-19. April performance was 39.2% and May performance increased but remains low at 49.2%.

- **Finance:** The Trust has delivered a year to date breakeven financial position which includes £4.9m retrospective top up income support. The Trust has identified financial pressures (increase in costs and reduction in income) due to COVID 19 of £7.3m, the Trust plan assumed £0.9m top up would be required to achieve a balanced position (before COVID costs) therefore underspends within the plan of £3.3m have been made to net down the impact to £4.9m. The key underspends to plan are: Drugs (£1.8m) mainly due to reduction in Oncology and Ophthalmology high cost drugs, pay underspends (£1m) mainly within A&C and STT staff groups due to higher than planned vacancies, £1.1m underspend within clinical supplies due to reduction in elective activities and £0.2m underspend within independent sector usage. These underspends are partly offset by pressures associated with Car Parking (£0.3m), Laundry (£0.2m increase in dilapidation reserve), EPR project costs (£0.3m), income reductions within Diagnostics relating to independent sector activity (£0.1m) and increase in reserves(£0.1m).

- **Workforce - Various:** The Safe Staffing Nursing Fill Rate increased in May to 90.4% but remains below usual levels which has impacted on the overall fill rate. There has not been any staffing level risk to wards. The overall sickness rate has increased further to 6.1% in May which was impacted by the COVID-19 Pandemic (at least 2.5% of total) which has led to an increase in the use of agency staff in May. Non-Covid related sickness has continued to reduce in May, however the COVID-19 related sickness has started to increase. May Vacancy rate decreased to 9.1%.

- **Staff and their Families Swabbing:** Capacity is higher than uptake with an average utilisation of 26% in April (15% 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 480 tests per day. The proportion of all tests undertaken that are for NHS Staff has decreased from 41% in April to 32% in May. The Trust has also been undertaking the antibody test and currently around a third of all staff have been tested.

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)	23.6	16.4	21.7	13.8	22.6	21.5	↘
S2	Number of cases C.Difficile (Hospital)	5	2	9	3	55	48	↘
S3	Number of cases MRSA (Hospital)	0	2	0	2	0	2	↓
S4	Rate of E. Coli Bacteraemia	14.1	32.9	21.7	41.3	21.5	21.5	↑
S5	Rate of Hospital Pressure Ulcers	*2.30*	2.5	0.9	3.0	2.3	1.49	↑
S6	Rate of Total Patient Falls	*5.80*	7.97	*6.28*	7.89	*5.80*	5.20	↓
S7	Number of Never Events	*0*	0	0	0	0	0	→
S8	Number of New SIs in month	11	9	32	14	132	124	↗
S9	SIs not closed <60 Days Monthly Snapshot	24	9	99	9	24	9	→
S10	Overall Safe staffing fill rate	93.5%	90.4%	94.5%	87.4%	93.5%	93.5%	↑

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	1.0120	1.0296	1.0120	Band 2	Band 2	→
E2	Standardised Mortality HSMR	Lower conf <100	92.3	97.2	92.3	Lower conf <100	92.3	→
E3	% Total Readmissions	14.1%	14.3%	14.1%	14.8%	14.1%	14%	↘
E4	Readmissions <30 days: Emergency	15.2%	14.2%	14.8%	15.0%	15.2%	15.0%	↘
E5	Readmissions <30 days: Emergency (excl SDE	14.0%	13.2%	14.0%	14.4%	14.0%	14%	↘
E6	Readmissions <30 days: Elective	6.8%	9.1%	6.8%	7.9%	6.8%	6.8%	↘
E7	Stroke: Best Practice (BPT) Overall %	50.0%	No data due to technical issue					
E8	Nat CQUIN: % Dementia Screening	90.0%	94.3%	99.7%	95.9%	90.0%	95.9%	↗
E9	Nat CQUIN: % Dementia Risk Asssessed	90.0%	98.2%	94.5%	101.2%	90.0%	101.2%	↗
E10	Nat CQUIN: % Dementia Referred to Specialist	90.0%	98.1%	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	1.40	2.25	1.33	2.96	2.81	→
C3	% complaints responded to within target	75.0%	64.7%	37.5%	64.8%	75.0%	75.0%	↘
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 on 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%						

Target Indicator Key:	
On or above Target	
Review and Corrective Action required	
Significantly below target - urgent action required	

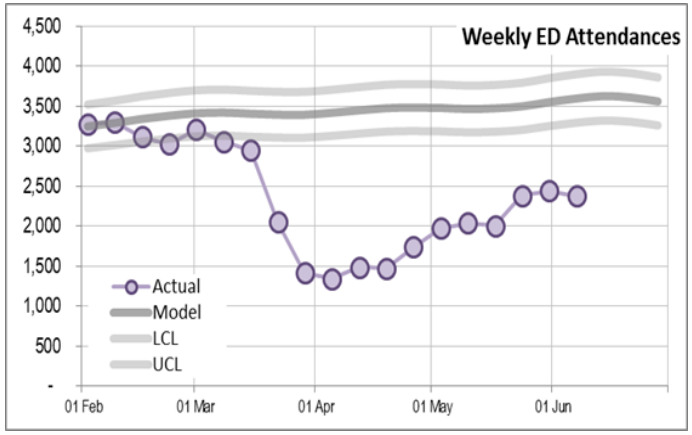
Responsive		Curr Month		Year to Date		Year End		Change on Prev Mth
ID	Key Performance Indicators	Plan	Actual	Prev Yr	Curr Yr	Plan	FOT	
R1	Emergency A&E 4hr Wait	87.9%	98.1%	90.6%	98.1%	88.0%	98.1%	↗
R2	Emergency A&E >12hr to Admission	0	0	0	0	0	0	→
R3	Ambulance Handover Delays >30mins	359	32	1025	193	4084	3560	↑
R4	RTT Incomplete Pathway (October)	86.5%	61.5%	85.2%	61.5%	86.7%	61.5%	↓
R5	RTT 52 Week Waiters (New in Month)	10	113	16	161	0	161	↓
R6	% Diagnostics Tests WTimes <6wks	99.0%	49.2%	99.1%	49.2%	99.0%	49.2%	↑
R7	Cancer two week wait	93.0%	93.4%	82.6%	93.4%	93.0%	93.4%	↗
R8	Cancer two week wait-Breast Symptoms	93.0%	91.9%	56.4%	91.9%	93.0%	93.0%	↓
R9	Cancer 31 day wait - First Treatment	96.0%	96.5%	96.5%	96.5%	96.0%	96.5%	↘
R10	Cancer 62 day wait - First Definitive	85.0%	86.4%	64.5%	86.4%	85.0%	86.4%	↗

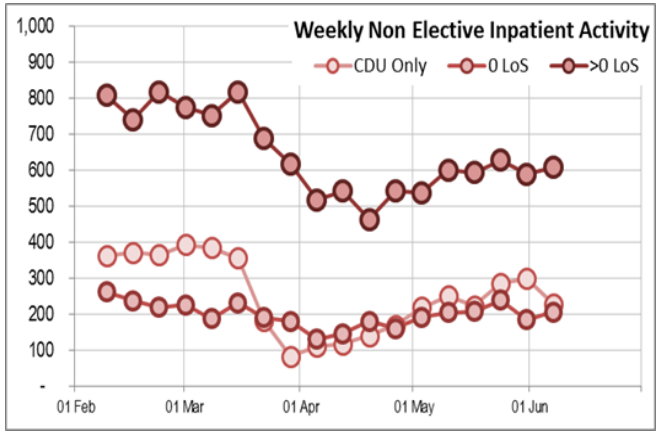
Responsive - Flow		Curr Month		Year to Date		Year End		Change on Prev Mth
ID	Key Performance Indicators	Plan	Actual	Prev Yr	Curr Yr	Plan	FOT	
R11	Average LOS Non-Elective	6.85	5.34	7.12	5.81	6.40	5.81	↑
R12	Theatre Utilisation	90.0%	77.5%	88.4%	15.4%	90.0%	15.4%	↗
R13	Primary and Non-Primary Refs	15,005	6225	33,619	10457	199,800	179458	↑
R14	Cons to Cons Referrals	5,724	3712	12,739	7013	76,216	71,480	↑
R15	OP New Activity	17,516	9813	35,981	19254	233,240	216540	↗
R16	OP Follow Up Activity	30,602	18278	56,238	37725	372,228	349832	↘
R17	Elective Inpatient Activity	568	133	1,163	230	7,557	6622	↑
R18	Day Case Activity	3,798	768	8,026	1321	50,576	44101	↑
R19	Non Elective Activity (inc Maternity)	6,038	4329	10,718	7566	71,089	66775	↑
R20	A&E Attendances : Type 1	15,060	9710	27,683	16499	176,581	163711	↑

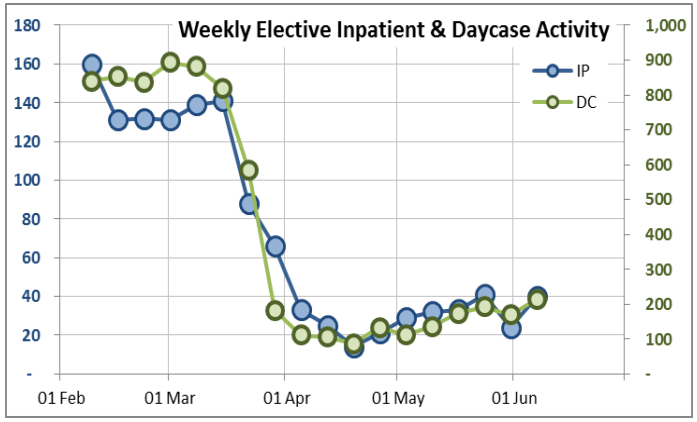
Well-Led		Curr Month		Year to Date		Year End		Change on Prev Mth
ID	Key Performance Indicators	Plan	Actual	Prev Yr	Curr Yr	Plan	FOT	
W1	Surplus (Deficit) against B/E Duty	0	0	-2,072	0	0	0	→
W2	CIP Savings	Suspension of CIPs Nationally						
W3	Cash Balance	-	49,236	39,537	49,236	-	1,000	→
W4	Capital Expenditure	-	606	403	1,540	-	-	→
W5	Finance use of Resources Rating	3	-	3	-	-	-	→
W6	Staff Turnover Rate (%)	10.0%	11.8%	9.8%	11.8%	10.0%	10.0%	↗
W7	Vacancy Rate (%)	8.0%	9.1%	10.7%	9.4%	8.0%	8.0%	↗
W8	Total Agency Spend	772	1,465	3,303	2,649	-	-	↘
W9	Statutory and Mandatory Training	90.0%	85.3%	87.1%	85.5%	90.0%	90.0%	↘
W10	Sickness Absence	3.3%	6.1%	3.4%	5.6%	3.3%	3.3%	↘

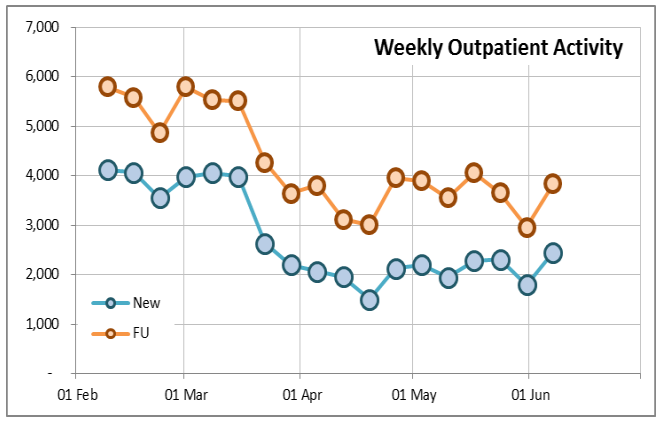
Change on Previous Indicator Key:		Change on Previous Indicator Key:	
Significant improvement on Previous (>5%)	↑	Deterioration on previous (<5%)	↘
Improvement on previous (<5%)	↗	Significant deterioration on previous (>5%)	↓
No Change	→		

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 20-30% down. Minor attendances have been reduced more than major - ambulance arrivals are now around 15% down, whilst non ambulance are 30-35% down.

Emergency Admissions: Non-Same Day Emergency Care (SDEC) admissions have been ~20-25% down on normal over the past 3 weeks, whilst SDEC admissions are down ~5-10%. Admissions to CDU only is down 25-30%, but this is due to a reduction in use of CDU. Similar to ED, the activity took 2-3 weeks to reduce.

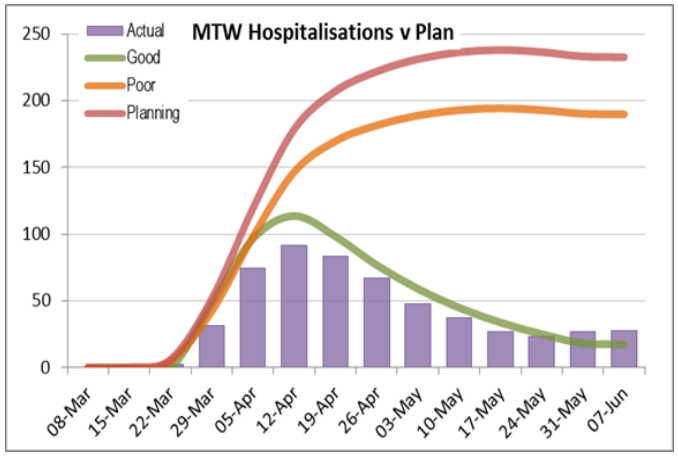
Elective / Daycase Activity : Large scale cancellations of elective activity resulted in admitted electives reducing by 75-80% on normal levels, and daycases by 75-80%. Both have recovered slightly. Elective has taken longer to fall off than non-elective, as it reflects our cancellation / postponement practices rather than patient's behaviour. Levels of Daycases declined more sharply. Due to the COVID response most of the elective activity had ceased apart from urgent cancers being undertaken internally, however the Trust is now implementing it's Reset and Recovery Programme and therefore some non-cancer elective activity is now taking place. In addition, some urgent and cancer activity continue s to be undertaken in the Independent Sector.

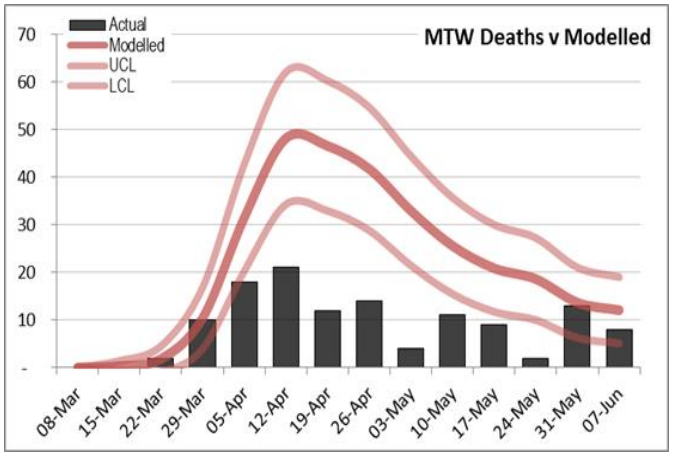
Outpatient Activity : New Outpatient activity is still 45-50%, and follow up by around 35-40%. As with elective activity, the week-by-week reduction has been slower than seen in emergency activity.. Outpatient attendances have been impacted by COVID-19 but where clinically appropriate appointments have been moved to either a telephone or virtual appointment to avoid cancellations & DNAs.

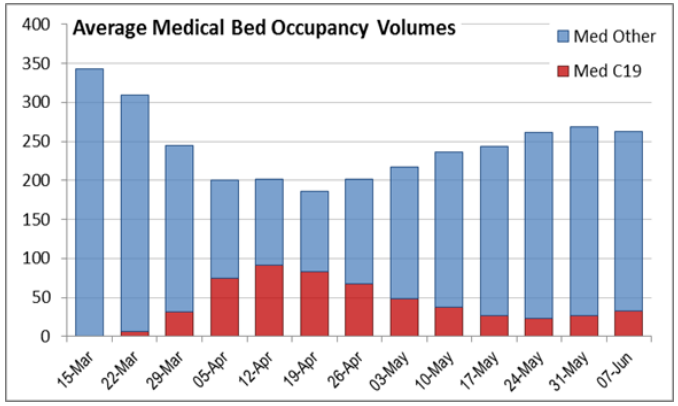
Summary : All activity levels have reduced but are gradually increasing:

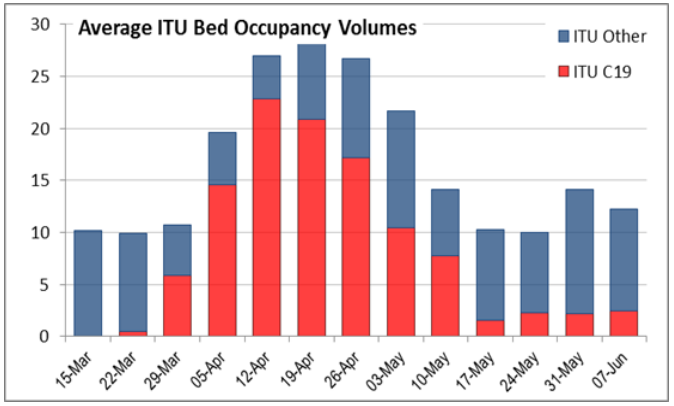
- Minor ED attendances now 30-35%
- Major down ~15%
- Emergency admissions down 20-25%
- Daycase & elective activity down 75-80%
- Total Outpatient activity down ~40%, with First attendances lower than Follow Ups.

Escalation: COVID-19









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 went down to 180-220 at the peak in early April. In the past 3 weeks, around 10% of medical bed occupancy has been Covid -19 Patients.

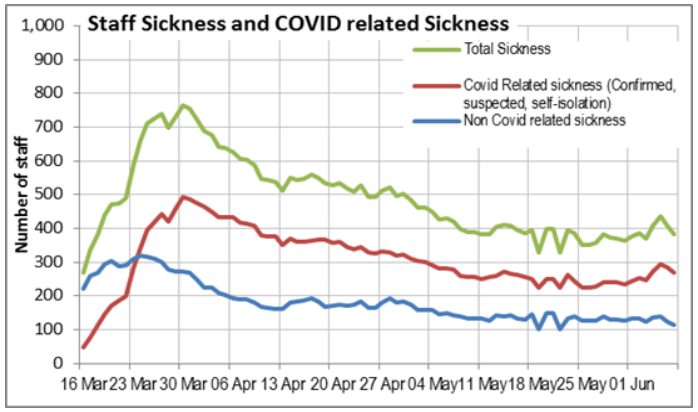
ITU Occupancy: This was around normal levels of 8-12 for the two weeks before the first Covid -19 patients arrived, before rising sharply to 25-30. For 3 weeks now, it has averaged 2 or 3 Covid -19 patients.

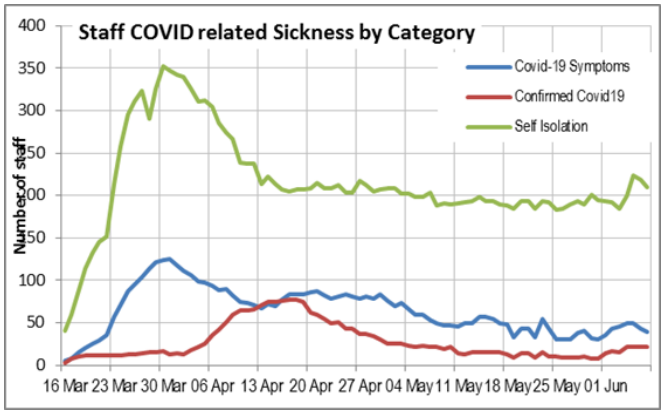
Caseload v Planning: The bed planning figures had two scenarios – good compliance with lockdown creating a peak in early April followed by a rapid falloff, and poor compliance creating a higher peak in mid-May, followed by slower falloff. Bed planning totals were set at this plus around 22%
Numbers are now increasing following the relaxation of lockdown on 11-May, though this trend is not observed nationally. There is some suggestion that we have a local cluster of cases, which is being investigated.

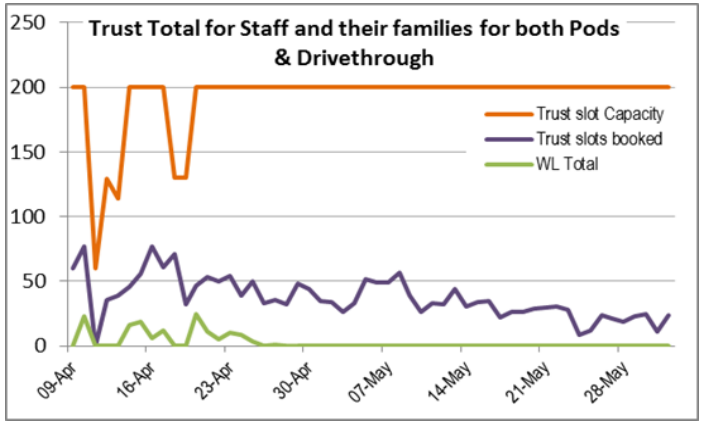
Deaths: The national total being quoted daily is hospital deaths. If deaths were spread evenly throughout the country, then by Sun 07-Jun, we would have expected our cumulative total to be 300-310. In reality it was less than half of that at 124. This, along with our caseload, indicates that our local area has not been hit as badly as others. However, along with cases, numbers of deaths have risen in recent weeks .

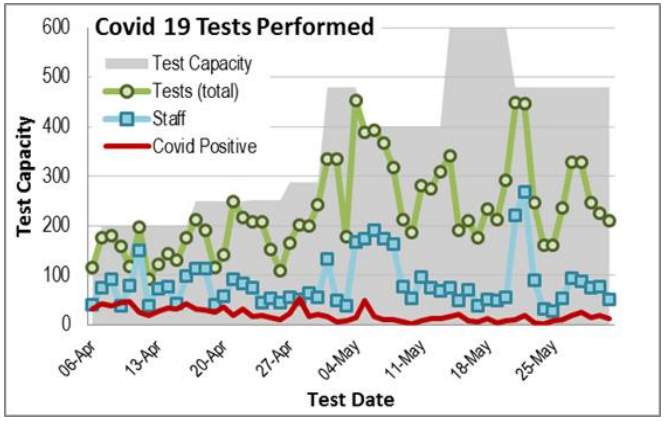
Summary :
MTW caseloads & deaths have both been tracking well below what we would expect, indicating that our region has been hit less than others. Covid-19 patients currently account for 14% of medical & 50% of ITU bed occupancy.

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 is now at an average of 130 per day.

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 250 in May, however this has started to rise slightly.

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 but has since rose again to an average of 76% (around 200 staff)

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 15% 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. During May 1,720 swabs were taken of which 46% were for MTW, 12% were for other NHS Trusts and 11% were for nursing/care homes

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 (65% May) and 64% of total capacity at the weekends (44% May). The percentage of Tests where the result was Covid positive has decreased from an average of 22% in early April, to 12% late April to 5% in May. The proportion of all tests undertaken that are for NHS Staff has decreased from 41% in April to 32% in May. The Trust laboratories are carrying out tests for other parts of Kent.

Summary: Non-Covid related sickness has continued to reduce during May.

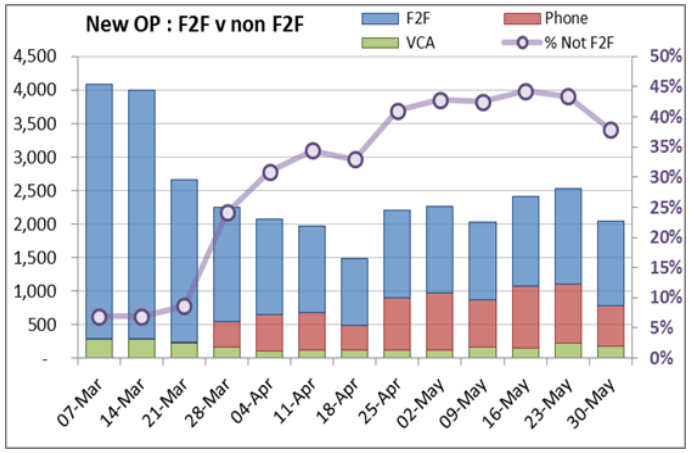
Covid-19 related sickness increased sharply after national lockdown but then showed a downward trend in April and May. Started to rise slightly in June.

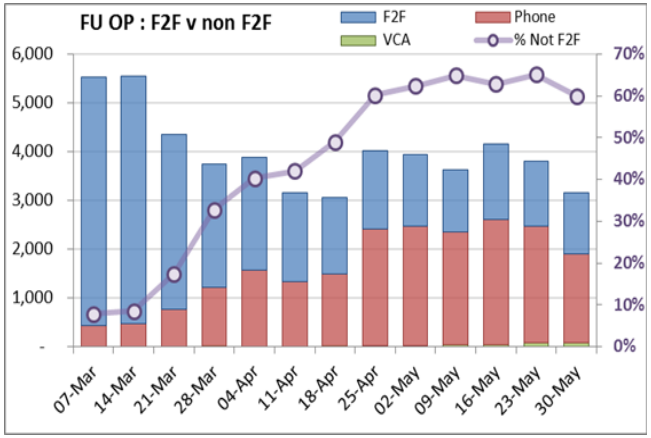
Staff Confirmed Covid-19 cases increased when central sickness line was set up as swabbing capacity increased.

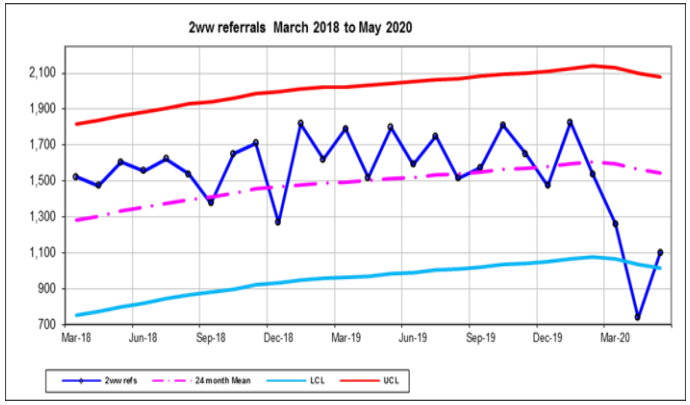
Swabbing Capacity is higher than uptake

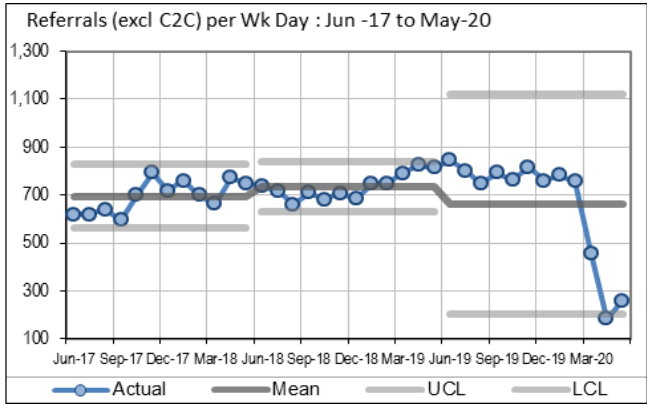
Pathology Tests performed has increased along with capacity (41% on NHS Staff)

Escalation: COVID-19









Outpatient Activity Face to Face (F2F) vs Virtual (Phone and VCA): The level of virtual outpatient activity for first (new) appointments is showing an increasing trend week on week form around 7.5% prior to the COVID-19 Pandemic to a high of around 45% in May. For follow up appointments this has also seen an increasing trend but at an even higher level from around 8% prior to Covid to around 65% in May. The main areas that are still seeing more face to face appointments are Paediatrics, Obstetrics and Therapies. With these specialties excluded the percentage of new appointments that were virtual was 58.3% for New Appointments. Other areas that continue to have more Face to Face appointments are Gynaecology and Breast Surgery.

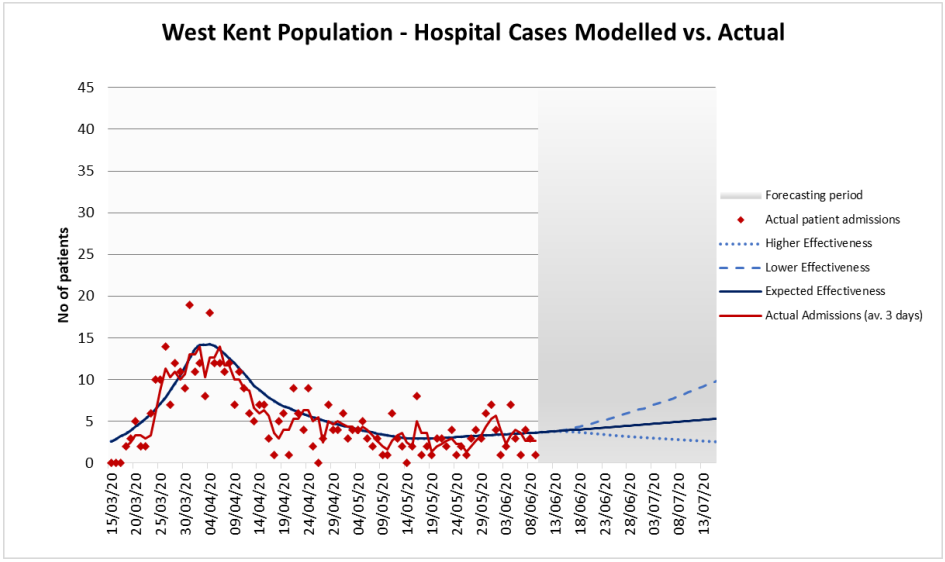
Cancer 2ww Referrals: With the effect of Covid-19, the lowest number of 2ww referrals received was at the beginning of April with weekly averages of 27 and 20 referrals received in the 2 weeks prior to Easter (10th April). The incoming referrals are increasing weekly and the numbers received are currently up to 75% of the average daily referrals from January / February 2020.)

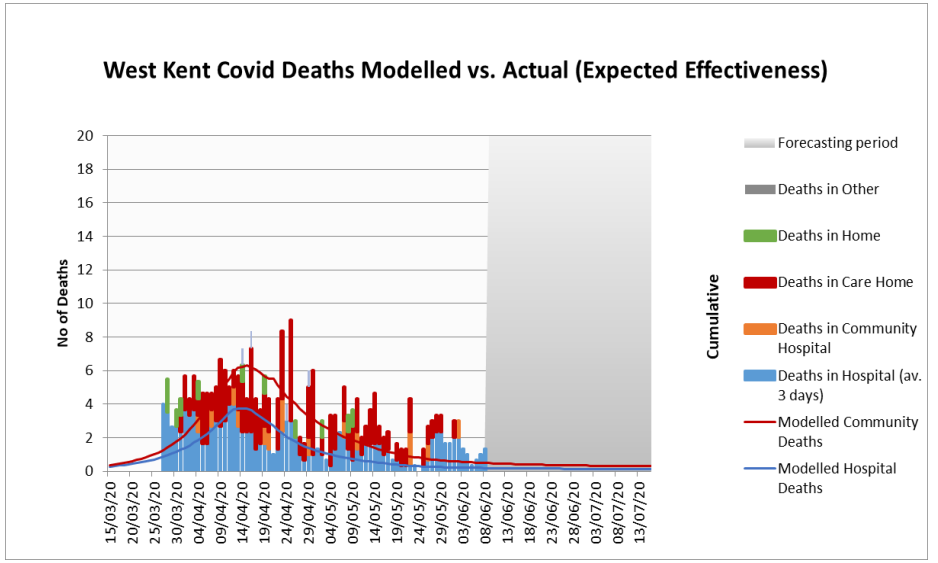
Summary: Non-Face to Face (Virtual) outpatient activity is increasing for both New and Follow Up appointments and is currently at 45% of the total new appointments being undertaken and 65% of the total follow up appointments being undertaken

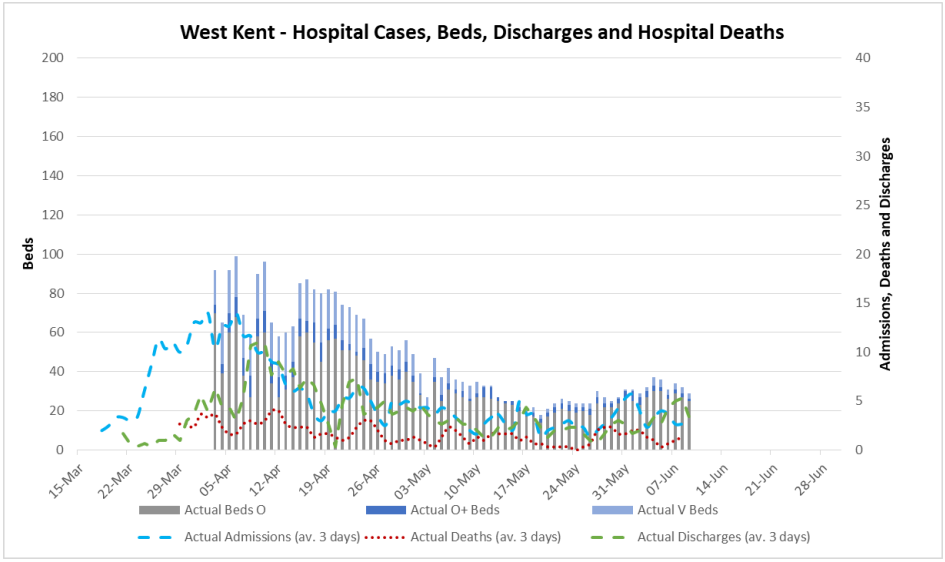
Cancer 2ww Referrals: Following the dip in 2ww cancer referrals, the level is now beginning to increase but is still currently at 75% of the average daily referrals in January and February 2020.

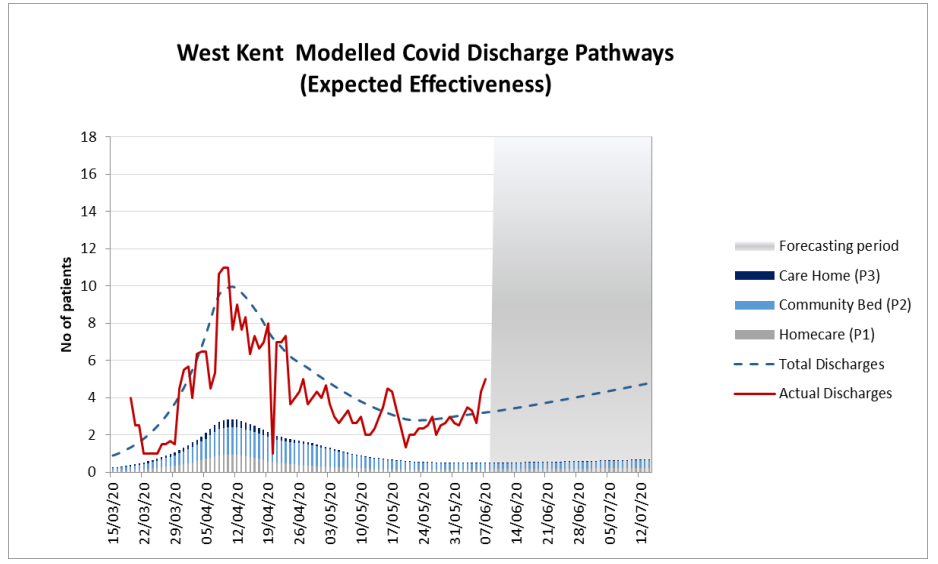
Referrals: As expected due to the COVID-19 Pandemic the overall level of referrals started to reduce in March and reduced significantly in April. Referrals have started to rise in again in May but remain significantly lower than previous levels (254 per working day in May compared to an average of 785 per working day prior to COVID-19 -68% reduction).

Escalation: COVID-19 – West Kent ICP View









The CCG has been preparing some regional modelling for commissioners and providers to use to monitor our system's response to the pandemic. These have been produced at ICS and ICP level. Above are a sample of the information that has been made available for the West Kent ICP.

Appendices

IPR Development

Integrated Performance Report Development

The Board received a presentation from NHS England and Improvement at the December Board Away Day on 'Making Data Count', a national campaign designed to improve Board-level assurance through the use of Statistical Process Control charts (SPCs). This approach is consistent with the QSIR methodology that managers across MTW are being trained in and feedback following the session was positive, with the Board expressed a desire to adopt this approach in the Trust's performance reporting. The BI Team are working on options for an updated IPR in this format with a view to launching a new style report for the July Board as per the attached project plan.

Coverage of data

Historically the performance report has focused on a set of 60 metrics that are categorised using the framework provided by the CQC domains. A subset of these metrics (25) have been used to drive a performance wheel to highlight domain level and Trust-level performance for the previous and current month as well as a forecast outturn view.

As part of the redesign of the IPR we are trying to introduce a more fluid approach to the information that is included in the report. Our intention is to have a wider bank of metrics that can be brought into the main report to support a piece of analysis or highlight a potentially unseen aspect of our performance. Equally this bank of metrics can be added to at any time to take account of the changing environment that we operate in e.g. to support the analysis of a pandemic such as Covid-19.

Reset and Recovery Programme and Strategic Objectives

There will need to be new or updated metrics included to take account of the Reset and Recovery Programme. Each workstream will have defined KPIs within their PIDs (an early view of has been provided on the next two pages). Some are existing measures (but may have revised targets), but there will also be the need to report against new metrics to track the performance and outcomes of these workstreams and the Trust Objectives as shown.

Consistent approach

All data added to the IPR will be subject to the same SPC methodology to provide a consistent view across all services and programmes. This will also ensure that all staff are familiar with the methodology and use the same terminology and language when discussing performance.

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IPR Development

	Workstream / Objective	Metric 1	Metric 2	Metric 3	Metric 4	Metric 5
Reset & Recovery Programme	Outpatients	Percentage of Non-face to face OP activity / Total activity vs.	OP Utilisation	DNAs / Cancellations / 6 Week Cancellations	Call time for patients	Reduction in time in OP waiting areas
	Elective care	RTT (Incomplete Pathways) performance against trajectory	Number of patients waiting over 40 weeks	52 week breaches	Average for new appointment	Theatre Utilisation
	Acute & Urgent	Referrals to ED from NHS 111	Super Stranded Patients	Delayed Transfers of Care	Medical Bed Occupancy / LOS / Utilisation	Ambulance Handovers / ED Performance
	Cancer	Performance against the 31 day Standard	Performance against 62 Standards	Size of backlog	Access to Diagnostics (<6weeks standard)	2 Week Wait / 28 day Target
	Social Distancing / Home Working	Number of staff home working against plan	Staff swabbing compliance against guidelines	Compliance with risk assessments e.g. BAME / at-	Use of associated technology e.g. MS Teams	Staff reporting having the equipment they need to comply
	Staff Welfare	Number of staff adopting flexible / new ways of working post-covid-	NHS Staff Engagement and Friends and Family (patients and	Appraisal Completion / Compliance and effectiveness	Take up of training and development opportunities –	Health and Wellbeing metrics
	Patient and Staff Safety	Safe Staffing Levels	Sickness Rate - Covid / Non-Covid	Infection Control - Hospital acquired Covid, MRSA, C-Diff,	Serious Incidents (Falls, Pressure Ulcers etc.)	Mortality - HSMR
	ICC	Implementation of Teletracking	PPE availability	Nursing vacancies	Covid Positive - numebr of patients	

Data available for reporting

Data source to be confirmed / put in place

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IPR Development

	Workstream / Objective	Metric 1	Metric 2	Metric 3	Metric 4	Metric 5
Organisational Objectives	Finance & Contacts (SO)	Surplus (Deficit) against B/E Duty	CIP Savings	Cash Balance	Capital Expenditure	Use of Financial Resources
	Operational Performance (SB)	Cancer - 2 Week Wait	Cancer - 62 Day	A&E	RTT	Diagnostics
	Quality and CQC (COB + PM)	Mortality	Serious Incidents	Readmissions	Stroke Best Practice Tariff	Complaints
	EPR (PM + SO)					
	Education / KMMS (PM)					
	Strategy – Estates (DW)					
	Strategy – Clinical (AJ)					
	OD / EPOC (SO)	SLDP participation and feedback metrics	Leadership & Talent Development Strategy Metrics	Culture and Leadership Programme Phase 2 (discovery)	Equality, Diversity and Inclusion reducing inequalities metrics /	Vacancy Rate / Turnover metrics
	ICP / External (AJ + PM)					
	Workforce (SH)	Sickness	Turnover	Vacancy Rates	Use of Agency	Stat and Mandatory Training

Data available for reporting

Data source to be confirmed / put in place

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REVIEW OF LATEST FINANCIAL PERFORMANCE

- The Trust delivered the year to date and May's financial position by achieving a breakeven position. In line with national guidance this included retrospective top up income support from NHSE/I (£4.9m YTD, £1.4m in May). 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 financial pressures (increase in costs and reduction in income) due to COVID 19 of £7.3m year to date (£2.8m in May). The Trust plan assumed a £0.9m top up would be required to achieve a balanced position (before COVID costs) therefore underspends within the plan of £3.3m have been made to net down the impact of COVID 19 costs to £4.9m.

- The key year to date variances to plan are as follows:
  - Drugs underspend mainly due to reduction in Oncology and Ophthalmology high cost drugs (£1.8m)
  - Pay underspends mainly within A&C and STT staff groups due to higher than planned vacancies (£1m)
  - Clinical supplies underspend (£1.1m) due to reduction in elective activities.
  - Car Parking pressure (£0.3m)
  - Laundry increase in dilapidation reserve (£0.2m)
  - EPR project costs (£0.3m)
  - Income reductions within Diagnostics relating to independent sector activity (£0.1m)
  - Increase in contingency reserves (£0.1m).

- The key current month variances are as follows:
  - Income excluding Top up income support and pass-through related costs is £1m 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, £0.4m adverse variance relating to private patients (although the PPU is net breakeven to plan), £0.1m underperformance associated with injury cost recovery and £0.1m reduction in Pathology independent sector charges.
  - Pay budgets adjusted for pass-through items overspent by £1.1m in May. Scientific and Technical (£0.2m) were the only staff group underspent which was due to vacancies within Diagnostics (£145k) and Medicine (£100k). Overspends within Nursing (£0.2m), A&C (£0.1m) and Support staff (£0.1m) are all offset by COVID related costs (£0.8m for these staff groups). Nursing and A&C have underspends (£0.4m) partly offsetting the COVID costs, these underspends are due to reduction in temporary staffing usage following ward closures as well as A&C vacancies within corporate directorates. Medical staffing overspent by £1m, which included £0.6m COVID related costs therefore £0.4m is due to pressures against budgets which is mainly in Surgery (£0.2m) due to the delay in surgery reconfiguration and £0.1m pressure within Womens and Childrens Division.
  - Non Pay budgets adjusted for pass through items underspent by £0.9m in May which includes £0.6m COVID related costs therefore a net £1.5m underspend within budgets. The key underspends to budget are: Drugs (£1.2m) mainly due to reduction in high cost Ophthalmology and Oncology drugs, clinical supplies (£0.7m) due to reduction in elective activity (mainly impacting pacemakers, pathology reagents and hearing aids) and £0.1m reduction in outsourcing costs (reduction in MRI and Endoscopy activity). Additional pressures partly offsetting underspends include; Car Parking (£0.3m), Laundry (£0.2m) increase in dilapidation reserve), and EPR project costs (£0.3m).

- The closing cash balance at the end of May 2020 was £49.2m which is similar to the closing cash balance at the end of April. The Slightly higher than normal balance is due to the Trust receiving an advance on SLA income within April. The Trust will continue to receive the "block" SLA income value for June and July as it received in May.
- Capital spend by the end of month two is £1.5m of which £1.1m relates to Covid 19 equipment, ICT and estates costs – these costs have been submitted to NHSE/I as part of the funding claims and discussions remain ongoing.
- The Trust submitted its capital plan in line with the STP/ICS level control total on the 29th May, and is making a resubmission to adjust for PFI residual interest capital on the 17th June. If the overall plans are approved by DHSC then the Trust is expecting to be able to access the element of the local control totals that includes external PDC funding, in addition to its internally generated funds (which include the £2m of cash for asset sales brought forward from 2018/19).

Maidstone and Tunbridge Wells NHS Trust

1. Dashboard

May 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	42.2	42.3	(0.1)	(0.1)	(0.1)		86.8	84.6	2.2	(0.2)	2.4	
Expenditure	(39.8)	(39.7)	(0.1)	0.1	(0.2)		(81.8)	(79.4)	(2.4)	0.2	(2.7)	
EBITDA (Income less Expenditure)	2.4	2.6	(0.2)	0.0	(0.2)		4.9	5.2	(0.3)	(0.0)	(0.3)	
Financing Costs	(2.4)	(2.6)	0.2	0.0	0.2		(5.0)	(5.2)	0.2	0.0	0.2	
Technical Adjustments	0.0	0.0	0.0	0.0	0.0		0.1	0.0	0.1	0.0	0.1	
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	49.2						49.2				0.0	
Capital Expenditure	0.6						1.5				0.0	

Summary Current Month:

- The Trust delivered the financial plan in May by achieving a breakeven position. In line with national guidance this included £1.4m 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 in May has identified £2.8m of costs and income reductions associated with COVID 19, the Trust plan assumed £0.45m top up would be required to achieve a balanced position (before COVID costs) therefore underspends totalling £1.85m have been made to net the impact down to £1.4m. The key underspends against plan are: Drugs £1.2m due to reduction in high cost Cancer and Ophthalmology drugs, £0.6m clinical supplies due to reduction in elective activity and £0.4m underspend with A&C (£0.1m) and STT (£0.3m) staff groups due to higher than planned vacancies, £0.2m depreciation less than planned and £0.1m underspend within independent sector usage. Overspends due to pressures associated with Car Parking (£0.3m), Laundry (£0.2m increase in dilapidation reserve), EPR project

Year to date overview:

- The Trust has delivered a breakeven financial position which includes £4.9m retrospective top up income support.
- The Trust has identified financial pressures (increase in costs and reduction in income) due to COVID 19 of £7.3m, the Trust plan assumed £0.9m top up would be required to achieve a balanced position (before COVID costs) therefore underspends within the plan of £3.3m have been made to net down the impact to £4.9m. The key underspends to plan are: Drugs (£1.8m) mainly due to reduction in Oncology and Ophthalmology high cost drugs, pay underspends (£1m) mainly within A&C and STT staff groups due to higher than planned vacancies, £1.1m underspend within clinical supplies due to reduction in elective activities and £0.2m underspend within independent sector usage. These underspends are partly offset by pressures associated with Car Parking (£0.3m), Laundry (£0.2m increase in dilapidation reserve), EPR project costs (£0.3m), income reductions within Diagnostics relating to independent sector activity (£0.1m) and increase in reserves(£0.1m).

Key Points:

- In line with Aprils funding assmption the Trust recieved £3.5m retrospective topup income from NHSI/E on the 15th June.

Risks:

- The Trust won't be notified by NHSI/E of the final retrospective top up value for May until the 15th July

2. COVID 19 Expenditure and Income Impact

2020/21 Summary of Cost Reimbursement

Total Revenue (£000s):	6,301

Breakdown by Allowable Cost Type	£000s
Expanding medical / nursing / other workforce	154
Sick pay at full pay (all staff types)	0
COVID-19 virus testing (NHS laboratories)	857
Remote management of patients	0
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)	1,272
Segregation of patient pathways	549
Enhanced PTS	0
Business Case (SDF) - Ageing Well - Urgent Response Accelerator	0
Existing workforce additional shifts	355
Decontamination	0
Backfill for higher sickness absence	719
NHS 111 additional capacity	0
Remote working for non patient activites	197
National procurement areas	1,470
Other	728

Summary: Loss of income

Total (£000s):	1,005

Breakdown by income type	£s
Car parking income	422
Catering	107
Pathology Trade Income	120
Private Patient Income	186
Injury Recovery Income	54
Other	116

Grand Total

Total (£000s):	7,306

Commentary:
The Trust has identified the financial impact relating to COVID to be £7.3m, which includes £6.3m associated with additional expenditure and £1m 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, sickness cover, additional on calls and extended opening hours for support teams.

The Trust has received the funding relating to 2019/20 (£2m) as well as the April 2020 retrospective top up funding (£3.5m). The Trust will be notified on the 15th July of the retrospective top up funding for May (£1.4m).

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST
Women's and Children's
Perinatal Mortality report
June 2020
Covering Quarter 1 2020/2021

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Division:	Women's and Children's
Specialty:	Maternity

1. Introduction

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

The tool supports:

- Systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care;
- Active communication with parents to ensure they are told that a review of their care and that of their baby will be carried out and how they can contribute to the process;
- A structured process of review, learning, reporting and actions to improve future care;
- Coming to a clear understanding of why each baby died, accepting that this may not always be possible even when full clinical investigations have been undertaken; this will involve a grading of the care provided;
- Production of a report for parents which includes a meaningful, plain English explanation of why their baby died and whether, with different actions, the death of their baby might have been prevented;
- Other reports from the tool which will enable organisations providing and commissioning care to identify emerging themes across a number of deaths to

support learning and changes in the delivery and commissioning of care to improve future care and prevent the future deaths which are avoidable;

- Production of national reports of the themes and trends associated with perinatal deaths to enable national lessons to be learned from the nation-wide system of reviews.

- Parents whose baby has died have the greatest interest of all in the review of their baby's death. Alongside the national annual reports a lay summary of the main technical report will be written specifically for families and the wider public. This will help local NHS services and baby loss charities to help parents engage with the local review process and improvements in care.

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

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

2. Overview:

There was one outstanding PMRT review from 2019 which was a second trimester loss where the mother had a complication due to previous surgery. This pregnancy was the subject of a SI and there were no avoidable factors identified in relation to preventing the unexpected demise of the fetus.

The content in this report covers activity up to and including the 15th June 2020 due to the scheduling of the Trust Board Meetings.

There has been one fetal loss in Quarter 1 2020/2021. This was in the 3rd trimester. This case involved a teenage mother who concealed her pregnancy; she received no antenatal care and delivered her stillborn baby at home alone. The Bereavement Team sought advice from MBBRACE and was advised that a PMRT review was not necessary in these circumstances and the case would not be counted in our statistics. Similarly it was decided that an internal review was not needed by the Risk Team as there was no care to review. There was some learning identified from the Safeguarding Team in relation to other agencies' processes in the earlier stages of the mother's pregnancy and these are being monitored by the CCG.

2020 Cases

Date	Case type	SI declared	PMRT COMPLETED
15/01/20	25+6 Stillbirth	No	PMRT complete. Report to be amended to include parental comments after a postnatal appointment.
07/02/20	35 Stillbirth	No	Report complete
25/02/20	29+3 Stillbirth	No	Report complete
25/2/20	41+5	No	Report complete
10/03/20	40 Stillbirth	No	Report complete
27/03/20	Term stillbirth. Exact gestation unknown	No	PMRT not required according to MBBRACE as concealed pregnancy, delivery at home with no antenatal care. Learning required from outside agencies, CCG monitoring this learning.

4. Learning from cases

Learning from cases 2019	Action	Action required/Completed	Completed
Adequate documentation of review of ultrasound scans.	If ultrasound scans are carried out for women thought to have underlying risk factors then there needs to be clear documented evidence that there has been reviewed and any appropriate action taken. Community midwives are to ensure that there is documented evidence that scan results have been reviewed either by themselves if normal or appropriate obstetric referral if necessary.	1. Rachel Thomas to email the community team leads and the Antenatal clinic team lead to ensure that midwives know that this is the expectation By 31st March 2. Invigorated training for Gap and Grow needs to be undertaken. This will be led by the new in post Fetal Wellbeing midwives that are due to start in April. Till then there is a focus on the online training compliance and feedback to individuals where issues have been identified. <u>Update 15/6/20</u> Fetal Wellbeing Team in place and have commenced virtual and limited numbers in house for Gap and Grow training. An infographic will be sent out shortly as an aid to Midwives in plotting SFH as an interim measure until compliance is up to	√ 20/3/2020 Fetal Wellbeing Midwives May 2020 15/6/20

		standard.	
Apparent capacity issues in obstetric antenatal clinics and lack of clarity amongst midwives over how to escalate this if necessary	Review of process followed to obtain antenatal clinic review appointments Review of agreed process of escalation if difficulty experienced by community midwife in obtaining obstetric review appointment. Involvement of assistant General Manager in this review	1. Nathan Sims/Sarah Mander-McGregor/ Alison Mendes to formulate pathway should there be lack of antenatal clinic appointments Update 15/6/20 This action was on hold due to Covid 19 but is now being addressed. AM has left the organisation and so SMM will lead. This is due to be completed by 15th July 2020	30th April 2020 NS/SMM/AM
The mother should have had an interpreter at every visit and especially at booking. However it was not clear on the referral what language was spoken by the mother and so the midwife would not have known to book one. It is unclear whether the mother understood the information about smoking cessation as she declined intervention.it is documented that she was waiting for a prescription for aspirin at 20w which suggests that she had not fully understood that process for obtaining aspirin and the importance of taking it from 12 weeks. Every effort should be made by the maternity service to ensure that an interpreter is present or that language line	Matrons to be aware of the case and cascade to teams the importance of booking a face to face interpreter. It is difficult when no language is specified on the booking however the appointment should be rebooked with an interpreter is necessary	Email to ensure awareness that interpreters are necessary at every visit Community midwives leads to do an audit to assess whether partners are being used as interpreters. This will be fed back through the Maternity Forum in September	√ 11/2/2020 Sept 2020
The mother had investigations on the antenatal ward and was discharged before the results were available. There is no pathway for ensuring the results are communicated to the woman until the next	The Antenatal ward should formulate a robust system for following up test results and communicating them to the women	Majority of women will have their results before they are discharged. There is a results book now on Antenatal ward which is the responsibility of the Band 7 to check each day to see if any results are communicated. As a failsafe, women are also told to call Triage if they do not hear about their results	√ Louise Jarvis, Deputy Antenatal Ward Manager 20/3/2020

contact with a health professional that would be relied upon to look up them up.			
Symphysis Fundal Height not correctly plotted on Gap and Grow chart	Invigorate training for Gap and Grow. New Fetal Wellbeing Midwives to start in April who will undertake the training. Random audits to be undertaken by community leads	Fetal Wellbeing midwife will include SFH training in their remit. In the meantime, midwives are reminded to use the correct methods by their team leads. Update 15/6/20. Delay in commencement of new Fetal Wellbeing team due to Covid 19 and recruitment issue. The new Gap and Grow training package adapted for Covid 19 has now been launched as a virtual and in house learning. Fetal Wellbeing Team will produce an infographic tool to advice on correct plotting of SFH. This will be in addition to the training package and will support Midwives until all staff is compliant.	15/6/20Training package has now been launched. Email sent to team leads 20/3/2020
Inadequate assessment on Triage when presenting with abdominal pain at 25+4w	Feedback to individual doctor	Maggie Matthews Consultant Obstetrician	30th April 2020 Update needed from Miss Matthews requested
Learning from cases 2020	Action	Action required/Completed	Completed
Understanding the correct route of administration of Mifepristone on initial dose. Error made by staff member, administered vaginally instead of orally	Internal review completed Action plan made. Duty of Candour to patient.	Staff member responsible to write reflective practice and discuss with educational supervisor. Fetal loss guideline to be adjusted to reflect that mifepristone must be given orally. Feedback to pharmacy lead and refection requested	Reflective work completed by staff member. Pharmacy staff have been involved in the internal review process and have evidenced their learning from the incident. Guideline adjusted to emphasise route of administration. 5/3/20

5. Summary

All families that have had a PMRT review were asked for their questions and these were all included in the terms of reference for the review. Families are given feedback from the review and it is discussed where possible at the postnatal follow up appointment with the obstetrician. Where possible, the obstetrician is present at the PMRT review so that they are fully informed of the discussion around the case.

In 4 out of the 5 cases there was an external person involved in the review. This is a requirement of the CNST standard. We have a network of individuals from neighbouring Trusts and SECAMB which help us gain an independent perspective. There was 1 review which did not involve an external person; this was during the peak of the Covid crisis on the 15/4/20, however the review was attended by 2 Obstetric Consultants and 4 senior Midwives.

For all 5 cases reviewed in 2020 there were no issues with care identified up to the point that the baby was confirmed as having died. The Risk Team work within the PMRT process and a running action log on their internal review database is kept, which monitors and records actions from PMRT cases. All of the actions identified on completion of the 5 reviews have been completed or are in progress and being monitored for completion.

All PMRT cases from 2018 and 2019 will be reviewed as part of a wider analysis of all complaints, Serious Incidents, legal and HSIB (Healthcare Safety Investigation Branch) cases in this timeframe. This “deep dive” aims to give assurance to the Trust Board (via the Quality Committee) that risks, incidents and patient experience are being managed safely and compassionately within the Directorate. Themes and learning will be extracted from these data and the Directorate will ensure that actions have been taken and that learning has been embedded into practice. This report will be presented to the Quality Committee “deep dive” meeting in October 2020. The review of the 2018 and 2019 PMRT cases will be included in the next PMRT report.

Families continue to be supported by the bereavement midwives. The maternity service presented a proposal to offer 6 counselling sessions for bereaved parents at a “Dragon’s Den” event. This idea was wholly supported by the executive and plans for how this can be realised are being discussed.

Work is ongoing to embed the standards of the National Bereavement Care Pathway (NBCP) within our care of bereaved parents across the areas of A/E, Screening, Gynae, Maternity, NNU and Paediatrics.

Planned and actual ward staffing for May 2020.

May-20		DAY				NIGHT				TEMPORARY STAFFING								Financial review		
Hospital Site name	Health Roster Name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Bank/Agency Usage	Agency as a % of Temporary Staffing	Bank / Agency Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand Unfilled -RM/N (number of shifts)	Overall Care Hours per pt day	Falls	PU ward acquired	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Stroke Unit (M) - NK551	103.0%	101.9%	-	100.0%	109.0%	121.3%	-	-	21.4%	4.1%	50	3.25	6	13.5	3	0		118,547	151,706	(33,159)
MAIDSTONE	Cornwallis (M) - NE959	79.5%	67.0%	-	100.0%	85.5%	71.0%	-	-	2.3%	0.0%	2	0.14	0	13.0	1	0		80,201	73,655	6,546
MAIDSTONE	Culpepper Ward (M) - NS551	88.9%	78.7%	-	-	101.6%	99.9%	-	-	16.0%	13.0%	53	3.67	2	10.0	0	0		101,835	110,328	(8,493)
MAIDSTONE	John Day Respiratory Ward (M) - NT151	107.6%	79.1%	-	-	114.3%	96.8%	-	-	30.0%	22.2%	92	6.41	16	13.9	3	0	Redcued fill rate in line with bed occupancy between 8-17. Staff redeployed to supportstaffing on Peale ward.	143,870	148,257	(4,387)
MAIDSTONE	Intensive Care (M) - NA251	113.2%	148.8%	-	-	107.1%	125.9%	-	-	17.3%	8.6%	106	6.31	18	41.5	1	1	1 fall above threshold. Increased fill rate with staff mapped across two ITU areas in response to managing COVID	163,807	199,422	(35,615)
MAIDSTONE	Pye Oliver (Medical) - NK259	101.5%	88.4%	-	-	120.4%	109.7%	-	-	31.9%	56.4%	122	8.46	10	9.3	2	1		115,683	118,113	(2,430)
MAIDSTONE	Chaucer Ward (M) - NS951	89.9%	87.5%	-	-	104.8%	96.1%	-	-	34.4%	25.5%	89	6.00	15	131.2	0	0		95,723	108,774	(13,051)
MAIDSTONE	Whatman Ward - NK959	80.0%	89.4%	-	100.0%	148.4%	116.1%	-	-	40.6%	28.9%	110	7.73	7	12.6	1	0	Staffing reflective of bed occupancy between 6-15 throughout the month. Staffing supporting with TNA and aspirant nurses.	81,444	108,077	(26,633)
MAIDSTONE	Lord North Ward (M) - NF651	91.1%	90.8%	-	100.0%	81.7%	100.0%	-	-	2.8%	0.0%	8	0.59	0	9.6	0	0	Bed occupancy between 8-15.	94,903	97,252	(2,349)
MAIDSTONE	Mercer Ward (M) - NJ251	99.1%	129.4%	-	100.0%	100.0%	124.2%	-	-	23.1%	26.2%	45	3.03	3	7.7	5	0	Increased CSW fill rate to support enhanced care requirements	106,119	112,980	(6,861)
MAIDSTONE	Edith Cavell (M) - NS959	87.7%	61.9%	-	100.0%	69.6%	71.4%	-	-	1.7%	19.7%	4	0.17	0	6.2	1	3		66,317	90,620	(24,303)
MAIDSTONE	Acute Medical Unit (M) - NG551	94.6%	111.5%	-	-	115.1%	196.8%	-	-	28.9%	22.2%	99	6.48	13	20.4	2	0	Increased CHPPD reflective of bed occupancy between 4 and 10 across the month	151,755	143,258	8,497
TWH	Ward 22 (TW) - NG332	119.0%	79.3%	-	100.0%	111.9%	88.0%	-	100.0%	27.1%	4.5%	82	5.68	3	6.6	3	0	Staffing supported throughout the month with redeployed staff from ward 10	101,813	104,045	(2,232)
TWH	Coronary Care Unit (TW) - NP301	106.8%	97.8%	-	-	104.8%	-	-	-	15.7%	11.5%	32	2.00	1	13.9	2	1	2 falls above threshold. Bed occupancy between 2-8	70,590	67,228	3,362
TWH	Ward 33 (Gynae) (TW) - ND302	98.1%	96.3%	-	-	100.0%	96.2%	-	-	13.8%	0.0%	28	1.76	0	14.8	0	0		116,857	103,072	13,785
TWH	Intensive Care (TW) - NA201	119.7%	136.2%	-	-	108.6%	94.1%	-	-	9.3%	0.0%	72	4.55	7	37.0	0	0		230,298	242,953	(12,655)
TWH	Acute Medical Unit (TW) - NA901	86.9%	84.4%	-	100.0%	93.6%	97.8%	-	-	17.6%	12.1%	112	7.54	16	15.0	4	0	Reduced fill rate reflective of lower bed occupancy. Staff redeployed to support organisation staffing in ED and medicine.	213,340	168,362	44,978
TWH	Surgical Assessment Unit (TW) - NE701	100.0%	100.0%	-	-	100.0%	100.0%	-	-	13.8%	0.0%	9	0.62	0	193.2	0	0	Patients all triage (no overnight stays)	64,955	64,255	700
TWH	Ward 32 (TW) - NG130	83.7%	87.5%	-	-	95.3%	63.4%	-	-	8.6%	2.4%	17	1.10	1	8.5	3	0	1 fall above threshold	143,059	113,581	29,478
TWH	Ward 10 (TW) - NG131	61.3%	54.7%	-	100.0%	69.4%	80.6%	-	-	0.0%	No hours	No Demand	No Demand	No Demand	-	-	-	Ward remained closed but staffing aligned to base cost centre	122,602	91,052	31,550
TWH	Ward 11 (TW) Winter Escalation 2019 - NG144	12.5%	25.0%	-	-	20.0%	17.5%	-	-	0.0%	No hours	No Demand	No Demand	No Demand	-	-	-	Ward remained closed but staffing aligned to base cost centre	0	356	(356)
TWH	Ward 12 (TW) - NG132	110.7%	105.9%	-	100.0%	123.7%	99.2%	-	-	23.6%	40.1%	81	5.38	7	8.2	11	0	4 falls above threshold. Staffing supported with aspirant nurses.	130,719	139,174	(8,455)
TWH	Ward 20 (TW) - NG230	150.4%	92.6%	-	-	98.9%	100.8%	-	-	34.6%	4.5%	69	4.60	6	6.3	15	0	8 falls above threshold	123,701	128,439	(4,738)
TWH	Ward 21 (TW) - NG231	112.5%	120.4%	-	100.0%	97.4%	119.4%	-	-	25.1%	20.5%	96	6.28	12	11.6	5	2	Bed occupancy between 12 - 30 during the month. Additional staffing levels to support COVID and increased acuity.	134,598	143,969	(9,371)
TWH	Ward 2 (TW) - NG442	117.1%	110.5%	-	100.0%	100.6%	104.3%	-	-	23.0%	7.9%	51	3.35	8	9.7	7	1	Bed occupancy increased since last month review. Some increased fill rate due to enhanced care needs on	132,182	124,575	7,607
TWH	Ward 30 (TW) - NG330	98.4%	93.7%	-	-	84.1%	107.5%	-	-	20.5%	12.3%	46	2.90	1	6.6	8	1	3 falls above threshold. Enhanced care requirements reported throughout the month	124,424	122,289	2,135
TWH	Ward 31 (TW) - NG331	98.7%	87.2%	-	100.0%	103.2%	87.1%	-	-	16.2%	8.9%	45	2.80	3	8.7	3	1	Bed occupancy between 10 and 29. Staffing levels supported with redeployed staff from MOU	129,079	130,553	(1,474)
Crowborough	Crowborough Birth Centre (CBC) - NP775	66.8%	111.1%	-	-	100.5%	100.0%	-	-	4.3%	0.0%	18	1.05	0			0	Considered action to prioritise the night with Community teams support during the day	69,332	81,415	(12,083)
TWH	Midwifery (multiple rosters)	83.9%	54.9%	-	-	99.6%	71.8%	-	-	13.8%	0.7%	473	26.49	17	26.6	0	0	Delivery suite prioritised to ensure safe staffing levels. MSW	727,859	676,272	51,587
TWH	Hedgehog Ward (TW) - ND702	88.7%	212.3%	-	-	84.5%	-	-	-	9.0%	38.2%	50	3.32	4	16.7	0	0	Bed occupancy between 7 - 16. RMN requirements across 5 days / nights and enhanced care on 2 nights.	155,237	141,237	14,000
MAIDSTONE	Maidstone Birth Centre - NP751	101.4%	100.0%	-	-	98.5%	96.8%	-	-	16.8%	0.0%	34	2.12	1		0	0		72,755	69,379	3,376
TWH	SCBU (TW) - NA102	78.0%	550.6%	-	-	99.9%	-	-	-	11.6%	0.0%	89	4.55	2	15.6		0	Cot occupancy between 7 - 15. Recorded 3 amber days during the month all other days green.	175,775	172,402	3,373
MAIDSTONE	Short Stay Surgical Unit (TW) - NE901	102.8%	28.6%	-	-	92.9%	0.0%	-	-	2.2%	0.0%	5	0.34	0	6.7	0	0		46,531	55,616	(9,085)
MAIDSTONE	Short Stay Surgery Unit (M) - NE751	-	-	-	-	-	-	-	-	0.0%	No hours	No Demand	No Demand	No Demand	-	0	0		86,027	52,192	33,835
MAIDSTONE	Chronic Pain Escalation - NE751	86.2%	59.7%	-	-	106.5%	-	-	-	6.3%	26.6%	5	0.34	0	23.5	3	0	3 falls above threshold			
MAIDSTONE	Accident & Emergency (M) - NA351	111.1%	81.1%	-	-	128.1%	93.5%	-	-	38.5%	30.9%	275	18.21	14		1	0	MH-1 fall above threshold. Some increased fill rate to support COVID pathways	199,158	255,703	(56,545)
TWH	Accident & Emergency (TW) - NA301	97.8%	120.7%	-	100.0%	103.6%	157.3%	-	-	36.7%	33.6%	349	23.71	15		2	0	TWH - 2 falls above threshold Some staff sickness during the motnh	335,142	383,646	(48,504)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	36.6%	47.4%	-	-	0.0%	-	-	-	0.0%	No hours	No Demand	No Demand	No Demand			-	Ward remained closed but staffing aligned to base cost centre	52,889	20,025	32,864
MAIDSTONE	Peale COVID - ND451	118.7%	52.3%	-	-	94.8%	90.3%	-	-	40.2%	54.8%	99	6.97	4	23.5	1	0	Increased CHPPD refelctive of reduced bed occupancy between 1-8 throughout the month.	0	53,865	(53,865)
																		Total Established Wards	5,079,126	5,171,104	(91,978)
																		Additional Capacity beds Cath Labs	38,844	40,975	(2,131)
																		Whatman	0	0	0
																		Foster Clarke Winter Escalation 2019	0	3,006	(3,006)
																		Edith Cavell (M) - NS459	0	6,725	(6,725)
																		Ward 32 (Wells Suite) (TW) - PP010	0	0	0
																		Other associated nursing costs	3,552,045	3,484,223	67,822
																			8,670,015	8,703,027	(33,012)

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

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

Enclosed is the Infection prevention and control board assurance framework.

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 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

Publications approval reference: 001559

Infection prevention and control board assurance framework

22 May 2020, Version 1.2

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and also as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May
Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, PHE and related guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users and staff.

We have developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. In the context of COVID-19, there is an inherent level of risk for NHS staff who are

treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated effectively.

Infection Prevention and Control board assurance framework

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• infection risk is assessed at the front door and this is documented in patient notes	• ED triage in place at front door on both sites. Patients assessed with temperature check and observations prior to booking in. Infection risk assessed and documented in ED notes and Symphony. Copy of ED notes in in-patient record for admitted patients. Pathway documented and agreed with CRG and ICC	• No audit data available	• Deviations from pathway reported as Datix incidents
	• Temperature checks in place at front door for obstetric patients and accompanying birth partner. Elective C section patients have Covid swab 48 hours prior to admission. Pathway documented and agreed with CRG and ICC	• No audit data available	• Deviations from pathway reported as Datix incidents
	• All patients and visitors have temperature check at front door. Mask provided to patients and visitors who do not have face coverings		
• patients with possible or confirmed COVID-19 are not moved unless this is essential to	• Patients with confirmed Covid infection cohorted in specified wards. Patients moved for escalation of care and de-		

their care or reduces the risk of transmission	escalation from ICU care only. • Stated aim is to keep confirmed cases in Covid cohort area throughout their inpatient stay. Where step-down is necessary for clinical reasons, two negative swabs are required at least 14 days after diagnosis before step down can be actioned. Infection prevention approve on case-by–case basis. Guidance published through ICC on Covid intranet page		
• compliance with the national guidance around discharge or transfer of COVID-19 positive patients	• National guidance followed in all cases. Local guidance developed from national guidance and published through daily staff Bulletin and Covid pages on intranet.		
• All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to PPE that protects them for the appropriate setting and context as per the PHE national guidance	• National guidance on PPE implemented within Trust. FIT testing for FFP3 masks in place with resources identified and PPE project team managing resources on day to day basis. • Regular discussion at executive level. • Procurement lead sits in ICC • Active monitoring of PPE burn rate and stocks • All patient facing staff trained in use of PPE and supported by PPE officers • New continual mask wearing guidance implemented. Masks provided for non-patient facing staff as appropriate • Use of powered air respirators monitored through site offices with documented log and cleaning	• PPE audits ongoing but not yet reviewed at Infection Prevention and Control Committee • Just-in-time deliveries of PPE limit flexibility in burn rate • Availability of differing types of FFP3 masks is variable • National shortage of single use hats	• PPE officers on duty every day. Educational, supportive and monitoring role. Advise on PPE use. Induction training for new staff • Active management of stocks by procurement leads. Electronic monitoring system in place • Repeated FIT testing required on new mask stocks • Investment in reusable respirator masks • Purchase of reusable hats

	• Regular updates provided to staff through ICC and daily bulletin • PPE guidance available on Covid page of Trust intranet • Posters and signage with PPE information in donning and doffing areas.		
• national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	• DIPC and deputy DIPC responsible for checking for updates to national guidance and advising executive team. • Updates shared with staff in daily Covid Bulletin and Covid intranet page • DIPC is SRO for Patient and Staff Safety work stream • IPC team support ward staff in implementing changes • IPC team work arrangements flexed to provide 24/7 cover during escalation • IPC leadership on key workstreams		
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• DIPC is member of exec team and updates as required • Covid update is standing item on Board agenda		
• risks are reflected in risk registers and the Board Assurance Framework where appropriate	• ICC risk register reflects IPC risks associated with Covid-19 • DIPC attends Trust Board meetings		
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• All pre-existing IPC risk assessment processes and policies remain in place for non-Covid-19 infections • Trust compliant with Hygiene Code prior to pandemic.	• IPC PPE requirements for non-Covid infections are superseded by Covid requirements. Additional risks	• IPC team advising on a case-by-case basis. Variation to some policies required. Documented on ICNet.

	• IPC team reinforce practice at ward level	recognised eg for C. difficile and Covid co-infection	
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	• Covid cohort areas on both sites including respiratory HDU and ICU escalation areas. • ICU training programme for non-ICU trained staff required to work on ICU. • Consultant anaesthetist rota to provide 24/7 on site ICU cover. • ICU-trained nurse/patient ratio decreased during escalation with additional staff to assist. • Covid wards fully staffed. Consultant of the week rota for senior medical cover • IPC team and PPE officer support to Covid wards • Respiratory HDU staffed by respiratory trained nurses and consultants		
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	• Cleaning standards in place for cleaning during the pandemic. • Facilities staff trained in donning and doffing PPE and FIT tested where appropriate.		
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried	• Decontamination and terminal cleaning completed according to national	• Cleaning audits to be reported to IPCC and divisions	• Lapses in cleaning standards reported as Datix incidents

out in line with PHE and other national guidance	guidelines. • All surfaces cleaned with Diff X including walls • In-house cleaning teams in place		
• increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	• Increased frequency of cleaning complies with national guidance for most areas • Regular cleaning audits undertaken and results monitored. • Report to IPCC	• Further resource required to meet standard fully.	• Will be in place by 22/6/20
• Attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas	• Increased attention is given to cleaning of toilets and bathrooms • Ongoing reminders to staff to ensure this is maintained		
• Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (ICPT) should be consulted on this to ensure that this is effective against enveloped viruses	• Diff X confirmed as suitable cleaning agent for enveloped viruses by IPCT		
• Manufacturer's guidance and recommended product contact time' must be followed for all cleaning/disinfectant solutions/products	• Manufacturer's guidance is followed in all areas • Instructions are displayed where needed • Environmental cleaning policy reflects manufacturers requirements		

• As per national guidance: o 'frequently touched' surfaces, eg door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids	• In place for most areas	• Additional resource required for full compliance	• Will be in place by 19/6/20
o Electronic equipment, eg mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily	• Staff advised to clean equipment as in guidance. • Pre-existing guidance for clinical areas	• Difficulty in sourcing sustainable supply of suitable cleaning product for work stations in non-clinical areas	• Limited supply secured
o Rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	• Regular daily cleaning in place	• Additional resource required for full compliance	• Will be in place by 19/6/20
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	• All linen from Covid cohort wards treated as infectious linen		
• single use items are used where possible and according to Single	• Single use items used widely across the Trust.		

Use Policy • reusable equipment is appropriately decontaminated in line with local and PHE and other national policy • Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	• Policy in place and available to staff on the Trust intranet • The provider of surgical reusable instrument decontamination for MTW: IHSS Ltd: is run in accordance with audited quality management systems. • The service is accredited to EN ISO 13485:2012 and MDD 93/42/EEC-Annex V. • In respect of Covid-19 all processes have been assessed to meet the current guidance. Additional precautions and measures have been put in place in line with local, PHE and national policy. • Tunbridge Wells Hospital was constructed fourteen years ago and is designed with ventilation supply and extract systems in clinical, rest, dining and administration areas. The ventilation in this building is compliant with the NHS Health Technical Memoranda HTM 03-01. HTM 03-01 specifies a high standard of supply and extract ventilation design with single pass air supply and no recirculation of internal for infection control purposes. • Maidstone Hospital was constructed in 1986. The building is a “Nucleus Design“ hospital constructed on design concept of natural ventilation rather than mechanical ventilation by the use of opening windows. Operating Theatres and pharmaceutical		

	production areas all installed with HTM 03-01 ventilation systems.		
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained	• Antimicrobial stewardship continues as for pre-Covid. • Antimicrobial stewardship group has continued to meet throughout. ASG reports to Drugs, Therapeutics and Medicines Management Committee • Antimicrobial report to IPCC • Training for new doctors has continued • Ward pharmacists review prescribing • Guidance for antibiotic prescribing in Covid patients issued by ASG	• Routine ward based audits suspended for April and May	• C. difficile PII audits continuing • Reports to IPCC reinstated for June
• mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Mandatory reporting of antimicrobial usage has continued. • IPCC and DTMMC report to Quality committee		
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a	• Visitors permitted only on compassionate grounds and to assist		

care setting	patients with specific needs • Birth partner allowed. Both parents can visit in neonatal unit. Covid testing in place to facilitate this. • Outpatients have accompanying person only when required for care needs • Review of visiting is included in objectives of Patient and Staff Safety work stream • All visitors have temperature checks at the front door • Mask provided to patients and visitors who do not have face coverings • Support in place for relatives to deliver patient property • Ethics committee have reviewed Visiting policy • Viewings of deceased patients have continued in the Trust mortuary including for patients diagnosed with Covid-19		
• areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	• Signage is in place to identify Covid areas and advise on PPE requirements on entry • Restricted access by swipe card only is in place		
• information and guidance on COVID-19 is available on all Trust websites with easy read versions	• Information for staff is available on the Trust intranet Covid page • Coronavirus information for the public can be found at https://www.mtw.nhs.uk/2020/06/latest-information-on-the-coronavirus/	• Easy read version not yet available	• Information currently under review prior to submission to the Accessible Information Standard group for conversion into easy read.

• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	• For inter-departmental transfer, handover of information by telephone or accompanying nurse • PHE guidance on discharge of patients is implemented. Local guidance based on national guidance is published on trust intranet Covid page and has been shared through ICC bulletin. • Integrated discharge team manages discharge of patients to residential care facilities. • All patients being discharged to residential care have Covid test 24 hours before expected date of discharge. • Any patients self-isolating following confirmed Covid contact receive a letter explaining their need to self-isolate. Medically fit patients may complete their self-isolation at home • Staff use appropriate PPE for all patient transfers • All patients have EDN on discharge		
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • front door areas have appropriate triaging arrangements in place to cohort	• ED triage in place at front door on both sites. Patients assessed with temperature check and	• Audit data not yet available	• Non-compliance with pathways reported as

patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection	observations prior to booking in. Triage nurse performs infection risk assessment and patient directed through red or green pathway for further assessment and separation. Pathway documented and agreed with CRG and ICC • Temperature check and triage in place at front door for obstetric patients and accompanying birth partner. Elective C section patients have Covid swab 48 hours prior to admission. Pathway documented and agreed with CRG and ICC • All elective patients have Covid swab 24-48 hours prior to admission including patients for outpatient procedures • All patients and visitors entering through main entrances have temperature check and are given masks • Paediatric patients triaged in paediatric assessment area which is zoned for Covid risk • All pathways documented and agreed with CRG and ICC and published on Covid page of Trust Intranet	• Audit data not yet available • Audit data not yet available	Datix incident • Non-compliance with pathways reported as Datix incident • Non-compliance with pathways reported as Datix incident
• Mask usage is emphasized for suspected individuals • Ideally segregation should be with separate spaces, but there is potential to use screens, eg to protect reception staff	• All patients asked to wear a face mask on entering ED. • Red and green pathways are accommodated separately in different zones of ED • ED reception has physical separation of staff by Perspex		

	screens • Perspex screens on outpatient reception areas, outpatient pharmacy and main entrance reception		
• For patients with new onset symptoms it is important to achieve isolation and instigation of contact tracing as soon as possible	• Patients who develop symptoms after admission are tested promptly and moved to side room on Covid ward. • Contact tracing carried out if patient tests positive. Business Intelligence programme in place to track contacts • Patients exposed to confirmed case are isolated and given information letter. Medically fit patients who are discharged to their own home continue to self-isolate at home. Patients from residential care are swabbed prior to discharge and care facility informed of the result. IDT manage discharge to residential care.	• Audit data not yet available	• Non-compliance with pathways reported as Datix incident
• patients with suspected COVID-19 are tested promptly	• All non-elective admitted patients (suspected and non-suspected) are tested for Covid-19 in ED, SAU, EGAU, Woodlands unit or delivery suite. Suspected medical patients are admitted directly to side rooms on Covid cohort ward awaiting results. Non-suspected patients remain in AAU/AMU until results available. Surgical, T&O, gynae, paediatric and obstetric patients admitted directly to single room on specialty ward pending results.	• Audit data not yet available	• Non-compliance with pathways reported as Datix incident

	Pathways in place and agreed through CRG and ICC. • All suspected patients who do not require admission are tested prior to discharge from ED. Positive cases are followed up by ED with results to provide anticoagulation therapy. Pathway approved by ICC		
• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested	• Suspected patients who test negative have medical review prior to step down to non-Covid ward. Those who continue to be suspected cases have repeat testing and remain in side room on Covid ward • Contact tracing carried out if patient tests positive. Business Intelligence programme in place to track contacts • Patients exposed to confirmed case are isolated and given information letter. Medically fit patients who are discharged to their own home continue to self-isolate at home. Patients from residential care are swabbed prior to discharge and care facility informed of the result. IDT manage discharge to residential care.		
• patients attending for routine appointments who display symptoms of COVID-19 are managed appropriately	• All outpatients have temperature checking at the front door. • Patients with fever are reviewed by clinician to determine whether to continue with appointment or to go home to self-isolate and rebook		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • all staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	• Local induction for new staff. PPE officers provide training. • Nurse in Charge of a shift ensures bank and agency staff aware of PPE expectations • Online training for medical care of Covid patients • ICU training in place for non-ICU trained staff • PPE officers provide face to face training on wards. • IPC team provide training to staff	• On-line IPC training package requires updating to include Covid-19	• Face to face training widely available. • PPE videos available • On-line package remains valid for non-covid infections
• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	• Donning and Doffing videos available on Trust intranet site. • PPE officers provide workplace training. • PPE helpers available in ICU • Donning and doffing areas provided on Covid wards • FIT testing available for all staff who require it. • Signage and posters displayed in donning and doffing areas		
• a record of staff training is maintained	• Fit testing and cleaning of reusable masks records maintained		

	• Records maintained of formal IPC training • On line learning and development system records mandatory training		
• appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	• Re-use of visors and cleaning guidelines available and communicated through daily staff bulletin from ICC • Guidelines in place for cleaning of re-useable respirator masks • Individual reusable respirator masks allocated • Site team holds records of reusable air powered respirator use and cleaning • EME support monitoring and management of powered air respirators • Other PPE will only be re-used with ICC and IPC agreement and release of clear guidance	• Policy not yet agreed	• No re-use without formal decision with ICC and IPC agreement
• any incidents relating to the re-use of PPE are monitored and appropriate action taken	• All incidents relating to PPE reported as datix incidents • Risk assessments in place for reusable respirator masks and air powered respirators • Incidents investigated and learning shared • ICC monitors incidents and takes urgent action as required		
• adherence to PHE national guidance on the use of PPE is regularly audited	• PPE audits ongoing but not yet reported to IPCC	• Audits not yet reported	• To be reported to IPCC in August (bi-monthly meeting)

• staff regularly undertake hand hygiene and observe standard infection control precautions	• In place. Triangulation audits completed monthly and reported to IPCC		
• hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	• All hand wash basins are co-located with paper towel dispensers		
• Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff toilets	• All hand wash soap dispensers have hand washing and drying guidance on back boards in both clinical and public areas		
• staff understand the requirements for uniform laundering where this is not provided for on site	• Scrubs are worn on all Covid wards and several other wards and clinical areas. • Scrubs are laundered by the Trust laundry and staff are advised not to take them off-site • Staff launder their own uniforms. Guidance has been published through the daily bulletin and Covid intranet page. • Uniform bags gifted to the Trust provided for staff to carry uniform home and launder with uniform. • All staff advised to travel to and from		

• all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	work in their own clothes and change on site • Staff changing and shower facilities provided on both sites • Staff sickness line available to report symptoms • Information on symptoms of Covid shared widely including posters, staff bulletin and intranet site • Staff testing available in drive through facility and on-site testing pods. On-line appointment system in place. Also available for family members and partner organisations • All staff members testing positive for Covid-19 have their result delivered by occupational health. • Occupational Health support and maintain contact with self-isolating staff • Staff testing positive self-isolate for a minimum of 14 days. • Back to work swab at 14 days. Negative result required for return to work		
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	• All suspected and confirmed Covid patients are placed in designated cohort wards. Suspected cases are placed in side-rooms until test results are available		

• areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	• Cohort bays have privacy curtains between the beds to minimise opportunities for close contact. • Separated from non-segregated areas by closed doors • Signage displayed warning of the segregated area to control entry • Cohort areas differentiate the level of care (general, respiratory HDU, Covid ICU) • Paediatric confirmed patients isolated in single rooms with en-suite facilities • Pre-existing IPC policies continue to apply. • Some variance required to meet the requirements of Covid levels of PPE and co-infected patients • Active management of side room provision by ICP team	• A designated self-contained area or wing is not available for the treatment and care of Covid patients. No separate entrance is available	• Access is through closed doors with swipe card card access. • Not used as staff/visitor throughfare
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals • patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other	• Testing undertaken by registered BMS staff with documented competencies. • Method validated prior to diagnostic testing • In house testing turnaround time of less than 24 hours • Tests sent to Pillar 2 labs when		

national guidance • screening for other potential infections takes place	demand outstrips capacity • Extended laboratory working hours to deliver service • All non-elective patients are tested on admission • All positive patient results are phoned to ward by IPCN and provided to site team and ICC. • All results reported to PHE via Co-surv • All elective patients are tested 24-48 hours prior to admission • Online booking for staff and elective patient testing. • Weekly testing for all patient-facing staff by end of June 2020 • All staff positive results are delivered by Occupational health staff • Staff results sent by text message directly from on-line system • Antibody testing available to all patients and staff on request • MRSA, MSSA, GRE, and CPE screening continues as in pre-covid policies • All routine diagnostic microbiology continues including C difficile.		
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to			

ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms	• IPC team supports wards. All wards visited daily. Full range of policies and procedures in place. • Advice available from IPC team and consultant microbiologists. On call rotas in place.		
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	• DIPC and deputy DIPC responsible for checking for updates to national guidance and advising executive team. • Updates shared with staff in daily Covid Bulletin and Covid intranet page • IPC team support ward staff in implementing changes		
• all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	• All clinical waste related to possible, suspected or confirmed Covid-19 cases is disposed of in the Category B (orange) clinical waste stream.		
• PPE stock is appropriately stored and accessible to staff who require it	• PPE central stocks held on both main sites • Active management of stock levels by procurement to ensure safe levels of stock • Regular (twice daily) deliveries of PPE to clinical areas. • Central email address for PPE orders. • Reusable masks distributed to named staff as required following FIT testing		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Appropriate systems and processes are in place to ensure:			
• staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	• Staff risk assessment in place. Managers advised to ensure all staff risk assessed. Risk assessment developed with BAME network and Ethics committee • Redeployment opportunities and working from home enabled for high risk staff • Staff welfare programme in place including wobble rooms, free food, breakout areas, psychological support. • Staff sickness phone line in use.		
• staff required to wear FFP3 reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	• FIT testing in place including training on fit, maintenance and cleaning. • Powered air respirators available for staff who fail all fit testing • Individual use reusable respirator masks available • FIT testing register held in ICC		
• Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between panned and elective care pathways and urgent and emergency care pathways, as per national guidance	• Patient and Staff Safety workstream (part of Reset and Recovery programme) has defined the principles to be used when developing elective pathways • Green pathways for elective care developed. • Weekly executive and divisional meeting to discuss progress and interdependencies		

• All staff adhere to national guidance on social distancing wherever possible, particularly if not wearing a facemask and in non-clinical areas • Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	• Staff screened for Covid-19 • Ward areas maintained as secure with minimal footfall • Theatre SOP in place designating green and red pathways to avoid cross over • Staff social distancing in corridors and queues. • Work to ensure that office spaces are socially distanced with risk assessments completed. • CCG review identified good practice in social distancing interventions • Staff working from home wherever possible • Consideration to 7 day working and shifts to reduce the number of staff in non-clinical areas. • All ward staff to wear masks at all times on wards from 1 June • Continual mask wearing guidance implemented for patient facing staff from 10 June. Non-patient facing staff from 22 June • Computers on wheels provided in some areas to support social distancing • Managers asked to review all office space to ensure social distancing in COO letter 12 June. • Managers also requested to review staff working patterns and breaks to reduce the number of non-clinical staff working on site at any time • Additional breakout areas created on		

	both sites including outdoor space		
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	• Staff welfare programme in place including wobble rooms, free food, breakout areas, psychological support/ first aiders. • Staff sickness phone line in use. • ICC monitors sickness • Occupational health support staff who are self-isolating and shielding. • Managers support staff working from home • All staff able to access testing via on-line booking system • Symptomatic staff can access testing • Weekly asymptomatic testing to be rolled out to all patient facing staff by end of June • Review of cases of staff Covid infection to identify any key themes and learning • Trustwide Pulse survey in April and May. Results reviewed at executive and divisional level. Learning identified		
• staff that test positive have adequate information and support to aid their recovery and return to work.	• Occupational health support Covid-positive staff and advise on return to work and re-testing • Psychological support available		

Board Checklist - workforce risk factors linked to COVID-19 and an update on BAME staff risk assessments — **Director of Workforce**

NHS England / Improvement (NHSE/I) wrote to all organisations on 18th May 2020 in respect of the known disproportionate impact of COVID-19 on Black, Asian and Minority Ethnic (BAME) staff and the actions required at a regional and local level. The letter is enclosed.

As part of this communication NHSE/I recommended that the enclosed Board Checklist was completed. The document provides assurance that the Trust has actively and positively responded to the concerns and needs of its BAME staff and other staff in vulnerable staff groups and has taken steps to engage with its BAME workforce and to listen to their concerns.

An update on BAME staff risk assessments has also been enclosed, for information and assurance.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 23/06/20

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

South East Region
Wellington House
133-155 Waterloo Rd
London
SE1 8UG

anne.eden1@nhs.net

Tuesday 19th May 2020

Sent by email to: -

SE Provider Chief Executives
SE CCG Accountable Officers
SE STP/ICS Leads

Dear colleagues,

Re: South East BAME Disparity Work Programme

We are writing to you as the co-chairs of a new Covid-19 South East BME Mortality Disparity Advisory Panel that has been established to explore and respond to the emerging evidence of the disproportionate impact of COVID-19 on our BAME workforce and communities in the South East.

The group was established last month to complement national work underway exploring the risk to the BAME community. It is chaired by myself and Scott Durairaj, Director of ICS Development, Sussex Health and Care Partnership drawing on the experience and expertise of a number of colleagues from across the South East *(the composition of the Regional Advisory Group can be found in Appendix 1).*

The group's Terms of Reference are to ensure and assure that a robust risk assessment of all BAME colleagues across the South East is undertaken and acted on, that we have informed decision making across the region in respect of the management of COVID-19 and that offer consistent and best-practice health and wellbeing support to our colleagues.

We have asked each system across the region to work and share with us their own plan describing how you are responding strategically to disparities across both the BAME workforce and the communities they serve. These plans have now been received and as an advisory group, we will be reviewing them and sharing the best practice with all to ensure the strongest response possible.

Today we are sharing additional, regional guidance that complements the national *Risk Reduction Framework for NHS Staff at risk of COVID-19 infection* (12th May) and local guidance that has been developed *(the regional guidance can be found in Appendix 2).*

A critical element of these risk assessments is that due consideration is given to any workforce factors that may increase risk as well as any long-term health conditions. This is not an alternative to tackling the risks faced by all staff and ensuring all staff are as safe as possible, but recognises the evidence that some staff groups, notably BAME staff, are especially at risk.

This regional guidance has been developed to tackle the additional workplace risks and builds on the excellent work developed by Royal Berkshire NHS Foundation Trust. We

are considering additional guidance for nursing homes and social care colleagues, in partnership with Local Authority colleagues.

As an Advisory Group to the region, we would welcome your early feedback on the practical application and value of these resources within your organisations. Please send your feedback to tim.omo-bare@nhs.net **by midday on Friday 22nd May.**

We are determined that our commitment and action responding to the evidence around the disparity in respect of our BAME colleagues will form part of a positive legacy from Covid-19 in the South East. There is no time to be lost, so I ask that we move at pace. The advisory group is here to answer any questions you may have.

Yours sincerely,

Anne Eden
Regional Director (South East) / Co-Chair Regional Advisory Panel
NHS England and NHS Improvement

Scott Durairaj
Director of ICS Development/ Co-Chair Regional Advisory Panel
Sussex Health and Care Partnership

CC:
SE BAME Network Chairs
SE Directors of Nursing
SE Directors of HR

Appendix 1 – composition of SE BAME Disparity Regional Advisory Group

Name	Job title
Terry Roberts	Chief People Officer – Oxford University Hospitals
Shahana Ramsden	Head of Workforce Transformation South East – NHSE/I
Shahed Ahmad	NCD Cardio Vascular Prevalence – NHSE/I

Cavita Chapman	Director- Engagement and Inclusion, South of England- NHSE/I
Lola Banjoko	Co-Lead - SHCP ICS
Marcus Riddell	Head of Equality and Inclusion, NHSE/I
Tim Omo-Bare	Programme Manager – NHSE/I
Caroline Beardall	Director of Workforce and OD South East – NHSE/I
Adam Doyle	SRO - Sussex Health and Care Partnership ICS
Duncan Burton	Chief Nurse, South East – NHSE/I
Vaughan Lewis	Regional Medical Director – NHSE/I
Tom Edgell	Locality Director – Kent Surrey and Sussex, NHS E/I South East.
Gayle Carrington	Regional Head of Communications – NHSE/I
Roger Kline	Independent Specialist Advisor
Kevin Holton	Head, Experience of Care and Equalities and Health Inequalities, NHSE/I
Alison Barnett	Director of Public Health, South East, Public Health England

Appendix 2 – Regional Guidance as referenced above (attached).

Appendix 3 – Interactive Excel Risk Assessment tool (attached).

1. Governance

Risk	Potential risk mitigation	Owner
1.1 *Is the Board sighted on and has it put in place **appropriate accountability and resource into Covid-19 workforce assessment and support**?	The workforce committee has reviewed staffing data in relation to COVID and regularly discussed the actions taken to support the workforce for COVID-19 The Board has reviewed actions in relation to the support of the workforce as part of its oversight of the Trust response to COVID-19 Dedicated workstreams on staff welfare, swabbing and staff and patient safety have been created and resourced. The Trust ICC regularly reviews staffing data in relation to potential areas of concern and engages with Infection control teams to support	Director of Infection Prevention & Control – Clinical Nurse Manager for Occupational Health
1.2 *Does your organisation hold **data** (disaggregated by White/BAME) that will demonstrate the effectiveness of engagement on COVID-19 and BAME staff?	Data is collected on i) Numbers of COVID+ staff, disaggregated by gender, ethnicity, age, grade, profession and department ii) The number of days absence for COVID-19 disaggregated by gender, ethnicity, age, grade, profession and department iii) Numbers of risk assessments completed for BAME and vulnerable staff iv) Levels of identified risk for BAME and vulnerable staff and actions taken	Head of Staff Engagement and Equality & Head of Occupational Health
1.3 *Is the Board clear on the additional risks BAME staff face?	1.3 The Board is fully engaged on the additional risks BAME staff face and t Board Members have been involved in formulating the latest Risk	Head of Occupational Health & Director of Workforce

Risk	Potential risk mitigation	Owner
1.4 Has the board considered the medium-term implications of the impact of Covid-19? 1.5 Is Occupational Health centrally involved in oversight and support?	Assessment. (Director of Workforce, Medical Director, Chief Nurse, Director of Infection Prevention and Control). Board members have participated in Culture & Ethnic Minorities Network (CEMN) meetings to discuss additional risks for BAME staff 1.4 the Board has considered the medium term implications of COVID 19 via its Reset and Recovery Programme. Staff and Patient safety is a key element of this programme and encompasses the need for the safety of BAME and other vulnerable staff groups 1.5 OH have led on the Risk Assessment and all its amendments. The risk assessment redesigned for BAME staff was completed and approved by ethics committee before being shared by ICC. OH has provided ongoing support to staff and managers on an individual basis as well as via webex and regular communication of guidance.	
1.6 Is there **BAME representation** in senior decision making/oversight? 1.7 Is your BAME Network fully involved in decision making around the risks to BAME staff?	Collect information on demographic makeup of Gold Command; there is one Board member of a BAME demographic who is part of Gold Command The Chair and Deputy Chair of the CEMN have been fully involved in amendments to the risk assessment and all communications regarding supporting our BAME staff.	Head of Occupational Health and Head of Staff Engagement and Equality
1.8 Is there an emphasis, wherever possible on strong **staff engagement** to both receive suggestions and hear concerns, before significant	Clear, repeated messages from CEO, Medical Director and Chief Nurse and other executives have emphasised the need for engagement with	CEO & executive directors Freedom to Speak Up Guardian

Risk	Potential risk mitigation	Owner
changes in working practices? Bear in mind research, for example, the Francis Freedom to Speak Up report 2015 and recent reports indicate some groups of BAME staff are less likely to raise concerns either because they don't believe they will be heard or because of possible adverse consequences for them.	staff and the raising of concerns where necessary. The Director of Workforce has run a weekly staffside meeting for all union stewards to be able to raise concerns Staff pulse surveys – strong links with Culture and Leadership Programme reflected in leadership of Staff Welfare Group. Trust communications issued regularly inviting feedback and referring to the Speak Up process. The Cultural & Ethnic Minority Network host weekly Webex conferences where BAME staff can share concerns and issues. These are attended by Board members The Freedom To Speak Up Guardian is a member of the BAME network as well as other staff network groups and attends meetings / webinars to offer support, advice and invite staff to make contact if they have concerns	Director of Workforce Ass. Director of OD
1.9 Does your organisation hold **data** on staff Covid-19 sickness and staff Covid-19 deaths by department, grade, and protected characteristic? 1.10 Are you being proactive in using such data to triangulate with soft intelligence from areas of concern – and with other workforce data e.g. WRES and WDES - especially data for reported bullying?	Data is captured by HR, Infection Control and Occupational Health. There is cross department working to highlight and address any emerging trends such as instigating regular wider spread testing of staff in higher incident areas of COVID-19 amongst staff, closing of areas and deep cleaning where appropriate, changes to working practices and PPE processes.	Director of Infection Prevention and Control & Head of Occupational Health

2.0 Risk assessment and deployment

Risk	Potential risk mitigation	Owner
2.1 Is there a focus to ensure some staff groups are specifically included in risk assessments e.g. **returners, agency staff, newly qualified staff, staff returning from sick or annual leave, and night shift staff**? It is important to ensure these groups are assessed as they may be especially vulnerable (e.g. RCN survey indicates temporary agency nurses are currently much less likely to be offered tests).	All staff are assessed and or offered assessment under the COVID-19 staff assessment. Non agency staff & volunteers pass through OH and or line managers for assessments.	Clinical Nurse Manager for Occupational Health Head of Employee Services
2.2 Is there effective management and governance to **follow up risk assessments** both for individuals and at employer wide basis?	Managers requested to report on the number of risk assessment and residual risk after measures have been put in place. Managed by the ICC.	Incident Command Centre Director of Workforce
2.3 Do **deployment decisions** correlate with risk assessments i.e. done fairly and proportionately? There is growing evidence that BAME staff may be disproportionately redeployed to Covid-19 wards.	Deployment decisions correlate with risk assessments and where indicated staff in vulnerable groups including BAME staff have been moved away from COVID-19 wards where their individual risk assessment identifies the need . These decisions are made in conjunction with Occupational Health which provides a level of consistency across the organisation	Head of Employee Relations & Clinical Nurse Manager for Occupational Health
2.4 Are specific steps being taken proactively to ensure **BAME staff are specifically being risk assessed** not just for health risks but for exacerbating workplace treatment factors?	All managers are expected to risk assess their BAME staff whether they have been identified as needing risk assessment previously or not. Support is offered through the Head of Staff	Head of Staff Engagement and Equality & Head of Occupational

Risk	Potential risk mitigation	Owner
	Engagement and Equality, Occupational Health and the Trusts CEMN. Data on completion and outcomes of BAME risk assessments are collected via the ICC	Health

3.0 Protection

Risk	Potential risk mitigation	Owner
3.1 Is the **PPE Fit** process effective without disproportionate impact on some staff groups, notably BAME and female staff? Note: HSJ reports that younger female workers are twice as likely to die as other staff NHS Confederation, has published guidance about the use of PPE for staff, which includes information about cultural considerations.	PPE fit tests policy in place to ensure fairness. Expanded fit testing team offering almost daily clinics for fit testing and advice.	Director of Infection Prevention and Control
3.2 Are managers clear that **social distancing** must be observed in role/function including in spaces such as rest areas? How is that validated?	Repeated messages sent out through the command team. Signs on walls and floors to reinforce the message	Staff Welfare Team Social Distancing work stream

4. Removal from risk areas

Risk	Potential risk mitigation	Owner
4.1 Is the default position for staff who could effectively **work from home** or who have vulnerable family members at home that they work from home?	From the outset of the pandemic the Trust message was that all staff who could effectively work from home should do so regardless of shielding themselves or their family members. This message continues.	CEO Head of Occupational Health Social Distancing and Working from Home work stream

Risk	Potential risk mitigation	Owner
4. 2 In reaching decisions about working from home or site, is there an acknowledgement of risks from travelling on **public transport** which should avoided wherever possible?	Programme on staff buses (6X route) ensured provision for staff masks, signage in buses and larger buses for busy times. Additional on-site showers to support walking and cycling to work; free bicycle loan to staff, free on-site parking for staff have provided staff with alternatives to public transport.	Staff Welfare Team Director of infection Prevention and Control Director of Estates & Facilties
4.3 Is **social contact with co-workers** minimised with audit of open plan offices, shared workstations or hub environments and maximum use of homeworking? Are all possible similar steps taken in Outpatient clinics and reception areas?	Instructions to managers has been given on risk assessing the working environment to ensure staff can work in a socially distanced method where possible including the continued push to enable home working, 7 day working and early / late shifts to spread the workforce across the week. Additional IT equipment has been purchased to support remote working as well as conversion of current equipment for the same purpose	Social Distancing workstream

5.0 Tests

Risk	Potential risk mitigation	Owner
5.1 Is there a transparent policy of **prioritisation** to include all staff identified by risk assessment as being at greater risk and any staff with additional exposure e.g. travelling to work?	Our capacity to test staff and their household members has been consistently higher than the demand as such, no individuals needed to be prioritised.	Swabbing workstream
5.2 Do all staff know about rapid access testing for symptomatic staff and household members?	Guidance on accessing testing for symptomatic staff and household members is given by the staff sickness line as well as regularly communicated in	Zara Martin Occupational Health

Risk	Potential risk mitigation	Owner
5.3 Are testing arrangements in place for staff in isolation or working from home?	Trust updates. Support for staff in isolation to be swabbed was provided via a small mobile team	
5.4 Are all staff aware of the voluntary screening programme for asymptomatic staff?	Where pockets of COVID-19 amongst staff were identified, the Trust rapidly undertook testing of all staff and patients in that area regardless of symptoms and continued to test every 3 days until the infection rate reduced / was eliminated	Director of Infection and Prevention Control Clinical Nurse Manager for Occupational Health

6.0 Engagement, communications and support

Risk	Potential risk mitigation	Owner
6.1 Are managers confident (and do they get support) in having **honest and difficult conversations with BAME staff** about their circumstances?	Weekly webinars have been run for managers / shift leaders to supporting them in having difficult conversations and provide advice and guidance. A number of specific webex's have been held for managers on the application of the risk assessment for vulnerable and BAME staff and guidance and support given. Line managers are able to seek individual guidance from the OH team	Head of Occupational Health
6. 2 Are BAME staff prominent in decision making on COVID 19 both through staff networks with access at Board level but also via other means e.g. senior BAME managers?	The CEMN host weekly Webex for BAME staff – members of the Board attend. Weekly meetings with trade union stewards have regularly discussed and highlighted issues relating to BAME risk. This has included BAME trade union stewards	Head of Staff Engagement and Equality

Risk	Potential risk mitigation	Owner
6.3 Is there a clear **narrative** about this work, including EDI implications, owned by leaders and managers who are confident in sharing it?	The importance of the subject has been highlighted in daily communications as well as CEO, Medical Director and Director of Workforce video and podcast messaging	
6.4 Are arrangements in place through STPs and more widely to identify, understand and **share better practice?**	Kent, Surrey and Sussex Diversity Leads meet monthly to discuss issues and share best practice.	Head of Staff Engagement and Diversity

7.0 Mental and other health support

Risk	Potential risk mitigation	Owner
7.1 What steps have been taken to understand the staff needs during and after the COVID 19 pandemic with particular attention to **BAME staff**?	Weekly webinars are run for shift leaders and managers which not only provide a support and advice service, but also serve as an information gathering source. Other webinars are run for Psychological First Aiders to support and guide them and offer escalation. Again this session offers significant intelligence gathering from across the organisation to understand the needs of staff. The CEMN network offers weekly webinar as a source of support as well as information gathering on this staff groups needs The latest risk assessment was shared with all staff emphasising the psychological support materials and the need to provide them to staff and their families. One such document is available on the internet in various languages through a link provided	Head of Occupational Health & Head of Staff Engagement and Equality

Risk	Potential risk mitigation	Owner
7.2 What support is in place for staff in **self-isolation** or who are or have been ill with COVID 19?	Managers have been made aware of support offerings for staff in isolation. Calls have been made to staff who are or were sick. Calls have also been made to check on people self-isolating and working from home. Weekly webinars are offered to staff who are shielding	Head of Occupational Health Head of Staff Engagement and Equality
7.3 Are staff aware that **psychological suppor**t is available for any staff member concerned about their vulnerability to COVID 19?	Support offerings have been shared repeatedly in COVID-19 briefings and executive messages Purple leaflet issued with details of helplines, PFAs, wobble room	Head of Occupational Health
7.4 Staff who do not wish to be withdrawn from an area contrary to their risk assessment. Should there be any staff who have been advised to not work in their current role or location, but who then wish to continue working in a role or location deemed unsafe for them, then the employer's duty of care is likely to be that such an outcome of their risk assessment would result in an instruction to follow the outcome.	The Trust stance is to move staff according to risk. If the working environment / role was deemed unsafe, the staff member would not be allowed to continue working in that area.	Head of Occupational Health

Black, Asian, and Minority Ethnic (BAME) staff risk assessments

Executive Summary

Further to the recent BAME risk assessments carried out within the Trust the feedback has been reviewed and I can update you on the following.

Of 1528 staff members within ESR who self-identified at the point of recruitment as having a BAME background, a total of 845 risk assessment assurances have been returned to the Incident Command Centre (ICC), as of 19th June 2020.

Based on the current version of the risk assessment the advice for the categories is detailed below:

- *Green: Continue working in current environment following all safety precautions*
- *Amber: Ensure appropriate PPE is provided and used at all times. Maintain social distancing and avoid prolonged direct contact with covid patients.*
- *Red: Move to lower risk areas with appropriate support measures. Consider home working.*

BAME Risk Assessment Completion Levels:

Division	Not Completed	Completed	Total Staff	% Completed
Cancer Services	40	37	77	48.1%
Corporate and Support	29	36	65	55.4%
Diagnostic + Clinical Support	15	122	137	89.1%
Estates and Facilities	46	158	204	77.5%
Medical + Emergency Care	338	140	478	29.3%
Surgery	173	281	454	61.9%
Women, Children and Sexual Health	42	71	113	62.8%
Grand Total	**683**	**845**	**1528**	**55.3%**

Of the 845 that have been completed, risk assessment categorisation is as follows

	Risk Assessment Category				
Division	Category A	Category B	Category C	Not supplied	Grand Total
Cancer Services	25	10		2	**37**
Corporate and Support	26	7	2	1	**36**
Diagnostic + Clinical Support	68	18	2	34	**122**
Estates and Facilities	95	22	4	37	**158**
Medical + Emergency Care	108	20	1	11	**140**
Surgery	172	34	11	64	**281**
Women, Children and Sexual Health	46	13	2	10	**71**
Grand Total	**540**	**124**	**22**	**159**	**845**

Of the 845 that have been completed, this is how many adjustments have been made:

	Adjustments Required			
Category	**No**	**Yes**	**Not provided**	**Grand Total**
Category A	444	40	56	540
Category B	77	44	3	124
Category C	3	17	2	22
Not supplied	43	14	102	159
Grand Total	**567**	**115**	**163**	**845**

The ICC sought additional assurance from each Divisional lead as to what specific measures had been put in place to safeguard those members of staff who had scored highest risk.

The Divisional mitigation actions are as follows:

Surgery Division

Surgery

- For general surgery, they only have one staff member at high risk (changing status due to her pregnancy), for her she is set up with remote access and is doing virtual clinics, admin, governance work / triaging etc. She is entirely removed from the on call rota.
- For all staff members that demonstrated moderate risk, they have all confirmed that they are fit tested, have their PPE requirements and are social distancing where possible. We are undertaking regular catch ups.
- For the CAU's, all of those noted to be at increased risk are working from home and we have suitable social distancing in place at Maidstone – there is ongoing work at TWH as the office is shared with clinical staff but this isn't really an issue.
- Ward 10 & 30 staff have been assessed, including those redeployed from TSSSU- 5 moderate risk redeployed to green area, 2 pregnant are shielding. Remainder advised of correct PPE including appropriate fit-testing and discussions had regarding social distancing at work and home.
- SAU- 17 staff assessed- 1 very high risk shielding at home, remainder medium or low advised of correct PPE including appropriate fit-testing and discussions had regarding social distancing at work and home.
- Ward- 32 – 1 very high risk shielding at home, several moderate risk but Ward 32 low risk area and all trained in correct use of PPE, including FFP3 when relevant.

- SAU nurse's consultant has said she can work in "green" zone, so we are going to try and redeploy to Ward32.
- Pregnant nurses going on to maternity leave, other brittle asthma awaiting guidance from their doctor- hopefully will be Ok to work in Ward 32 as green.

Surgical Specialities

- There are two Cat C nursing staff, both are ward clerks and unable to do their job at home. They will shield until 30th June.
- They have a couple of secretaries doing their normal work from home. Typing of clinic letters and queries from patients etc.
- The doctors who are working from home are doing triaging of patients, virtual telephone clinics, clinical governance and admin.
- CAU have arranged social distancing for the staff within the offices.

Head & Neck

- Only one doctor BAME ENT middle grade at high risk. They are shielding and doing telephone clinics from home. They were shielding from the beginning and so additional risk due to ethnicity didn't affect the decision already in place.

Critical Care

- A proportion of staff remain shielding at home as advised by their GP or via NHS letter, these staff are working from home where possible with appropriate IT support.
- Those identified as high risk have been managed through a variety of strategies. Within theatres, staffs have been placed in green areas where elective patients have been swabbed and away from aerosol generating procedures. Where the deployment of staff within green areas has not been possible e.g. ICU where suction etc. even on a "green" or COVID swabbed negative patient is an aerosol generating procedure appropriate PPE is worn.
- The embedding of a social distancing policy is key to the ongoing safety of all staff and this has been enforced by the removal of chairs and limiting of numbers in coffee rooms, 7 day working across the Endoscopy booking department to ensure less people in the office at one time, vascular access have amended the theory part of the Intravenous therapy course to be on line so that only practical sessions need to be face to face with smaller numbers in the group.

- Critical care has now instigated weekly swabbing for staff which may provide additional reassurance.

Trauma & Orthopaedics

- For the nursing staff – only 1 nurse scored 'red' risk, she is currently working on a 'green ward' – and full PPE available if required.

For other staff in the Directorate -

Risk Assessment Outcome- T&O	Number of Employees
Category A/Low Risk/3-5	20
Category B/Moderate Risk/6-8	5
Category C/High Risk/9+	2
Moderate-High Risk	0
Other: Mat Leave/AL/Not Applicable/Not Populated	6
Total:	33

Green: Continue working in current environment following all safety precautions re social distancing/PPE etc

Amber: Ensure appropriate PPE is provided and used at all times. Maintain social distancing and avoid prolonged direct contact with covid patients.

- Telephone/Attend Anywhere clinics arranged in place of face to face
- Reduced face to face clinics to allow for appropriate social distancing and cleaning of the room

Red: Move to lower risk areas with appropriate support measures. Consider home working.

- Both high risk members of staff currently moved to lower risk areas
    - Admin- facilitated working from home
    - Medical – moved to non-patient facing duties

Medicine and Emergency Care Division

The Medical Division has opted for a centralised method of collecting, confirming and maintaining the Division's BAME risk assessment. The process has been as follows:

- List of BAME staff generated from the ESR record and broken it into clinical areas for ease of access.
- A central email was sent to all staff from the Divisional Manager asking them to complete the risk assessment and email it back to a dedicated email address.
- Assessments are RAG rate and individual managers follow up with staff to ensure staff had opportunity to discuss outcome and agree mitigation to support safety

Position to date:

- 297** of 574 risk assessments have been completed
- **Some staff have completed using the old risk assessment form as assessments previously undertaken in April/May
- Lag in completion by juniors doctors and ED and 2 wards – this is being followed up

Actions for those with 'red' RAG rating

- To date 5 staff have been rated as 'red'
- Actions to support these staff have included home working whilst undertaking a different role, relocation to green area, not working with AGPs and wearing of appropriate PPE

Further action:

- Completion of outstanding risk assessments
- Engagement with Educational Supervisors and College tutors to support junior doctor establishment completing risk assessment
- Review of risk assessments completed on earlier version of paperwork
- Ongoing monitoring of position and checking in with high risk staff on a regular basis in terms of working contingencies and whether there is a need for further support and mitigation

Diagnostics & Clinical Support Services

Total Number of BAME risk assessments performed.

Outpatient	2
Pathology	52
Pharmacy	22
Radiology	33
Therapies	22

Total Number of BAME risk assessments resulting in Red Risk level = 2

- One member of Therapy staff was assessed as high risk and has been enabled to work from home. This member of staff is on annual leave from this week and will then be starting maternity leave.
- One member of Radiology staff was assessed as high risk. The staff member has been removed from inpatient activity and advised on correct use of PPE.

Women's, Children's & Sexual Health Division

BAME risk assessments conducted throughout the Division with 1 Consultant Paediatrician being deemed high risk. This member of staff has been shielding at home with reviewing job plans.

Fit Testing with staff has meant that some BAME members have not been successful at securing a suitable mask and therefore have been removed from on call rotas to safeguard them from patient contact.

Next Steps

As there are a number of risk assessment versions some of the assurance returns have been based on previous outcomes and category titles e.g. moderate-high/not applicable. However, going forward a standardised version from the national work stream will support a common approach. Divisions will continue to review their risk assessment status and provide assurance around mitigating actions through the ICC Divisional updates.

Darren Palmer,
Head of Incident Coordination Centre
19/06/20

Trust Board meeting – 25th June 2020

Maidstone and Tunbridge Wells NHS Trust

Quarterly mortality data **Medical Director**

This report is submitted in line with guidance from the National Quality Board, March 2017. This stipulates that Trusts are required to collect and publish on a quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public board meeting in each quarter to set out the Trust's policy and approach and publication of the data and learning points.

This report also provides an update into the further actions that have subsequently been taken to understand and improve our Trust position, as a previous outlier, in regard to the Hospital Standardised Mortality Ratio (HSMR).

This report is based upon the Trust's most recent data, published by Dr Foster for the period of March 2019 to February 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, assurance and discussion

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

Mortality Surveillance Report

HSMR Current Performance

The standard HSMR calculation uses a 12 month rolling view of our performance. The latest results of this are shown below in Figure 1. The 12 months March 2019 to February 2020 show our HSMR to be 92.3, which is marginally lower than last month's figure 92.6.

Figure 1 Rolling 12 Month view

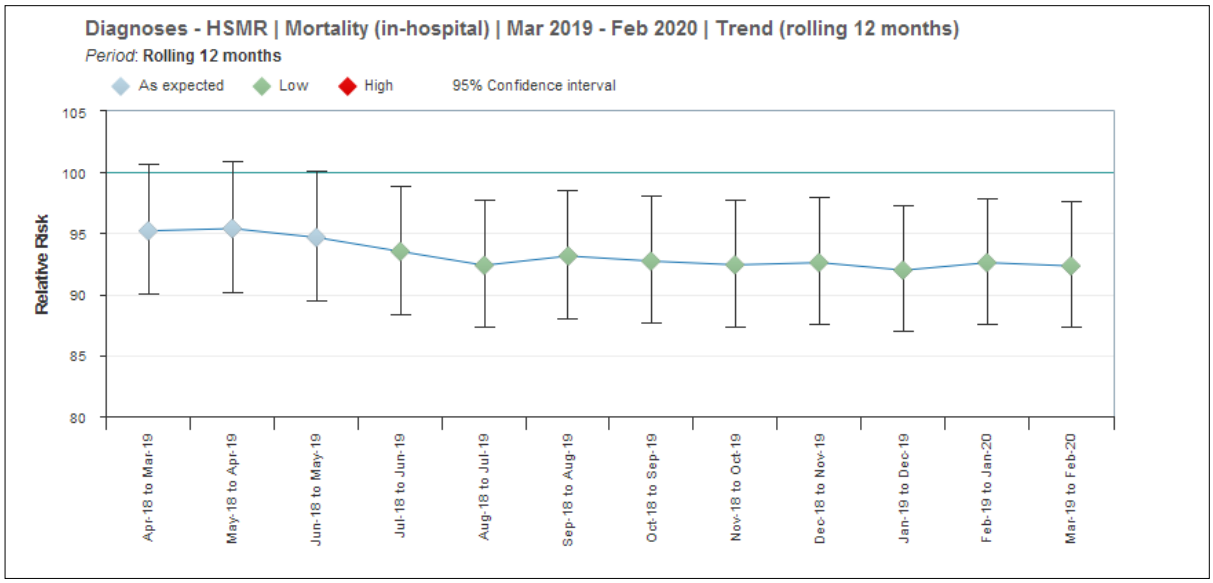
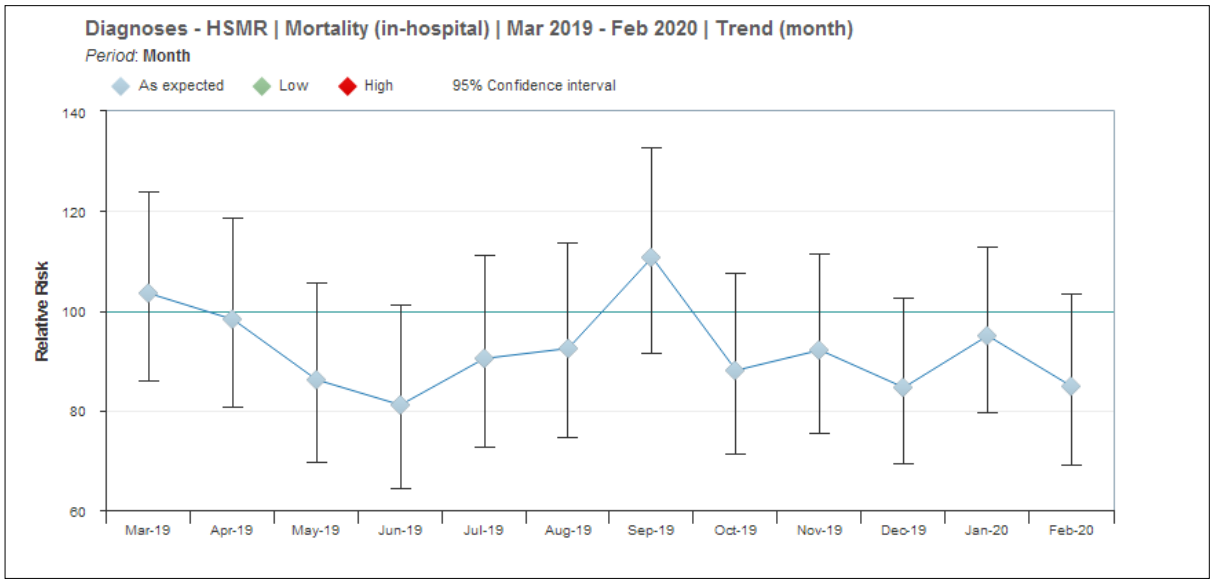


Figure 2 shows a monthly view of our HSMR performance. The latest month should be viewed with caution as this often shows a false position due to the lag in coding activity. Viewing the previous month, so February 2020 in this case, shows that the Trust's position has decreased to 84.8 from 95.0 in January 2020.

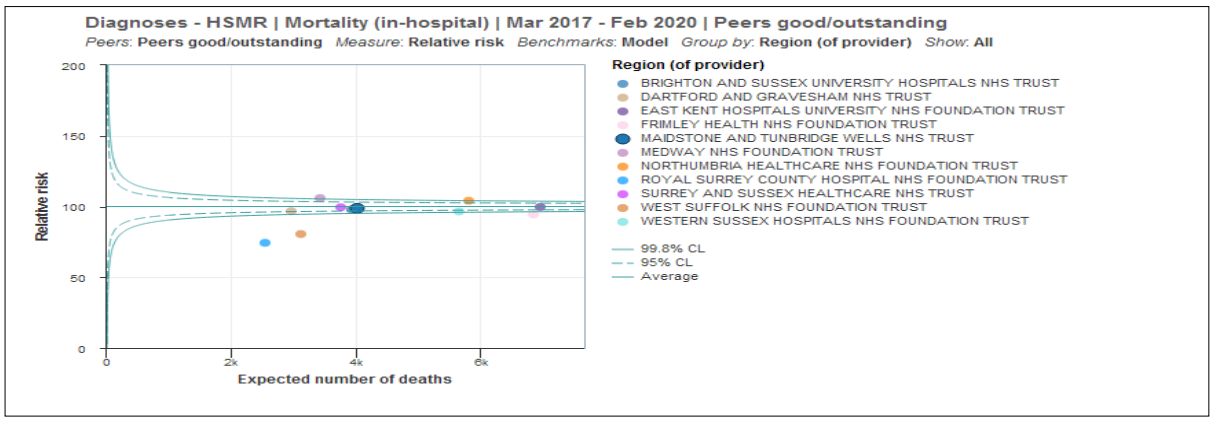
Figure 2 Monthly view

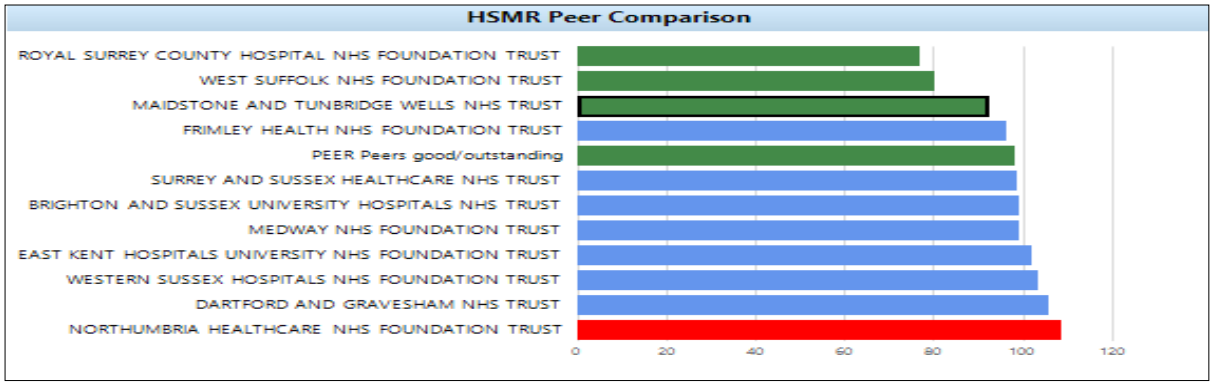


Benchmarking

Dr Foster enables us to benchmark our performance against our peers. There are various peer groups available e.g. GIRFT and Carter groups. Figures 3a, 3b and 3c demonstrate that the Trust is in a good position amongst comparable organisations with Good or Outstanding CQC status.

Figures 3a, b & c Benchmarking against good/outstanding acute non-specialist trusts (March 2019 to February 2020)





HSMR and Influencers

Performance	Site	Trust	Peer	National
HSMR		92.3	98.2	98.6
SMR		89.8	97.7	98.7
Elective (HSMR)		61.2	92.8	101.9
Non-elective (HSMR)		92.7	98.2	98.6
Weekday, non-elective (HSMR)		92.2	97.1	96.9
Weekend, non-elective (HSMR)		93.9	101.5	103.5
Coding / Casemix	**Site**	**Trust**	**Peer**	**National**
% Deaths in HSMR basket (elective)		81.8%	67.3%	63.3%
% Deaths in HSMR basket (non-elective)		85.0%	83.6%	83.3%
% Non-elective deaths with palliative care		40.8%	37.3%	33.9%
% Non-elective spells with palliative care		4.1%	4.5%	4.1%
% Spells in Symptoms & Signs chapter		8.3%	7.7%	6.7%
% Spells with Charlson comorbidity score = 0		56.9%	49.9%	47.3%
% Spells with Charlson comorbidity score = 20+		7.3%	9.6%	9.7%

Understanding and Improving upon HSMR

It is evident from figures 1 – 3 that the Trust has made a sustainable reduction in our HSMR and is now in a healthy position amongst our peers; having moved from a position of high relative risk to low relative risk has been the main objective of the Mortality Surveillance Group (MSG) during 2019/20.

This is also borne out by the significant improvements that can be evidenced in the downward trend of relative risk rates and crude rates since October 2017. In addition the volume of spells has continued to rise in the same period due to the change in casemix as demonstrated in Figures 4a & b.

Figure 4a HSMR – Relative Risk

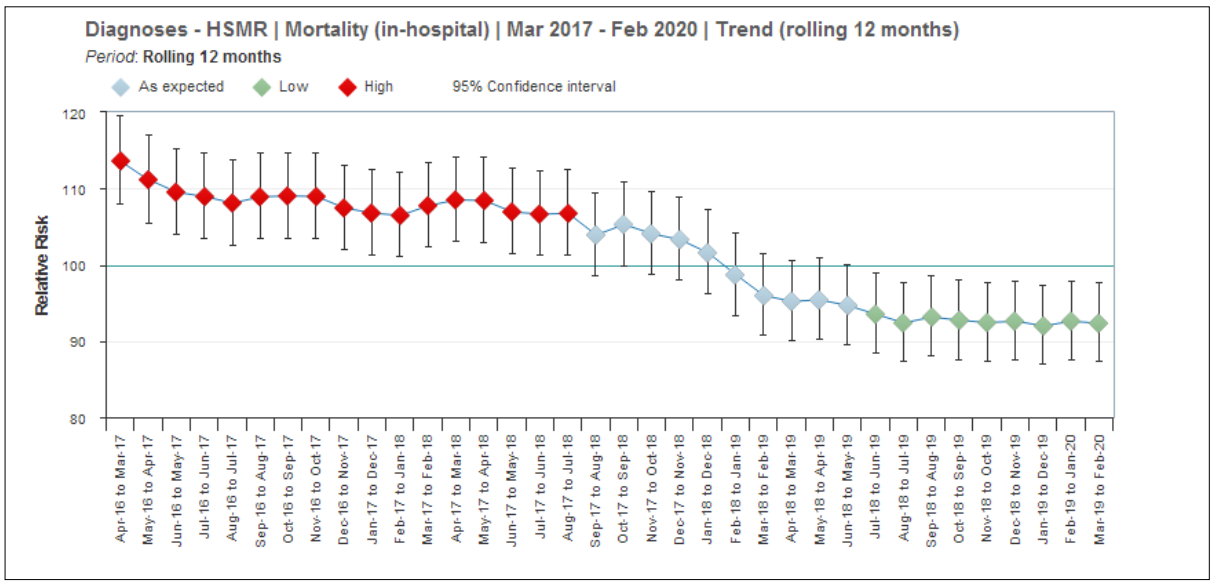
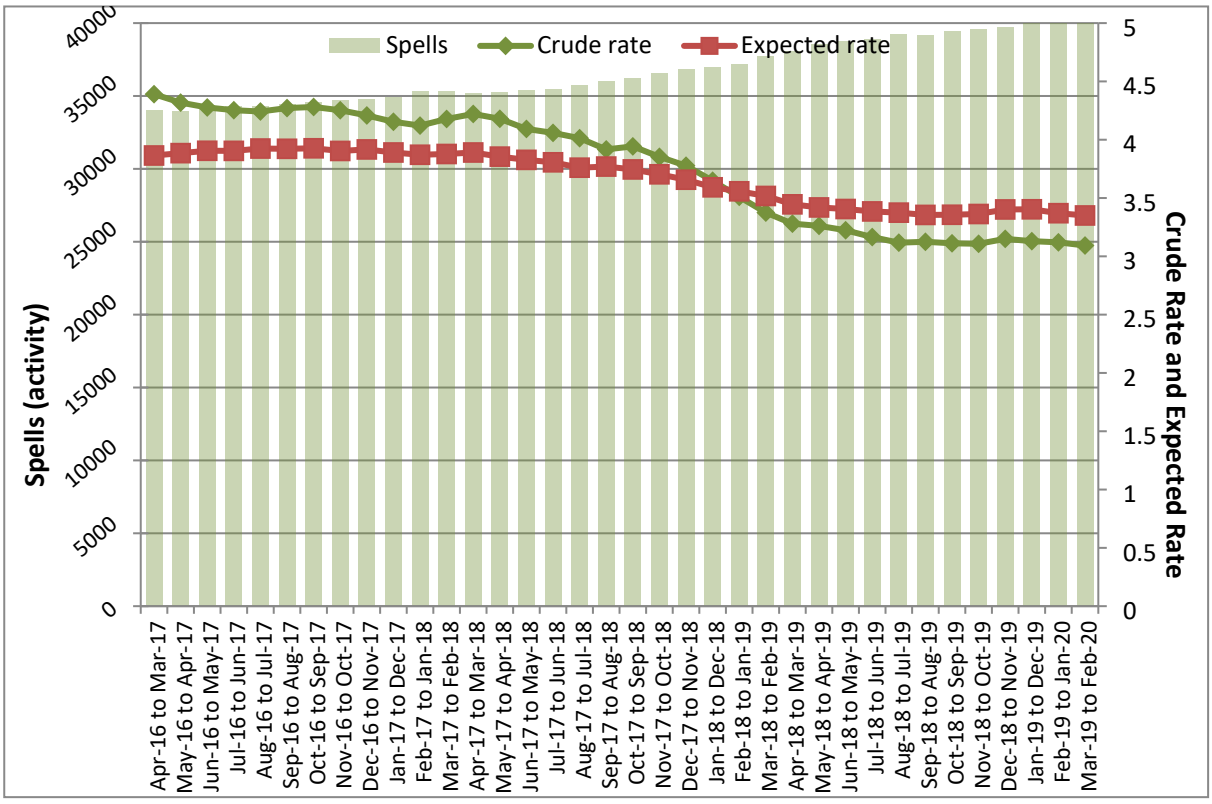


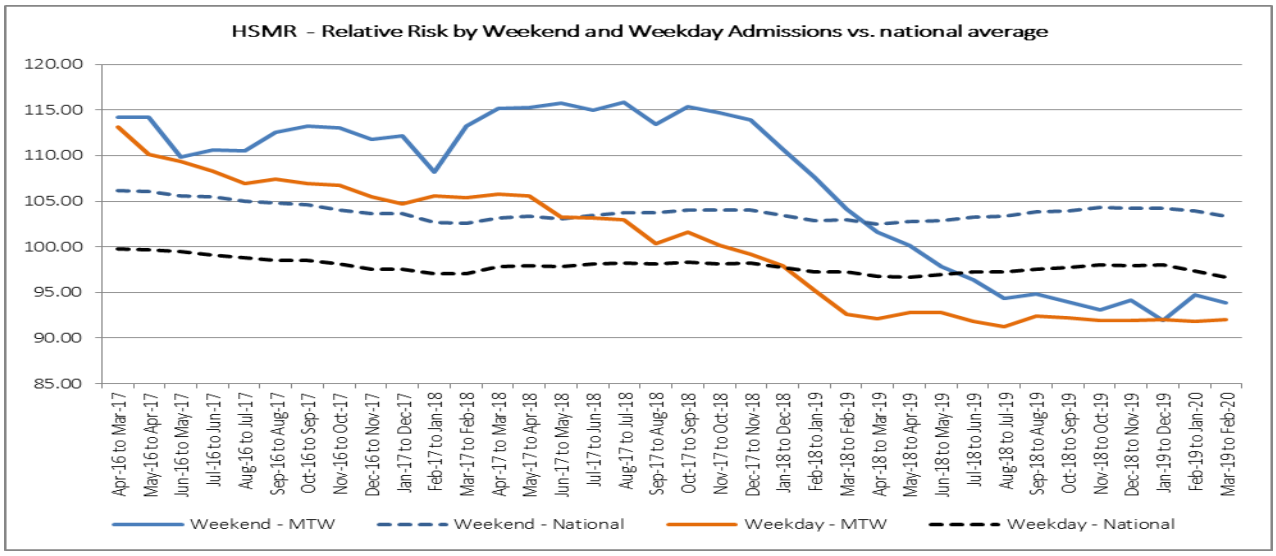
Figure 4b Spells against Crude Rate and Expected Rate



Weekend vs. Weekday Admissions

The Seven Day Services programme is focused around reducing variation in performance and mortality forms part of the scope of this work. The latest period has a HSMR of 93.8 (94.7 last month) for weekends and 92.0 (91.9 last month) for weekday admissions.

Figure 5 HSMR for Weekend and Weekday admissions vs. the National Average (NE Admissions)



The site split of the Weekday deaths for March 2019 to February 2020 is Maidstone – 87.2 (a decrease from last month of 86.6) and TWH – 95.4 (a slight decrease from 96.0 last month).

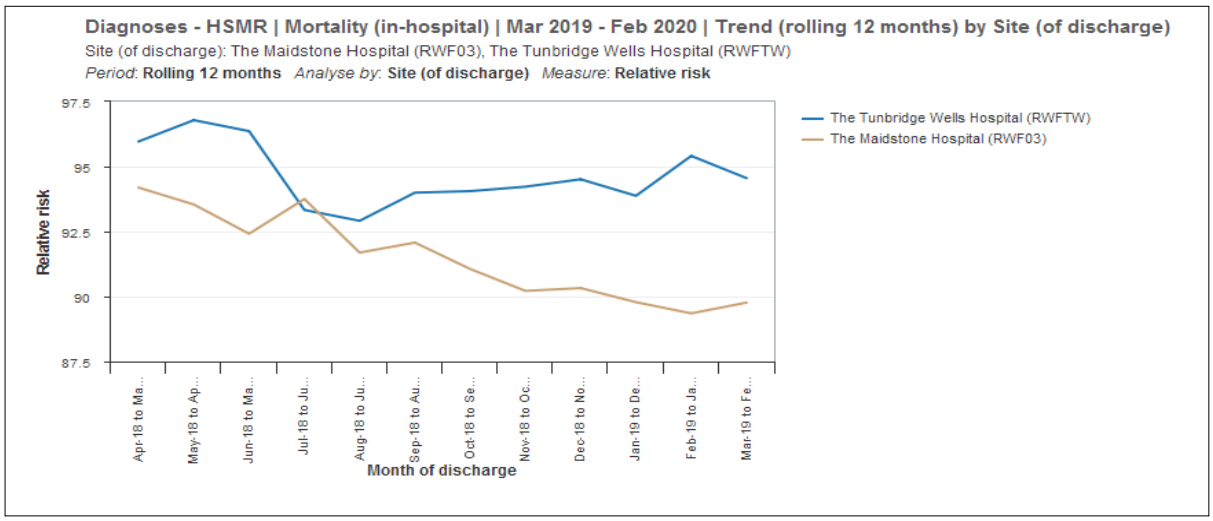
The site split of the Weekend deaths for March 2019 to February 2020 is Maidstone – 96.5 (a decrease from 96.7 last month) and TWH – 91.5 (a decrease from 93.1last month).

Latest analysis shows that patients admitted to the Trust on any day of the week have an 'as expected' or 'low' level of relative risk of death, previously Saturdays has a high relative risk.

HSMR – by site

Figure 6 shows the HSMR split by site. The HSMR at the Maidstone site has increased to 89.8 from 89.4 last month; the Tunbridge Wells site has decreased to 94.6 from 95.4 last month.

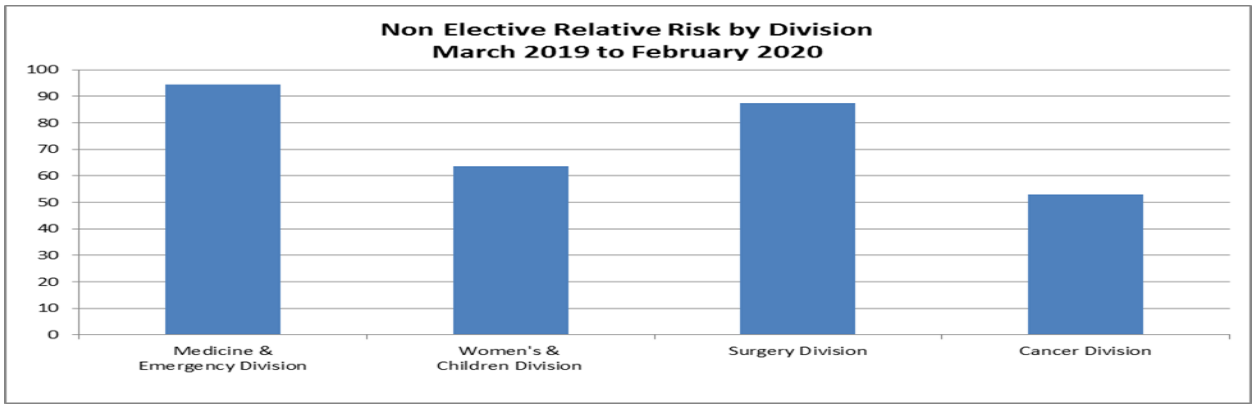
Figure 6 HSMR by site



HSMR by Division

All four divisions within the Trust have a non-elective relative risk within the expected range.

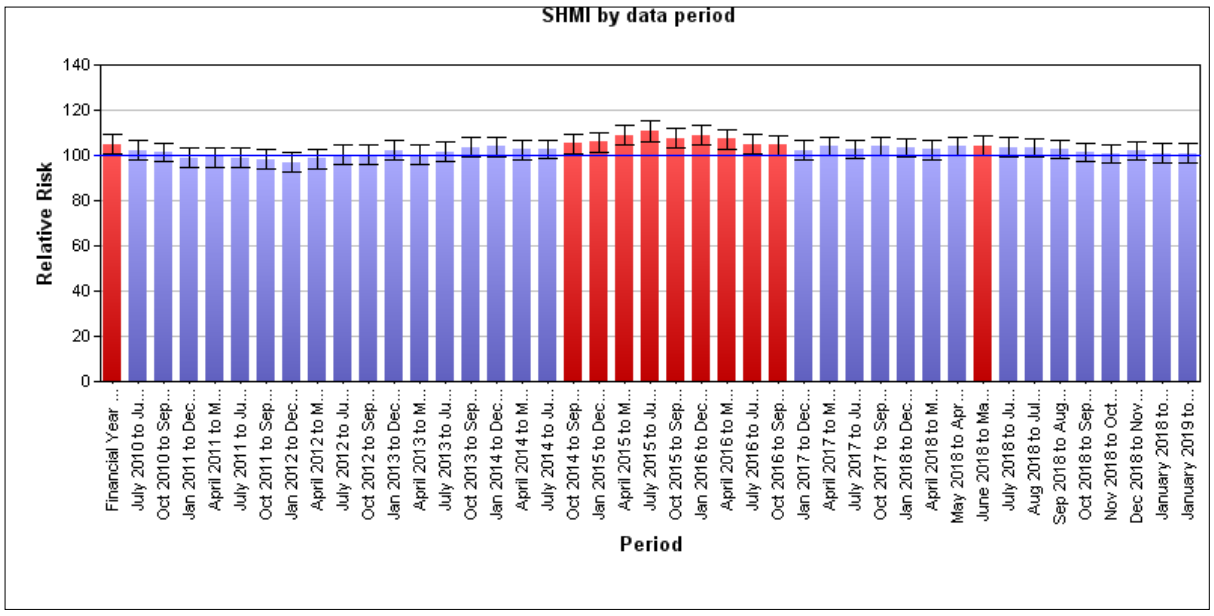
Figure 7 Divisional Non Elective Relative Risk



Summary Hospital-Level Mortality Indicator (SHMI)

SHMI is a measure of mortality and performance which includes all deaths in hospital regardless of diagnosis, in addition to all those individuals who die within 30 days of discharge from hospital. SHMI published by HSCIC for the period February 2019 – January 2020 shows SHMI as 1.0120 which is banded as level 2 “as expected”.

Figure 8 SHMI by data period



CUSUM (Cumulative SUM control chart) Alerts

CUSUM is a method of identifying areas where there are an unexpected cumulative number of mortalities which have been following treatment for a specific diagnosis; this can be both due to more and less than expected deaths. The below chart (Figure 9) demonstrates the diagnosis groups where the Trust has received negative alerts when using A ‘high’ (99%) detection threshold over the past 12 months.

Figure 9 Diagnosis with negative CUSUM Alerts

Relative risk & CUSUM alerts

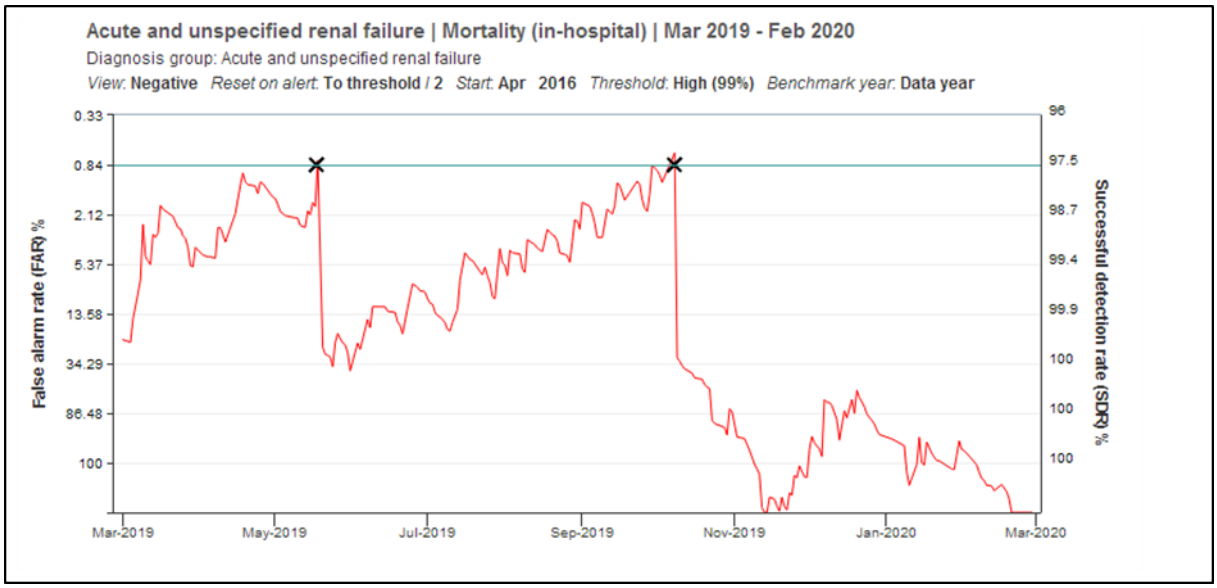
Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
All Diagnoses	1 4	120275	1458	1623.9	1.2	89.8				
HSMR (56 diagnosis groups)	3	40094	1240	1343.3	3.1	92.3				
Acute and unspecified renal failure	2	453	66	46.9	14.6	140.6				
Acute bronchitis	1	1241	18	22.6	1.5	79.7				
Parkinson's disease	1	96	6	2.0	6.3	300.8				
Sprains and strains	1	75	1	0.2	1.3	446.9				
All Procedures	1	79132	973	1046.7	1.2	93.0				
Rest of Miscellaneous operations	4	4255	47	21.4	1.1	219.8				

Healthcare records audits have been completed for Acute and Unspecified Renal Failure and Acute Bronchitis due to the number of observed deaths and the fact that two alerts have been triggered in the 12 month period (as per our local rule).

The Clinical Coding Team have reviewed the healthcare records for the following diagnosis groups where a CUSUM alert has been assigned but the number of observed deaths is low (<5 deaths):

- Parkinson's Disease
- Sprains and strains.

Figure 10 shows the CUSUM alert point for Acute and unspecified renal failure which has shown as having a red relative risk of 150.8 in March 2019 to February 2020, the patient level backing data for these alerts is supplied to the coding department to review.



Mortality Reviews

The Trust is required to review all in-hospital deaths following the Mortality Review Process. The results of these reviews are then collated and reported to ensure that any learning from deaths are identified and shared.

Trust & Specialty overview – March 2020 (reported one month in arrears) **–** Key <75% red, 75-95% amber, ≥95% green

Trust	2018/19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD
No of Deaths	1600	142	121	95	128	114	135	132	137	142	161	136	164	1607
No of Completed Reviews	1363	121	100	85	113	100	114	114	121	122	139	105	126	1360
%age completed reviews	**85.2%**	**85.2%**	**82.6%**	**89.5%**	**88.3%**	**87.7%**	**84.4%**	**86.4%**	**88.3%**	**85.9%**	**86.3%**	**77.2%**	**76.8%**	**84.6%**
No of Un-reviewed Deaths	237	21	21	10	15	14	21	18	16	20	22	31	38	247

%age completed reviews	2018/19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD
Specialist Medicine	88.9%	88.5%	80.0%	100.0%	84.2%	83.3%	81.8%	90.9%	93.8%	85.0%	68.8%	75.0%	78.3%	83.6%
Acute Medicine	84.5%	84.6%	83.7%	88.2%	91.8%	89.2%	87.5%	84.5%	87.0%	88.0%	88.5%	78.7%	76.7%	85.4%
Surgery	90.6%	100.0%	80.0%	80.0%	66.7%	60.0%	71.4%	78.6%	83.3%	66.7%	90.0%	100.0%	81.8%	80.6%
Trauma & Orthopaedics	40.7%	33.3%	0.0%	66.7%	66.7%	83.3%	50.0%	80.0%	66.7%	40.0%	66.7%	20.0%	50.0%	54.7%
Urol, Gonc, Breast, Vasc		100.0%	100.0%	100.0%			100.0%				50.0%		50.0%	77.8%
A&E	74.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.9%	85.7%	98.2%
Cancer & Haematology	90.9%	100.0%	100.0%		100.0%	100.0%		100.0%		100.0%	100.0%	0.0%	100.0%	100.0%
Children's	100.0%													
Head & Neck	100.0%							100.0%						100.0%
Women's & Sexual Health	100.0%										100.0%			100.0%
Trust Total	**85.2%**	**85.2%**	**82.6%**	**89.5%**	**88.3%**	**87.7%**	**84.4%**	**86.4%**	**88.3%**	**85.9%**	**86.3%**	**77.2%**	**76.8%**	**84.6%**

The table above shows the results for 2018/19 & April 2019 – March 2020 as at 12 May 2020.

During April 2019 – March 2020, 33 deaths have had an SJR completed which is 0.6% of the total deaths to date.

The Mortality Steering group is responsible for supporting the Trust in providing assurance that all hospital associated deaths are proactively monitored, reviewed, reported and where necessary, investigated. In addition it is to ensure that lessons are learned and actions implemented to improve outcomes.

Each Directorate has a nominated Mortality Lead with the key objective of ensuring that the Mortality review process is embedded locally and that deaths that have raised concern are fed-back to the Group from the Directorate and in addition that learning from the Directorates to the MSG and vice versa is sustained.

Learning from Mortality Reviews includes the need for:-

- Timely CTPAs
- Ensuring all appropriate assessments and safety netting is in place prior to discharging patients
- Regular and consistent senior review of patients
- Regular contact with families during discharge planning
- Discharging patients during sociable hours or where this isn't possible, to ensure that families are engaged with the discharge process and agree with the plan.

The following practice was highlighted in Mortality Reviews:

- Prompt reviews undertaken by Cardiology and ITU
- Detailed history and good management of chest issues by ED
- Good assessments undertaken by SHO in the MAU
- Good decision making regarding treatment escalation plans
- Good examples found of well documented discussions with families.

Medical Examiner Process Implementation Working Group

In addition to the Mortality Surveillance Group there is also a requirement for all acute Trusts in England to begin setting up medical examiner offices.

Since the last update, the working group has:

- Successfully recruited 5 Medical Examiners
- Successfully recruited 2 Medical Examiner Officers
- Provided induction and training packages for the Medical Examiner Officers
- Maintained regular contact with the regional Medical Examiner team
- Commenced work with the Medical Examiners on job planning, site cover, etc.
- Agreed a start date of the scrutiny process of September 2020 with an acceptance that not all deaths will be scrutinised by day 1 but all deaths should be scrutinised between 3-6 months of this start date.

The following next steps have been identified:

- Advertise for a 6th Medical Examiner and 3rd Medical Examiner Officer
- Confirm office space for the teams on each site and investigate the possibility of remote working
- Work with KCHFT to discuss future plans on the investigation of community deaths which is anticipated to be introduced in 2021/22.

Approval of Business Case for Point of Care Testing (POCT) — Chief Operating Officer

Enclosed is the Business Case for Point of Care Testing (POCT) which has been submitted following review by the Finance and Performance Committee on 23/06/20 for consideration for approval by the Trust Board. The outcome of the review by the Finance and Performance Committee will be reported verbally to the Trust Board.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 16/06/20
- Finance and Performance Committee, 23/06/20

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

Review and approval (by the Trust Board)

[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

BUSINESS CASE

Title: **A Compliant POCT Service for MTW via Managed Service Contract**

Issue date/Version number	Final Version 7 Year Option
ID reference	706
Division	Diagnostic and Clinical Support Services
Directorate	Pathology
Department/Site	Point of Care Testing
Author	Sue O'Brien-Wheeler
Clinical lead/Project Manager	Supriya Joshi

Approved by	**Name**	**Signature**	**Date**
General Manager/Service Lead	Mark Holland		
Finance Manager	Gemma Paling		
Clinical Director	Supriya Joshi		
Executive Sponsor	Steve Orpin		
Division Board	Neil Bedford		
Supported by	**Name**	**Signature**	**Date**
Director Estates & Facilities	Doug Ward		
Director of IT	Morfydd Williams		
Deputy Chief Operating Officer	Lynn Gray		
EME Services Manager	Michael Chalklin		
Procurement Partner	Jack Moss		
HR Business Partner	Angie Collison		

Business Case Summary

Maidstone and Tunbridge Wells NHS Trust

Strategic background context and need

This is a Trust-Wide business case led by Pathology rather than a single Divisional plan. It will enable the formation of a managed service contract for glucose/ ketone meters and blood gas analysers providing a standardised safe and robust service for patients of MTW.

Situation

- Point of Care Testing (POCT) is near patient **analytical** testing performed by non-laboratory staff.
- **Immediate** clinical decisions affecting patient outcomes are made based on the results obtained by POCT. It is vital to ensure that the results are accurate and precise enough to be fit for clinical purpose.
- The 9 blood gas analysers for replacement in this business case are all 8 to 11 years old with some replacement parts not available. There is supporting evidence of increased frequency of breakdown.
- The GEM5000 blood gas analysers purchased due to Covid-19 are outside the scope of this business case and are an additional requirement due to separation of Covid Red/Amber/Green patient containment and the need for additional testing capacity.
- Blood glucose/ketone meters are not networked (connectivity) so unfit for clinical needs (Diabetes GIRFT).

Background

- No strategic overview or overarching governance for POCT within MTW.
- Limited previous technical discussion around analyser selection, test performance relative to the main laboratories or advisory if POCT results were believed erroneous.
- Previous Datix category only for EME device fault - POCT sub-category now for poor results/governance.
- There is evidence of inferior governance and control of POCT impacting on patient care resulting in Serious Incidents and avoidable equipment failure SI 2017/105444, SI 2018/25350, SI 2019/10837.
- Coroners Regulation 28 report to prevent future deaths dated 22nd May 2019.
- Appropriate governance and updated equipment are needed to ensure results are accurate, precise, and recorded electronically just like laboratory results.

Assessment of Needs (of the Trust)

- Updated POCT equipment delivering accurate and precise patient results evidenced to current national standards by internal quality checks (iQC) and membership of external quality assurance (EQA) schemes.
- Selection and verification of new analysers for POC testing against lab results prior to clinical deployment.
- Centralised purchasing, receipt and quality checks for consumables prior to clinical deployment in MTW.
- Developing Trust standardised policies, SOPs, training and competency documents.
- Trust wide instrumentation training to ensure appropriate use of the instruments and handling of samples, internal quality control and external quality assurance, appropriate interpretation of results, and recognition of potential sources of error.

Recommendations

- POCT must be considered as a core Pathology Service and governed in line with the standards identified in MHRA, ISO and Pathology Quality Assurance Review documents.
- Current glucose/ketone meters and blood gas analysers should be replaced under a managed service contract (MSC) as a cost-efficient route for existing Trust revenue spend to initiate the required changes.
- Capital purchase of IT Middleware (POCcelerator) to conduit patient results into Sunrise and allow extraction of data from POCT equipment to empower better planning of daily and long-term services e.g. efficient utilisation of diabetes nurse specialists by identifying at-risk patients and facilitate NADIA reports.
- Capital purchase of stock management cabinets to enable efficient central purchasing, pre-clinical quality verification, and manage local distribution of Trust standard consumables following appropriate storage.
- Enhance the POCT team to centralise, manage and standardise service as stated above.

Objectives

1. Improve speed, accuracy and precision of results within a clear governance structure to promote patient safety, identify timely care and thereby reduce length of stay.
2. Increased controlled availability of blood ketone testing for safe management of diabetic patients. National guidelines now indicate testing for sick patients with Type 2 Diabetes on SGLT2 inhibitors.
3. Accurate electronic recording (just like laboratory results) to enable access to results for all clinical teams regardless of location and limit unnecessary test duplication causing stress and discomfort to the patient
4. Increased patient safety by automated alerts for critical results sent to specialist teams.
5. Increased patient safety by appropriate POCT staffing to meet quality service KPIs.

The preferred option

Managed service contract with Chrystal Consulting Ltd. for:

- 215 (+10% spare) connectivity Nova Statstrip glucose-ketone meters with new associated NovaNet server
- 9 replacement Werfen 5000 blood gas analysers managed by existing GEMWeb server

Capital purchase of:

- Siemens POCcelerator (specialist POCT Middleware)
- 3x Double unit dispensing cabinets for efficient centralised stock management with turn-key costs
- 3x Labcold under-counter size lockable fridges to work with cabinets
- 6x Tutela temperature monitoring probes to work with cabinets and fridges
- 1x Trust laptop with VPN
- 1x Trust tablet mobile device without VPN (on-site wireless)

Additional 2.0x WTE staff to support service development across both sites:

- 2x Band 4 POCT team

Main risks associated with the investment

Not undertaken:
Insufficient governance structure to meet required standards of patient safety. Continued risk to patients from outdated POCT equipment that is used by staff with minimum training and limited recognition of analytical errors. MTW Trust is exposed to medico-legal liability in the event of patient harm.

Not undertaken in the timescale:
MTW will continue to spend in excess of £550,000 per annum for sub-standard POCT provision until new cost saving MSC arrangements are in place. The glucose strip price for 2020 is fixed in 6-month periods until 31 December 2020.

Key risks associated with the delivery of the project:
1. Delay in getting IT infrastructure in place may change delivery timeline.
2. Release time for staff training must be agreed by ward managers which will impact on staff clinical availability.
3. Training is evidenced by personal barcodes registered in Middleware to unlock the analysers. Barcodes printed onto staff ID badges is desirable because affixing sticky barcode labels is inefficient, and replacing damaged labels impacts on lean process. Currently direct printing onto staff ID cards is not supported.

Financial Impacts
The financial modelling of each option is set out in section 4b within the economic appraisal, together with the assumptions. Further detail on the preferred option 3.3 is set out in the Financial Section 6.

The project requires £197k of capital to finance the Equipment, IT and Estates cost set out in the table below.

The economic appraisal sets out the whole life costs of each option against the baseline Option 1 'do nothing' option. The outcomes vary in a range of £85k over 7 years, based on the given assumptions and information. This is a narrow spread for a £4.3 - £4.4m whole life cost (c.2% range). Within this range, Option 3.3 reports the lowest whole life costs of £4.35m so is marginally preferred on this basis with a £17k cost reduction over the term on the current baseline. It should be noted that increased POCT infrastructure and governance under Option 3.3 will reduce the risk of successful medico-legal action against the Trust with consequent compensation awarded.

The new POCT infrastructure will also support connectivity and governance for multiple other MTW POCT including Pregnancy tests, Coaguchek INR, Clinitek SG8 Urinalysis, DCA HbA1c and iStat Creatinine

<table>
<tr><th colspan="4">Financial impact of the preferred option – full year effect – include VAT unless recoverable</th></tr>
<tr><th>CAPITAL COSTS</th><th>Sum(£)</th><th>Funding source</th><th>Sum(£)</th></tr>
<tr><td>Estates (Purchased)
6x Electric socket pair
3x Data point pair</td><td>
£6,300
£1,575</td><td>Identified in the Trust capital plan</td><td>2020/2021
Requested</td></tr>
<tr><td>IT (Purchased)
POCT Middleware (POCcelerator)
2x Demographic feeds
POCcelerator to Cloverleaf Interface</td><td>
£51,232
£30,000
£15,000</td><td>Identified in Trust revenue budgets
Blood gas/glucose/ketone service including reagents/ maintenance/ replacements/ syringes /capillaries/lancets and EQA costs identified by screening Integra and NHSSC. Cross-referenced to Abbott&Werfen data

Section 4b sets out the comparison of Preferred Option 3.3 costs against the baseline Option1 ‘Do Nothing’ which includes the projected spend of £554,134

<table>
<tr><th colspan="5">Variance to 'do nothing' Option 1 (- = increased costs)</th></tr>
<tr><th>Option 1</th><th>Option 2</th><th>Option 3.1</th><th>Option 3.2</th><th>Option 3.3</th></tr>
<tr><td>0</td><td>-15,082</td><td>-36,942</td><td>-68,328</td><td>17,062</td></tr>
</table>

<table>
<tr><th colspan="5">Variance of Option 3.3 to other Options (+ = savings)</th></tr>
<tr><th>Option 1</th><th>Option 2</th><th>Option 3.1</th><th>Option 3.2</th><th>Option 3.3</th></tr>
<tr><td>17,062</td><td>32,144</td><td>54,004</td><td>85,390</td><td>0</td></tr>
</table>
</td><td>Projected spend 2020/2021
£554,134
Inc. VAT

The 7-year value of ‘do nothing’ is £4,367,257</td></tr>
<tr><td>Equipment (Purchased)
3x Double stock cabinets
3x Lockable Labcold fridges
6x Tutela temperature probes
1x Laptop, dock/case and VPN
1x Tablet device without VPN</td><td>
£83,721
£3,260
£4,687
£1,000
£600</td><td rowspan="2">
<table>
<tr><th colspan="2">Proposed MSC Contract Costs – cash values for information</th></tr>
<tr><td>Year 1</td><td>£490,355</td></tr>
<tr><td>Year 2</td><td>£493,657</td></tr>
<tr><td>Year 3</td><td>£507,358</td></tr>
<tr><td>Year 4</td><td>£521,470</td></tr>
<tr><td>Year 5</td><td>£536,006</td></tr>
<tr><td>Year 6</td><td>£550,977</td></tr>
<tr><td>Year 7</td><td>£566,398</td></tr>
<tr><td>Total</td><td>£3,666,220</td></tr>
</table>

See section 6 for the MSC cost in the full context of the preferred option financials</td><td rowspan="2"></td></tr>
<tr><td>Total Capital cost of project</td><td>£197,375</td></tr>
</table>

The Business Case

1. Strategic context *Strategic Case*

National

Point of Care testing Standards require that management of laboratory services shall plan and implement the monitoring, measurement, analysis, and improvement processes needed to demonstrate conformity of POCT to the quality system, and that the governing body of the organisation shall be ultimately responsible for ensuring that appropriate measures are in place to monitor the accuracy and quality of POCT conducted within the healthcare organisation.

MTW Pathology is within an STP process with East Kent, Darent Valley and Medway Hospital NHS Trusts. As Pathology reconfigures POCT will be required to expand to meet urgent pathway requirement in the parent Trust and also the wider NHS Community services, where new focus is on partnership rather than competitive services.

Standards and national guidelines applicable to POCT

- ISO22870:2016 Point-of-care testing - Requirements for quality and competence
- MHRA 2013 Management and use of IVD point of care test devices
- Pathology Quality Assurance Review 2014
- British Journal of Haematology 2019
- BJDS-IP Management of Hyperglycaemia and Steroid (Glucocorticoid) Therapy 2014
- BJDS-IP A Good Inpatient Diabetes Service July 2019
- Diabetes GIRFT Report 2019 – Maidstone and Tunbridge Wells NHS Trust

Local

The need for POCT Coordinators was identified and initial funding derived from Pathology Blood Sciences budget. This resulted in the establishment of 1.2 wte band 7 posts to identify the scope of MTW POCT activity and develop governance for the service. The appointed staff joined MTW in June 2018.

- A full audit was performed of all POCT analysers in current clinical use. This identified an aged portfolio in which the software (configuration) was not standardised, and few devices had the ability to be networked via IT connectivity
- Audit of all POCT consumables purchase identified a total annual revenue spend of £620,000.
- Quality testing of consumables prior to clinical use was not performed or inconsistently recorded.
- No EQA scheme and inconsistent or no iQC for several tests
- POCT equipment was purchased through local budgets without sufficient evidence of technical evaluation, new technology options or comparison to main laboratory results for the same test.
- Pharmacy supplies blood glucose/ketone consumables centrally, but this requires Pharmacist authorisation for issue which impacts professional time and departmental space
- By sequential replacement of the two highest risk and spend elements (>80% POCT budget) within an efficient managed service contract, the IT and governance framework required to meet national standards can be implemented without addition to the existing revenue spend
- Blood glucose/ketones and blood gas equipment contracts are interdependent to achieve the best added value outcome for the Trust
- POCcelerator middleware installed as part of this business case will provide connectivity for other types of POCT analysers replaced in the future, forming a single efficient IT framework.

2. Objective(s) and Case for change of the proposed investment

Objective 1 – Improve speed, accuracy and precision of patient results within a clear governance structure to promote patient safety, identify timely care and thereby reduce length of stay

1.1 Blood glucose current situation:

- Approx. 215 Abbott Neo H meters are used Trust-wide in all clinical areas.

Problems / risks of current situation:

- Open access meter - anyone can pick up and use without Trust approved training – no audit trail
- Individual meters are small (pocket sized) and frequently lost/misplaced (average 10 per month)
- Evidence of instruments being used for patient testing without performing daily quality checks or despite evidence that the quality check had failed.
- Life threatening results are escalated manually - no real time alerts to the specialist team
- No centralised results to optimise targeting of DISN time (Diabetes Inpatient Specialist Nurse)
- A Pharmacist is required to sign off dispensing test strips – inappropriate use of Specialist time
- Difficult to collect and verify data for the annual Diabetes Audit, improper/inefficient use of diabetes specialist nurse time

The gaps from where we are to where we need to be:

- Quality testing (iQC) must be performed on **every day** of clinical use
- Automatic lock out of instrument when iQC fails, thus preventing patient testing with a faulty instrument
- Allocation of budget to ensure membership of External Quality Assurance (EQA) schemes
- Allocation of appropriate staff to manage samples, data, performance review and implement any changes identified
- Demographic feed to the meters via NovaNet for accurate patient ID via wristband barcode scan
- NovaNet can be configured to display MTW action prompts on the meter screen e.g. to highlight a critical result and indicate next steps that must be taken by care staff
- Acceptance testing of test strips per delivery prior to issue for clinical issue
- Connectivity meters to meet GIRFT recommendations

The expected benefits of achieving the change:

A. Improving Patient safety and quality of care by

- improving the accuracy and precision of results (see below for further information)
- escalation of life-threatening results to Inpatient Diabetes specialist nurses (DISN)
- efficient use of DISN time as they will have remote access to ALL inpatient glucose/ketone results
- Wireless transmission of results into Middleware in preparation for interface into EPR - accurate, fast and fully identified by scanned Patient ID/Operator ID/iQC history/Strip Lot info. with time and date providing excellent quality data. Top level access codes can extract data for national and local audit
- Meeting GIRFT recommendations

B. Improvement in the accuracy and precision of results through the following steps

- Only trust approved users will be able to use the machine - meter requires personal barcode scan to unlock – only issued after Trust approved training
- Quality checks (iQC) are programmed every 24hrs and must be successfully performed to unlock the meter for clinical use. Meters remain locked if not required e.g. weekly clinics
- EQA scheme membership fees are included within contract and additional POCT staff for EQA governance are included in this business case

- Test strip acceptance testing would be performed by POCT before strips are placed into the stock management cabinets for clinical collection – not via Pharmacy
- Acceptance testing on receipt allows time for replacement stock delivery if quality standards failed

1.2 Blood gas current situation *excluding Covid response analysers*:

- 9 GEM4000 in 8 areas – results include Hct, electrolytes, glucose, lactate, Hb fractions, bili
- Blood gas analyser range in age from 8 to 11 years
- TWH has one each in ED, ITU, Respiratory Ward 21, NICU, Labour Ward, and Cardiac Catheter
- Maidstone one in ED and two in ITU

Problems / risks of current situation:

- All blood gas analysers exceed expected lifecycle. Werfen engineer breakdown cases 2015-2019 number 3, 7, 6, and 10 respectively. Increasing risk of breakdown with older compatible parts not always available. Second visits required to change groups of hardware components to achieve a fix.
- MTW blood gas training has previously focussed on generating results rather than quality sample collection/pre-analytical sample handling/error recognition/method limitations. Non-standardised training leading to limited understanding can lead to erroneous results and potential treatment errors thus compromising patient safety
- Patient misidentification rate was 5.8% on audit - results not attributable or medico-legally valid
- Strong evidence of 4-digit access code sharing by untrained staff – Datix WEB78758
- Wastage due to expired reagents and unclaimed refunds which 2018/19 totalled £53,260 inc. VAT
- Analytical consumables are highly subject to storage conditions. There is audit evidence of inappropriate local storage and stock rotation. This is a risk to patient safety through generation of incorrect results

The gaps from where we are to where we need to be: Consider reallocation/reordering

- A demographic feed to analysers for accurate patient identification – IG data integrity
- Configuration of age-appropriate reference ranges using full accurate patient demographics
- Automatic new pack verification activates tests as each electrode becomes stable and passes iQC thus saving staff time and minimising errors associated with manual verification
- Improved screen software that simplifies use
- Technology alignment with other local Trusts for result comparability and consistent staff training

The expected benefits of achieving the change:

A. **Improved patient safety and quality of care**

- Faster analysis of samples and readiness for next test enabling increased throughput of samples, reducing queuing to minimise sample deterioration and to enable efficient use of staff time especially important in high workload areas such as ED and ITU
- Pre-deployment review of local reference ranges, clinical guidelines, and std. operating instructions
- Pre-deployment plan to ensure training content meets Trust needs and national standards
- Centralised ordering and storage of consumables in monitored temperature conditions prior to collection by local areas as required

B. Economic

- New state-of-the-art analysers provided with guaranteed 'up-time' throughout the whole life of contract. No additional warranty or EQA costs
- 100% pack usage guarantee – all credit reclaims issued by POCT will be verified paid by Chrystal
- Multiple local ordering with additional in case of pack failure leads to out-of-date stock – reduced by central ordering/storage

Objective 2 – Increased availability of blood ketone testing for safe management of diabetic patients

Current situation:

- Blood ketones are measured locally in ED, ITU and Hedgehog ward, however for all other wards/clinics it is available only when measured by DISN after phone referral 9am-5pm Mon/Fri

Problems / risks of current situation:

- Equipment is not fit for purpose as outlined above in Objective 1.1 glucose
- Unwell patients requiring blood ketone testing overnight or at weekends are at risk
- Evidence of 58% increase for ketone strip use to date in financial year 2019/20
- Uncontrolled testing is expensive and inappropriate for certain patient groups

The gaps from where we are to where we need to be:

- Ketone measurement possible to be turned on/off for each individual meter
- With result visibility, provision could be extended and monitored centrally for good practice
- Areas with a frequent need for blood ketones can have enabled meters with appropriate training
- Infrequent use areas can have ketones activated remotely by DISN or POCT when justified
- Ketone enabled meters can be stored centrally in stock management cabinets for collection overnight or at weekends to ensure strip and iQC solutions are stored correctly and within shelf life

The expected benefits of achieving the change:
Improvement in patient safety and quality of care by

- Access to ketone testing when indicated regardless of time and location of patient
- Escalation of critical results to DISN
- Improved patient management and efficient use of DISN staff time
- Safe, evidence managed increase of clinically targeted blood ketone testing within MTW

Objective 3 – Accurate electronic recording (just like laboratory results) to enable access to results to all clinical teams regardless of location within the Trust and limit unnecessary test duplication causing stress and discomfort to the patient

Current situation:

- Blood gas results are affixed into paper patient notes with sticky tape
- Blood glucose results are transcribed from the meter screen into the paper patient notes
- If accuracy is doubted or results are not readily to hand, POCT testing is repeated resulting in duplication of costs.
- Critical results must be notified by phone or bleep to the specialist teams

Problems / risks of current situation:

- Stuck in results fade over time or may become detached and fall out - loss of patient data, IG breach
- Staff may delay or fail to trigger appropriate escalation due to working pressures - recent multiple SIs in patients with diabetes
- Result transcription takes staff time, may forget, and with risk of mistakes
- A very basic Middleware programme (GEMWeb) is in place for the blood gas analysers. Data extraction is time consuming due to poor data formatting but has highlighted 20% wastage of reagent consumables. Only purchasing evidence is available to track blood glucose/ketones use
- Poor visibility of POCT results can lead to sub-optimal patient care

The gaps from where we are to where we need to be:

- A full blood gas profile contains 15 results (pH, pCO2, pO2, Na+, K+, Cl-, Ca++, Glu, Lac, tHb, O2Hb, COHb, MetHb, HHb, sO2). True paperless working in the Trust is not feasible until POCT results

transfer directly via Middleware into the EPR. Without this, over 5,000 individual test results per day would need to be typed and verified into Sunrise EPR between blood gas, glucose and ketones.

- POCT results must be available for current and historic review just like laboratory results as clinical decisions are based on them
- Access to results by clinicians regardless of location within MTW enables safe efficient working cross site
- Automatic, appropriate and timely escalation of critical results as part of patient pathways in agreement with specialist teams

The expected benefits of achieving the change:

A. Improving patient safety and quality of care

- Certainty of appropriate escalation in a timely manner to relevant staff.
- Time critical treatment can be delivered faster to improve likelihood of favourable outcome
- Direct upload of blood gas and blood glucose results into POCcelerator Middleware enabling paperless working
- A full audit trail is recorded in Middleware when patient results are viewed by staff
- Investigations, National Audit and clinical improvement reviews will become efficient

B. Economic

- POCcelerator Middleware (Siemens) is vendor neutral, has well established use within multiple NHS Trusts and is compatible with the largest range of connectable POCT devices.
- Vendor neutral competitor AegisPOCT (Abbott) is more expensive for original purchase. It has higher annual charges for Nova glucose/ketone meter connectivity, and lower functionality across other POCT devices. AegisPOC also had no launch date for GEM5000 drivers at time of comparison.
- When replaced all POCT devices will be linked into POCcelerator, and therefore be ready for single interface into Sunrise EPR, thus saving on multiple interfacing costs

Objective 4 – Improving governance in POCT and implementation of objective 1 and 2 through appropriate POCT staffing and stock management cabinets

Current situation:

- Lack of compliance with iQC and EQA testing across several POC platforms due to lack of identified budget and insufficient POCT staff for scheme management. Weekly iQC checks by the POCT team previously introduced for urinalysis has been suspended due to insufficient staff time
- Lack of testing of consumables prior to release in clinical use resulting in one serious incident and a separate Datix related to urine pregnancy testing (SI WEB81250, WEB89873)
- Evidence of overstocking and out of date consumables being used by staff
- Lack of protected time for compliance audits including regular feedback to managers
- Only 1.2WTE band 7 staff to drive up POCT standards across all clinical sites within MTW
- There is ongoing work to introduce governance around existing POCT devices, but staff are unable to fully address significant issues identified due obsolete equipment design and insufficient hours
- Increased training and documentation commitments from expanding governance and advisory

Problems / risks of current situation:

- Multiple SI for Diabetes services involving glucose/ketones and one for pregnancy testing
- No process to evidence that the Trust has taken measures to ensure accurate and precise results
- Consumable management (local ordering – not centralised) means there are multiple lot numbers in use without a register in the event of an urgent recall
- No ability/evidence that the quality of consumables is fit for clinical purpose. No acceptance testing and if introduced would be reliant on local staff not conversant with basic laboratory procedures

The gaps from where we are to where we need to be:

- The Trust must be able to demonstrate compliance with appropriate iQC and EQA measures, including evidence of remedial actions taken in cases of non-conformance
- The Trust must have a robust process for training and competency of staff to perform POC tests
- A Trust standard set of instructions is required per device – results can vary due to user technique
- Specialist POCT advisory is needed for introduction of new technology to improve patient flow
- Centralised management for consumable ordering and refund claims for maximum efficiency
- Delivery acceptance testing prior to release of consumables into Clinical areas

The expected benefits of achieving the change:

A. As outlined in objectives 1-3 and in addition

- Improved patient safety and quality of care through appropriate POCT governance

B. Economic

- Centralised ordering allows the Trust to maximise efficiency through economies of scale and ensure refund claims to achieve 100% blood gas reagent pack usage

3. Constraints and dependencies *Strategic Case*

As innovative POCT analysers came to market MTW introduced devices into clinical pathways without simultaneously developing an overarching strategy of governance to ensure that every analyser fulfilled its purpose to deliver evidence-based improvements for patient safety and flow. There are now also new POCT technologies for within-clinic diagnostics, but normally at higher cost individually than lab-based tests.

This business case identifies a unique opportunity for MTW to support a comprehensive POCT service redesign with new technology analysers fit for current national standards that is NOT constrained by residual capital value in existing IT (£0) or analysers (£0). Capital replacement of large numbers of relatively low value analysers cannot achieve the same scale benefits available by group procurement of testing services under a cost-efficient MSC.

Dependencies

- Pathology has limited spending currently allocated to POCT (blood gas EQA fees and 1.2wte staff redirected from core laboratory funding). If insufficient resources to provide compliant governance are allocated to Pathology, this business case will be withdrawn
- Revenue spending on POCT consumables currently sits in multiple Clinical budgets. To progress a POCT managed service contract one directorate must hold the contract. In light of national governance standards this should be Pathology. One-off budget transfer exposes Pathology to financial risk for any increased annual workload, thus Cross-Charging by Pathology is the preferred route to maintain local scrutiny of increased usage. This can be tagged on to existing EME cross charging methodology provided consumables can be stored in stock management cabinets
- The POCT Committee has overall responsibility to approve/reject applications for POCT devices

4. Short list of options *Economic Case*

Option 1 - Do Nothing

Description

1.1 Glucose/ketones – the current Abbott contract provides:

- Free iQC solutions
- Free replacement workstations (orange plastic storage box)
- Up to 2 Abbott days training and audit support between both sites per year
- Additional cost for replacement meters
- Additional cost for EQA

1.2 Blood gas - extend the existing Werfen agreement (no signed contract) which provides:

- List price reduction of 60% for reagent packs and ancillary consumables
- One analyser on extended loan in Maidstone ED (Trust owned unit was not repairable)
- Training and audit support when requested
- Refund for failed packs if judged faulty by Werfen from data download sent by EME/local managers
- Additional cost for annual warranties
- Additional cost for EQA

Key activity and financial assumptions

- Glucose activity reduced slightly overall in 2018/19 (434,681) from 2017/18 (449,200). There is no obvious reason for this and it is against national trends.
- Ketone testing is currently very limited within MTW. Increased prevalence of diabetes and national guidelines for inpatient testing will increase use. 2019/20 shows a 58% increase over 2018/2019. Comparison: MTW/EKHUFT/Medway NHS Trusts ketone tests performed 3016/13,000/37,260
- Blood gas workload increased by 14% in 2018/19 from 2017/18 predominantly due to higher testing on the TWH site in ED and ITU.
- Refunds are available for failed blood gas reagent packs. In 2018-2019 refunds were claimed for 16,538 tests but audit highlighted an additional 13,828 eligible test fails with a value of £24,513 inc. VAT were not claimed (£53,260 if expired tests included).

Non-financial risk associated with the option

- Multiple purchasing points leading to stockpile and/or shortage of consumables.
- Unverified consumable storage conditions leading to wastage or inaccurate performance.
- Insufficient POCT staffing to schedule with manufacturer and/or deliver training, develop Trust-wide standards of governance, or report performance efficiency to local managers and Trust.
- No delivery acceptance testing prior to deployment of consumables into Clinical areas
- Overall analyser up-time tracked by EME. Insufficient POCT time to track analyte availability.
- Continued dispensing of glucose/ketone strips through Pharmacy

Non-financial benefits associated with the option

- No deployment training – no staff release required

Option 2 - Replace Analysers by Capital Purchase with local consumable purchase and storage

Description

- Capital purchase of new analysers. Blood glucose/ketones replacement first due to significant risks with current technology and multiple SI.
- Blood gas GEM4000 replaced by GEM5000 due to equipment age/increased breakdowns.
- Capital purchase Middleware to provide patient result visibility, report functionality, and collate results in preparation for interface into Sunrise EPR.

Key activity and financial assumptions

- Capital purchases by the Trust and consumables will be subject to payment of 20% VAT
- Current 1.2wte staff will facilitate deployment training, manage operator access, NovaNet software

Non-financial risk associated with the option

- Local purchasing leading to continued stockpile and/or shortage of consumables
- 1.2wte cannot meet deployment/management standards
- Unverified consumable storage conditions leading to wastage or inaccurate performance
- No acceptance testing prior to deployment of consumables into Clinical areas
- Tracking of new equipment KPIs remains with POCT team and EME
- Continued dispensing of glucose/ketone strips through Pharmacy

Non-financial benefits associated with the option

- New connectivity analysers with operator management, iQC lockdown and full audit
- Results in Middleware ready for single interface into Sunrise EPR

Option 3.1 – MSC with additional POCT staff with local consumable storage

Description

- Three additional band 4 POCT staff to deliver service KPIs, centralised ordering **with delivery to departments.**
- Capital purchase Middleware to provide patient result visibility, report functionality, and collate results in preparation for interface into Sunrise EPR
- Managed contract by Chrystal Consulting Ltd. of blood gas and glucose testing services to include: equipment, all reagents and associated non-device consumables e.g. blood gas syringes, capillaries and finger-prick lancets. Also management of secondary suppliers performance KPIs and refund reclamation for faulty blood gas packs (100% usage guarantee except on-board expired)

Key activity and financial assumptions

- Chrystal Consulting Ltd. managed service provision to the Trust will be VAT recoverable at 20%
- Chrystal management fees are charged at a flat rate of 6% cost INCLUDED in figures below
- Centralised ordering/payment for services required by Chrystal Consulting Ltd. contracts
- Additional staff: POCT 3xBand 4 POCT staff
- Additional purchase of 1xlaptop with VPN and 1xtablet by capital spending

Non-financial risk associated with the option

- Collation of weekly consumable order via POCT team requires timely notification of requirements by local departments and POCT staff splitting up the delivery into labelled departmental bundles
- Unverified local consumable storage conditions leading to wastage or inaccurate performance.
- Local acceptance testing if performed is inefficient as it duplicates consumables and testing products used. Actions to take in case of quality failure may be poorly understood or overridden by no other consumables available for immediate use
- Continued dispensing of glucose/ketone strips through Pharmacy

Non-financial benefits associated with the option

- Connectivity analysers delivering result visibility and notifications to specialist teams
- Standardised performance reports for blood gas/glucose/ketones under current review and other POCT analysers as they are upgraded
- Results in Middleware interfaced to Cloverleaf ready for transmission into Sunrise EPR
- Additional POCT resources will enable scheduling/supporting of deployment training, development of Trust-wide standards of governance, and performance reporting to local managers and Trust
- Tracking of new equipment KPIs reported quarterly by Chrystal to POCT and the EME team
- Overall savings generated are employed to create a more robust governance service for all POCT including Middleware to support true paperless working across the Trust

Option 3.2 – MSC with additional POCT staff with centralised stock storage rooms

Description

- Three additional band 4 POCT staff to deliver service KPIs, centralised ordering with **delivery into three stock rooms** - two at Tunbridge Wells and one at Maidstone Hospital
- Stock rooms locked with access via Trust swipe cards
- Omnicell screens (recycled existing Trust owned units) inside each stock room for staff to book out all consumables taken from the room

- Capital purchase Middleware to provide patient result visibility, report functionality, and collate results in preparation for transmission into Sunrise EPR
- Managed service contract by Chrystal Consulting Ltd. as in option 3.1

Key activity and financial assumptions
Same as option 3.1 with additional:

- The Trust allocates three stock rooms large enough to contain fridges without undue heat gain
- Installation of access card locking for each stock room
- Capital purchase of 6x Tutela temperature monitoring probes
- Capital purchase of 3x Labcold fridges
- Installation of electrical and IT sockets for Omnicell screens, temperature probes and fridges

Financial risk associated with the option

- A stock room gives access to **all** consumables inside, risking mistaken or intentional removal of unaccounted items
- Sign-out compliance in **departmental** Omnicell stock rooms is around **70%+** however sign-out for **site-wide stock** could be even lower
- Accurate audit of waste not possible with unaccounted items, if staff do not sign items out
- **Continued supply of glucose/ketone strips through Pharmacy NOT via stock rooms**
- Loss of stock 'ownership' can lead to increased testing or wastage without local consequences
- Pathology exposed to budget shortfall due to unaccounted items (up to 30%) or increased usage if this service is commenced by start-up budget transfer rather than by monthly cross charging

Non-financial risk associated with the option

- Running out of stock due to additional items removed
- Frequent audit of stock required with investigation of discrepancies

Non-financial benefits associated with the option
Same as option 3.1 with additional:

- Weekly order collated by Omnicell software after confirmatory stock-check
- Centralised temperature monitored consumable storage, with 24hr automatic alert to POCT/EME if out of range thereby reducing wastage or inaccurate performance
- Acceptance testing of consumable deliveries prior to loading into stock rooms by laboratory trained POCT staff. This maximises efficiency ratio for the number of consumables/testing products required
- Connectivity analysers delivering result visibility and notifications to specialist teams
- Standardised performance reports for Trust POCT devices
- Results in Middleware ready for transmission into Sunrise EPR
- Additional POCT resources will enable scheduling/supporting of deployment training, development of Trust-wide standards of governance, and performance reporting to local managers and Trust
- Tracking of new equipment KPIs is reported quarterly to POCT and the EME team

Option 3.3 - MSC with additional POCT staff with centralised cabinets for stock management

Description

- Two additional band 4 POCT staff to deliver service KPIs, centralised ordering with **delivery into three double** stock management cabinets (Omnicell is Trust standard) – installing two at Tunbridge Wells and one in Maidstone Hospital.
- Capital purchase of three stock management cabinets
- Capital purchase Middleware to provide patient result visibility, report functionality, and collate results in preparation for interface into Sunrise EPR
- Managed service contract by Chrystal Consulting Ltd. as in option 3.1

Key activity and financial assumptions

- Capital purchase of 3 double stock management cabinets installed in Trust agreed locations
- Capital purchase of 6x Tutela temperature monitoring probes
- Capital purchase of 3x lockable Labcold fridges
- Installation of electrical and IT sockets for cabinets, temperature probes and lockable fridges

Financial risk associated with the option

- Management cabinets are a closed system that stores stock in multiple locked compartments accessed via individual doors. Potentially more units of identical stock could be removed from a compartment than registered by staff but compliance in other compatible Trust systems is around **90%+** which is significantly better than the 70%+ observed via departmental stock rooms.
- Audit of cabinet activity during the implementation phase will further reduce non-compliance.
- Loss of stock 'ownership' could lead to increased testing or wastage without local consequences
- Pathology exposed to budget shortfall due to unaccounted items (up to 10%) or increased usage if service commenced by budget transfer rather than by monthly cross charging
- To limit above financial risk to Pathology it is proposed that POCT consumables are charged to each location via extension of an existing EME cross charging process. POCT stock data will be aligned to the EME spreadsheet format and will be placed as an addendum to this file before it is submitted to Finance each month.

Non-financial risk associated with the option

- Periodic audit of stock would be required and any discrepancies investigated

Non-financial benefits associated with the option

Same as option 3.1 with additional:

- Weekly order collated by management cabinets for safe stock levels as users remove products
- Centralised temperature monitored consumable storage, with 24hr automatic alert to POCT/EME if out of range thereby reducing wastage or inaccurate performance
- Acceptance testing of consumable deliveries prior to loading into stock rooms by laboratory trained POCT staff. This maximises efficiency for number of consumables and testing products used
- Glucose/ketone strips through stock management cabinets NOT Pharmacy
- Connectivity analysers delivering result visibility and notifications to specialist teams
- Standardised performance reports for Trust POCT devices
- Results in Middleware ready for transmission into Sunrise EPR
- Additional POCT resources will enable scheduling/supporting of deployment training, development of Trust-wide standards of governance, and performance reporting to local managers and Trust
- Tracking of new equipment KPIs is reported quarterly to POCT and the EME team

Financial benefit

- Saving time and storage space for the Pharmacy department

Summary of options meeting business case clinical objectives

Options 1, 2 and 3.1 are given for illustration purposes only – they are unsustainable and do not meet Trust governance and sustainability requirements

Objective	Definition	Option 1	Option 2	Option 3.1	Option 3.2	Option 3.3
1	Improve speed, accuracy and precision of patient results within a clear governance structure to promote patient safety, identify timely care and thereby reduce length of stay	No	Implementation unsustainable due to insufficient POCT support staff	No with additional POCT Band 4 support	Yes with additional POCT Band 4 support	Yes
2	Increased availability of appropriate blood ketone testing	No		Yes	Yes	Yes
3	Accurate electronic recording (just like laboratory results) to limit unnecessary test duplication causing stress and discomfort to the patient - results available to all clinical teams	No		Yes	Yes	Yes
4	Increased patient safety by automated alerts for critical results to specialists	No		Yes	Yes	Yes
5	Increased patient safety by appropriate POCT staffing to meet quality service KPIs	No		Yes	Yes	Yes

4a. Summary of non-monetary benefits and risks of each option

Non - monetary benefits and risks of each option - *Summarise the non-monetary benefits and risks of each option*		
Option	**Benefits and risks**	**Option benefit and risk score and/or rank**
Option 1 **Do nothing**	**Benefits** No deployment training – no staff release required **Risks - glucose/ketone meters** *****Old design meters – new design has clear accuracy and IG benefits including automated safety features *****Inefficient DISN – no central register of most at risk or alerts *****Inefficient Pharmacy – dispensing non-drug test strips **Risks – blood gas analysers** *Analyser age – All exceed 7-year lifecycle. Design update means some repair parts not available. One on goodwill loan already *Analyser test back to ready cycle time is 4mins causing queues in busy areas delaying staff and impacting result accuracy **Risks – both** *Insufficient POCT time for governance/audit management *No acceptance testing of consumables *Local consumable ordering and storage - stockpile or shortage with risk of analytical reagents stored at wrong temperatures *No training update since deployment – skills are diluted	None – no benefit with highest risk
Option 2 **Replace Analysers by Capital Purchase**	**Benefits** *New technology analysers uploading quality patient results with real-time automatic specialist team alerts *Trust performance reports for blood gas/glucose/ketones *Results uploaded into Middleware ready for single interface into Sunrise EPR for paperless working across the Trust *Other POCT devices can be linked into this Middleware later **Risks** *Local consumable ordering and storage - stockpile or shortage with risk of analytical reagents stored at wrong temperatures *No acceptance testing of consumables *****Inefficient Pharmacy – dispensing non drug items	New analysers and IT but without sufficient POPCT staff to deploy and maintain support for governance improvements

Option 3.1 **MSC with additional POCT staff with local consumable storage**	**Benefits** *New technology analysers uploading quality patient results with real-time automatic specialist team alerts *Trust performance reports for blood gas/glucose/ketones *Results uploaded into Middleware ready for single interface into Sunrise EPR for paperless working across the Trust *Other POCT devices can be linked into this Middleware later *MSC savings released can be used to employ additional POCT staff to introduce compliant POCT service governance *Equipment KPI compliance reports via MSC to POCT/EME **Risks** *Collation of weekly consumable order via POCT team requires timely notification of by local departments. Limited loan/repay system may be possible *Unverified local consumable storage conditions leading to wastage or inaccurate performance *Local acceptance testing imposed for compliant governance duplicates consumables and testing products used. Actions to take in case of quality failure may be poorly understood or overridden by perceived need for immediate use *Inefficient Pharmacy – dispensing non drug items *Centralised budget leading to increased testing or wastage	New analysers and sustainable staffing but without evidence of appropriate consumable storage which is essential for accuracy and precision of patient results within a clear governance structure
Option 3.2 **MSC with additional POCT staff with centralised stock storage rooms**	**Benefits** *Weekly automated order for safe stock levels (audit by POCT) *Temperature monitored consumable storage with auto alert *Acceptance testing of consumables *New technology analysers uploading quality patient results with real-time automatic specialist team alerts *Standardised performance reports for Trust POCT devices *Results uploaded into Middleware ready for single interface into Sunrise EPR for paperless working across the Trust Other POCT devices can be linked into this Middleware later *MSC savings released can be used to employ additional POCT staff to introduce compliant POCT service governance *Equipment KPI compliance reports via MSC to POCT/EME **Risks** *Inefficient Pharmacy – dispensing non drug items *Centralised budget leading to increased testing or wastage *More stock removed from cupboard than recorded in software 70%+ compliance *Accurate audit of waste not possible with unaccounted stock *Glucose/Ketone stock dispensed via Pharmacy	New analysers with governance improvements
Option 3.3 **MSC with additional POCT staff with centralised cabinets for stock management**	**Benefits** *Automated order for safe stock levels *Temperature monitored consumable storage with auto alert *Efficient acceptance testing of consumables *Pharmacy time/space released – strips dispensed via cabinets *New technology analysers uploading quality patient results with real-time automatic specialist team alerts *Standardised performance reports for Trust POCT devices *Results uploaded into Middleware ready for single interface into Sunrise EPR for paperless working across the Trust Other POCT devices can be linked into this Middleware later *MSC savings released can be used to employ additional POCT staff to introduce compliant POCT service governance *Equipment KPI compliance reports via MSC to POCT/EME	New analysers with full governance improvements with lean workforce and working systems

	*Accurate departmental payments for POCT consumables used via extension of the existing EME cross charging process **Risks** *More stock removed from the management cabinet than stated by collecting staff 90%+ compliance	

4b. Summary of economic information on each option

	7 Year Revenue Costs				
					Preferred Option
Income and Expenditure Assessment per Option	Option 1	Option 2	Option 3.1	Option 3.2	Option 3.3
Purchased Asset Depreciation	-126,860	-427,739	-99,596	-118,105	-195,012
Purchased Asset Cost of Capital	-15,540	-52,398	-12,145	-15,561	-24,412
Consumables Expenditure	-4,224,857	-3,902,202	0	0	0
New Managed Service Costs	0	0	-3,666,221	-3,666,221	-3,666,221
Pay	0	0	-625,238	-625,238	-416,825
Recurrent Service Charges	0	0	-350	-9,811	-47,075
Non Pay (Non recurrent)	0	0	-650	-650	-650
Total Revenue	-4,367,257	-4,382,339	-4,404,199	-4,435,585	-4,350,195
Variance to 'do nothing' Option (- = increased costs)	0	-15,082	-36,942	-68,328	17,062

Comments

1. Each option shows the aggregated 7-year whole life costs in line with the proposed contract term of the preferred option. The variance to the baseline 'do nothing' Option 1 shows the aggregate change in costs.
2. Option 1 Do nothing assumes current costs continue without replacement of the asset base – this forms the baseline for comparison. All options assume 3% growth in demand so this has also been factored into the baseline for like for like comparison.
3. Option 2 assumes purchased asset replacement and models the capital charge impacts.
4. Options 3.1 to 3.3 use the Managed Service cost quotes, adjusted for growth. The Managed Service covers the consumables and equipment.
5. Further discussions with Chrystal have identified that as the analysers provided as part of this managed service contract are substitutable at Chrystal's choice, for their economic benefit, they do not fall to be assessed as leases under IFRIC 4 or IAS17.
6. The capital required for Option 3.3 (£197,375) will need agreement for funding within the Trust's capital allocation programme for financial year 2020-2021.
7. Options 3.1 to 3.3 include additional staffing (2 Band 4 posts) to support Point of Care Testing governance as set out in 5.d below. The higher point on the scale has been used to cost – if staff are appointed at the entry point the impact over the 7 years would be a further reduction of £41k.
8. Option 3.3 has higher recurrent service charges as it includes Omnicell as a key feature of this option.

The economic appraisal sets out the whole life costs of each option for comparison against the baseline Option 1 'do nothing' option. The outcomes vary in a range of £85k over 7 years, based on the given assumptions and information. This is a narrow spread for a £4.3 - £4.4m whole life cost (c.2% range). Within this range, Option 3.3 reports the lowest whole life costs of just under £4.35m so is marginally preferred on this basis with a £17k cost reduction over the term on the current baseline. It should be noted that increased POCT infrastructure and governance under Option 3.3 will reduce the risk of successful medico-legal action against the Trust with consequent compensation awarded.

The new POCT infrastructure will also support connectivity and governance for multiple other MTW POCT including Pregnancy tests, Coaguchek INR, Clinitek SG8 Urinalysis, DCA HbA1c and iStat Creatinine

Non-financial appraisal

Benefits *(non-financial)* score *and or rank of option*	None – Trust risk ongoing	**New analysers with connectivity governance**	**New analysers without consumable governance**	**New analysers with full governance improvements**	**New analysers with full governance improvements**
Risks score *and or rank of option*	Trust Risk Register 2447 No Change	Insufficient POCT staff to implement	Increased management. Pre-analytical storage risks	Increased audit/financial review. Pre-analytical risks	Reduced audit/financial review. Pre-analytical risks
	Risk rating 12	Risk rating 12	3x2 = 6	2x1 = 2	1x1 = 1
Summary of option (Preferred / discounted/ deferred)	Least preferred	Improved equipment but unsustainable staff levels for delivery	Improved equipment without appropriate consumable governance	Improved equipment with 70%+ efficiency consumable governance	Most preferred with 90%+ efficiency consumable governance

4c. Directorate decision on which option is preferred and why

Option 3.3

MSC with additional POCT staff and centralised dispensing cabinets for stock management

This provides us with analysers that are fit for current clinical use with full governance improvements with lean workforce and working systems and at the lowest whole life cost of the tested options

NOTE: From this point onwards the sections should be completed for the preferred option only.

5. Commercial considerations (Preferred option 3.3) *Commercial Case*

5.a. Services and/or assets required

1. Chrystal Consulting Ltd. managed service provision to the Trust
   This will be for blood gas and glucose testing services to include: equipment, all reagents and associated non-device consumables e.g. blood gas syringes, capillaries and finger-prick lancets.
2. Capital Purchase of:
   POCcelerator specialist POCT Middleware – annual licenses and support etc. in revenue spend
   1xlaptop with VPN
   1x iPad tablet without VPN
   3x double stock management cabinets
   3x lockable Labcold fridges
   6x Tutela temperature monitoring probes
3. Maintenance/support contracts on:
   VPN licence
   Tutela temperature monitoring probes
   Stock management cabinets
4. Trust costs for constructing IT demographic feeds and Cloverleaf interfacing have been allocated; however virtual server capacity is going to be provided from existing Trust capacity.

5.b. Procurement route

It is the intention of this business case to evidence that the transition to a fully governed networked connectivity portfolio is within fair and achievable budgetary constraints. It recommends the appointment of one Managed Service Provider from the Shared Business Services (SBS) framework to provide Point of Care testing services to MTW. The duration is for an initial period of 5 years extendable up to a further 2 years at 12month intervals. The 5+2 is from 1st July 2020. Any months / weeks prior to that start date will add on accordingly.

To balance costs and risks for the governance improvements required to introduce new devices a single procurement for blood glucose/ketone alone would not identify enough revenue savings. To evidence best value for the Trust both blood gas and glucose /ketones are presented together as they represent the highest risk and spend proportion of overall POCT activity (>80%).

- There are 6 providers on the SBS framework, and each company was considered with due diligence for POCT specialist experience, outline contract structure and management fees. In agreement with Procurement direct discussion with Chrystal Consulting Ltd. commenced in September 2019.
- Siemens POCcelerator Middleware was selected after benchmarking the 2 major POCT market options to identify which had the largest range of relevant POCT analysers and the most comprehensive level of device control and data transfer.
- Nova StatStrip meters were selected for highest technical merit and following consultation with clinical leads, including departments with additional clinical requirements e.g. paediatrics.
- Werfen GEM5000 analysers were selected for technical merit including the local support required to achieve consistent up-time. Trust familiarity, consultation with clinical leads and specific departments with additional clinical requirements.

5.c. Activity and service level agreement (SLA) implications. Commissioner involvement and input.

Changing the procurement vehicle for analysers and consumables will not in itself change future POCT activity within MTW. However by developing a compliant POCT service with overarching view of technical developments and Trust vision it will deliver a safer, more resilient and cost-efficient model.

5.d. Workforce impact

Point of Care Testing is a specialist Pathology discipline staffed by Biomedical Scientists and frequently Biochemistry specialists. This is due to the earliest POCT devices being for biochemistry tests and meeting governance standards tracks back to the parent discipline.

The POCT equipment audit in 2018 quickly identified clear and present patient risks for which immediate remedial actions were started. Reprogramming, relaunch of training and standardised 'Instructions for Use' have been implemented across several devices however time sensitive investigations and unplanned support requests create activity peaks that impact on routine tasks such as training, governance documentation, EQA and audit.

POCT is included in Pathology STP developments within multiple subgroups to plan for service challenges raised from core laboratory service redesign into 'hub and spoke' and closer working with Community.

Deployment of new generation devices requires additional workforce. It is unsustainable to develop further roles and responsibilities for the existing 1.2wte posts. Rotation of staff from core laboratories would destabilise core service delivery and allow insufficient time to develop the independent knowledge and skills required for working within the Clinical environments outside of Pathology.

Some existing tasks and connectivity service support could be achieved by POCT staff at band 4/5. Training for new support staff would be delivered by POCT device manufacturers and existing band 7 staff.
MSC signature to glucose/meter deployment will follow a 12week timeline. Recruitment of staff must begin immediately on approval of business case as appointment to commencement can also take up to 12 weeks.

The minimum additional staff and roles for preferred Option 3.3 are identified below:

Staff type & band	Current staffing (WTE)	Change (WTE)	The resulting staffing (WTE)
Band 7	1.2	0	1.2
Band 4 POCT	0	+2	2

5.e. Productivity Impacts

NaDIA report 2018 (National Diabetes Inpatient Audit)

Trending from 2018 (last year data available) shows that connectivity glucose meters will be used in 85% of hospitals nationally by 2020.

GIRFT visit 2019 evidence for MTW Type 2 Diabetes Patients:

- Length of stay for fractured neck of femur is 5 days above the national average.
- Length of stay for stroke patients is 4 days longer than the national average
- Re-admissions and mortality are also both higher than the national average
- DISN's have reached maximum capacity to see patients and must prioritise referred patients (38% seen during audit period).
- Not all patients are referred when needed and 10% of all referrals are not required.
- Connectivity blood glucose and ketone meters can be actively used to alert the diabetes DISNs to out of range glucose values and to monitor glucometrics across the trust and at ward level.

Comparative test usage to local Trusts

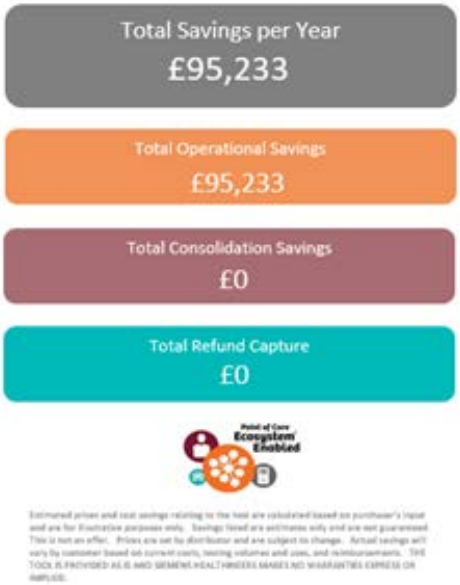
Glucose	
East Kent	460,000
Medway	299,420
MTW	426,681

Ketones	
East Kent	13,000
Medway	37,260
MTW	3,016

Connectivity meters with ketone lockout enable strategic Trust management of appropriate usage.

Questions			
General			
1	How many connectable POC devices do you have that are not connected to EPR?	215	Devices
2	How many tests are performed on nonconnected analyzers per day?	5.6	Tests
3	How many days per year do you perform testing?	365	Day
4	What is the average hourly rate for a POC coordinator?	26	GBP/Hour
5	What is the average hourly rate for a POC device operator?	17	GBP/Hour
6	On average, how long does it take to access all analyzers?	0.0	Minutes
Manual Entry of Patient Results			
7	How much time does it take to log results for one patient into the paper patient notes?	0.5	Minutes
iQC Documentation			
8	How many pairs of iQC tests are performed per analyzer per week?	5	Tests
9	How much time on average does it take to analyse one iQC test and then enter results into the record book to confirm correct performance	2	Minutes
Operator Certification			
10	How many operators are performing testing at the POC?	2,500	Operators
11	How much time does it take to update one operator entry, e.g., by manually entering the operator lists into point-of-care analyzers?	0	Seconds
12	How many operator entries do you need to update per month (e.g., adding new operators, deactivating operators who are no longer certified, removing operators who left the organization)?	0	Operators
13	How much time does it take per month to review the certification and training records of your operators?	180	Minutes
Device Configuration and Monitoring			
14	On average, how long does it take to customize one analyzer based on your site requirements?	0	Minutes
15	How many times per year do you change or check the analyzer setup to meet changing testing needs?	0	Times
16	How much time (including travel/walking time) does it take per week to monitor the functional and connectivity status of your analyzers?	0	Minutes
IT Consolidation			
17	What is the total cost of the IT hardware currently supporting your POC data-management system(s)?	0	GBP
18	What is the total cost of your current POC IT software, including interface connectivity, ADT, and annual fees supporting your POC data-management system(s)?	0	GBP
19	How many POC management systems are you running today?	0	System
20	What is the cost of your current third-party licensing fees, e.g., Microsoft, Oracle, etc.?	0	GBP
Unclaimed Refunds			
21	On average how many tests per day are lost and refund not claimed?	Unknown	Tests
22	What is the average refund for a failed test?	0.0	GBP

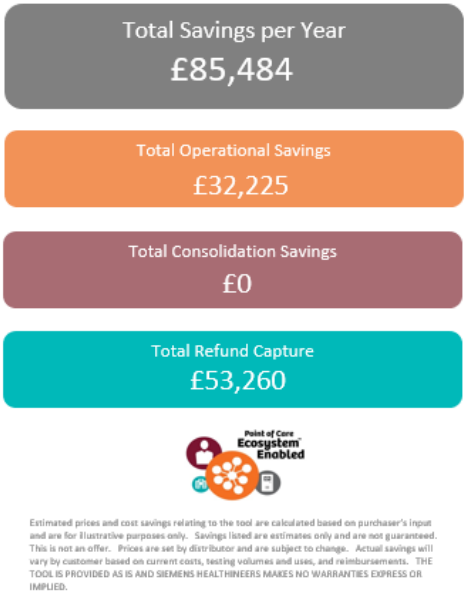
Potential productivity improvements from patient results transmitted direct to EPR, automated iQC result recording/verification and operator management via NovaNet.



Blood Gas Activity Review

	Questions		
	General		
1	How many connectable POC devices do you have that are not connected to EPR?	9	Devices
2	How many tests are performed on nonconnected analyzers per day?	30	Tests
3	How many days per year do you perform testing?	365	Day
4	What is the average hourly rate for a POC coordinator?	26	GBP/Hour
5	What is the average hourly rate for a POC device operator?	17	GBP/Hour
6	On average, how long does it take to access all analyzers?	0.5	Minutes
	Manual Entry of Patient Results		
7	How much time does it take to log results for one patient? (Note in future - manually entering patient results into the electronic record)	1	Minutes
	EQA Documentation		
8	How many EQA tests are performed per analyzer per week?	1.5	Tests
9	How much time on average does it take to analyse one EQA test, enter results into WEQAS website and local comparison spreadsheet to early identify performance issues and record performance in Qpulse once the national report is received?	12	Minutes
	Operator Certification		
10	How many operators are performing testing at the POC?	650	Operators
11	How much time does it take to update one operator entry, e.g., by manually entering the operator lists into point-of-care analyzers?	60	Seconds
12	How many operator entries do you need to update per month (e.g., adding new operators, deactivating operators who are no longer certified, removing operators who left the organization)?	20	Operators
13	How much time does it take per month to review the certification and training records of your operators?	40	Minutes
	Device Configuration and Monitoring		
14	On average, how long does it take to customize one analyzer based on your site requirements?	5	Minutes
15	How many times per year do you change or check the analyzer setup to meet changing testing needs?	1	Times
16	How much time (including travel/walking time) does it take per week to monitor the functional and connectivity status of your analyzers?	10	Minutes
	IT Consolidation		
17	What is the total cost of the IT hardware currently supporting your POC data-management system(s)?	0	GBP
18	What is the total cost of your current POC IT software, including interface connectivity, ADT, and annual fees supporting your POC data-management system(s)?	0	GBP
19	How many POC management systems are you running today?	1	System
20	What is the cost of your current third-party licensing fees, e.g., Microsoft, Oracle, etc.?	0	GBP
	Unclaimed Refunds		
21	On average how many tests per day are lost and refund not claimed?	78	Tests
22	What is the average refund for a failed test?	1.88	GBP

Potential productivity improvements from patient results transmitted direct to EPR, and centralised consumables management enabling efficient refund reclaims.



6. Financial Affordability (preferred Option 3.3) *Financial Case*

State all assumptions e.g. price base/part year impacts etc – include VAT unless recoverable

Option 3.3	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Total
Purchased Asset Depreciation	-27,950	-27,950	-27,950	-27,950	-27,950	-27,630	-27,630	-195,012
Purchased Asset Cost of Capital	-6,419	-5,441	-4,462	-3,484	-2,506	-1,533	-566	-24,412
New Managed Service Costs	-490,355	-493,657	-507,359	-521,470	-536,005	-550,977	-566,398	-3,666,221
Pay	-59,546	-59,546	-59,546	-59,546	-59,546	-59,546	-59,546	-416,825
Recurrent Non MSC Charges	-6,725	-6,725	-6,725	-6,725	-6,725	-6,725	-6,725	-47,075
Non Pay (Non recurrent)	-650	0	0	0	0	0	0	-650
Total Revenue	**-591,646**	**-593,319**	**-606,043**	**-619,176**	**-632,733**	**-646,412**	**-660,866**	**-4,350,195**

Financial Assumptions

- Purchased assets of £197,375 have been depreciated as follows, and are subject to the 3.5% cost of capital
  - Laptops and tablets – 5 years
  - Equipment and Middleware IT – 7 years
  - Estates Works – 10 years (End of year 7 closing NBV £2,363)
- The New Managed Service costs include an assumed 3% growth per annum and are based on quotes received from Werfen and Nova Organisations. It is assumed that VAT will be recoverable on the basis that the managed service meets the conditions of the contracted-out service rules.
- Pay costs assumes the requirement for 2.00wte @ Band 4 (£29,773 per annum) Trust cost per post; if staff are appointed at entry point there will be a further reduction of £41k over the 7 years.
- Recurrent service charges are for:
  - Stock cabinets Service and Support contracts
  - Tutela Service and Support contracts
  - Laptop Remote Access (VPN) annual fee
- Non recurrent non pay costs relate to the laptop software licenses that are not capitalisable.

Therefore there is a capital funding requirement for this case of:

1) **Purchased assets** **£197,375**

Monetised productivity improvements

Blood Glucose/Ketones Activity	£95,233
Blood Gas Activity	£85,484

Note: the values indicated are predominantly made up of **Clinical staff time** freed up by automated result capture and efficient refund process. These are additional and achievable under all options **except Option 1**

7. Quality Impact Assessment (Option5) *Management Case*

Clinical Effectiveness	
Have clinicians been involved in the service redesign? If yes, list who.	
Dr Supriya Joshi Consultant Chemical Pathologist and Clinical director of Pathology (Chair of POCT Committee) Dr Masud Haq **and** DrJesse KumarClinical Leads in Diabetes & Endocrinology directed to evidence in: 1. Coroners Regulation 28 report to prevent future deaths dated 22nd May 2019 2. MTW Diabetes GIRFT Report 2019 3. Capacity during Covid for DSNs to efficiently review ward patients with locally held glucose/ketone results Dr Tuck-Kay Locke – Consultant Respiratory and General Physician Quote: Access to accurate and timely blood gas analysis is essential for the delivery of high-quality respiratory care. The recent audit of acute non-invasive ventilation support for acutely unwell patients in our trust highlighted the close association between access to blood gas results with timely and appropriate clinical intervention. With Sunrise on the horizon, the ability to review all blood gas results on a single platform at MTW will greatly enhance the ability of Critical Care Outreach and Respiratory CNSs to respond to inpatients requiring urgent high dependency input. I believe this will be a great improvement to the current situation of manual entry of data in to patient's hospital records and result in better care for our patients.	
Has any appropriate evidence been used in the redesign? (e.g. NICE guidance)	
MHRA Management and use of IVD point of care test devices December 2013 ISO 22870:2016 Point-of-care testing (POCT) — Requirements for quality and competence	
Are relevant Clinical Outcome Measures already being monitored by the Division/Directorate? If yes, list. If no, specify additional outcome measures where appropriate.	
Clinical Outcome Measures not monitored - number and severity of SI indicate need for service redesign. Analysers and implied workload tested retrospectively 2017/18 and 2018/2019 - no previous Trust data	
Are there any risks to clinical effectiveness? If yes, list	
1. Release time for staff training will need to be agreed by ward managers which will impact on staff availability for ward duties	
Have the risks been mitigated?	
Arrange multiple trainings in central locations to allow ward managers to release 1 or 2 staff at a time	
Have the risks been added to the departmental risk register and a review date set?	
Multi directorate unrecognised risks because of historic lack of POCT governance POCT glucose/ketone provision is on Trust Risk Register (2447)	
Are there any benefits to clinical effectiveness? If yes, list	
Yes – significant benefit due to compliant sustainable POCT Service for MTW	
Patient Safety	
Has the impact of the change been considered in relation to:	
Infection Prevention and Control?	Y/N – Yes discussed with IP&C
Safeguarding vulnerable adults/ children?	Y/N – N/A
Current quality indicators?	Y/N – Yes significant improvements
Quality Account priorities?	Y/N – Yes significant improvements
CQUINS?	Y/N – Real time critical alerts support targets
Are there any risks to patient safety? If yes, list	
No risks – there will be significant reduction in existing risks	
Have the risks been mitigated?	
N/A	
Have the risks been added to the departmental risk register and a review date set?	
N/A	
Are there any benefits to patient safety? If yes, list	

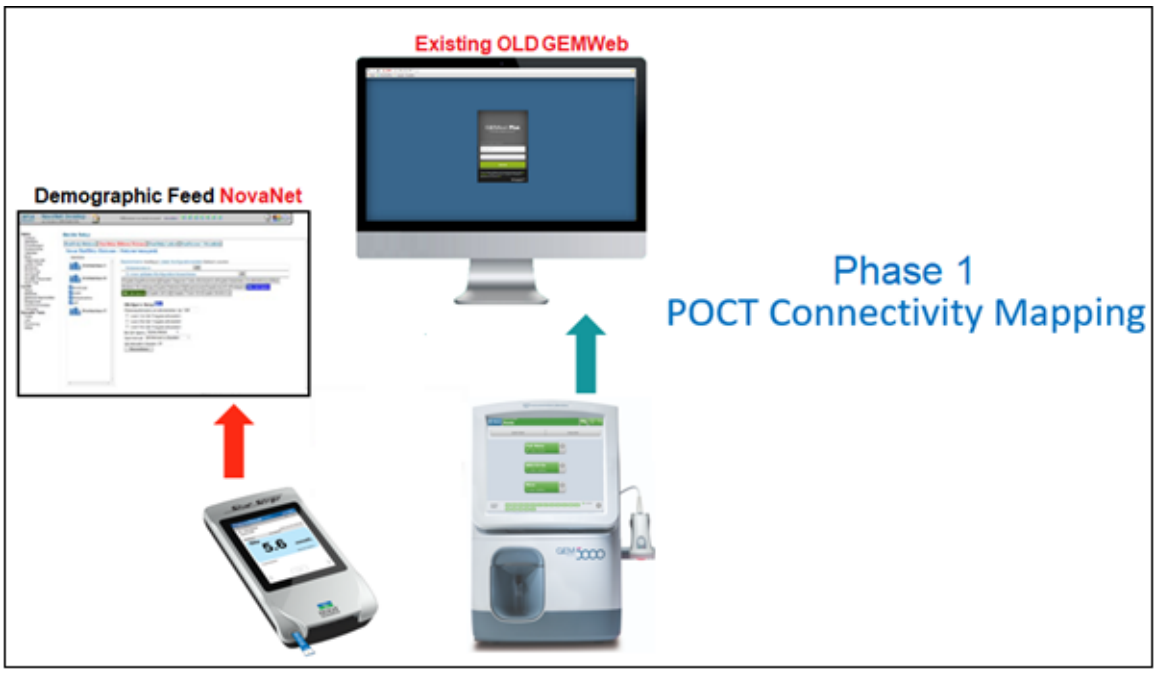
1. Increased accuracy and precision of point of care testing resulting in improved management of patients 2. Appropriate, automatic escalation of critical POCT results in a timely manner to specialist staff 3. Acceptance testing of consumables in each delivery to evidence they are fit for clinical use
Patient experience
Has the impact of redesign on patients/carers/members of the public been assessed? If no, identify why not.
No – Changing the procurement vehicle for analysers and consumables will not in itself be apparent to the patients/ carers/ members of the public. What will be achieved is significant improvements for accuracy/cost and IG management for the Trust within a compliant POCT Service.
Has the impact of the change been considered in relation to: • Promoting self-care for people with long-term conditions? • Tackling health inequalities?
No impact to self-care or tackling health equalities in this phase of service development. POCT in more evolved services can perform outreach into specific groups such as homeless or ethnicity that otherwise would not generally access traditional medical services or may have specific genetic risk factors.
Does the redesign lead to improvements in the care pathway? If yes, identify
1. Real time alerts for critical results sent directly to specialist teams for rapid intervention thereby improving likelihood of favourable outcome. 2. Appropriate levels of POCT staffing will support new technical evaluation for evidence based POCT in multiple care pathways. However, within this business case only blood gas/glucose/ketone are for immediate action.
Are there any risks to the patient experience? If yes, list
No
Have the risks been mitigated?
N/A
Have the risks been added to the departmental risk register and a review date set?
N/A
Are there any benefits to the patient experience? If yes, list
1. Limit unnecessary test duplication that causes stress and discomfort to the patient. Result availability for all POCT tests within POCcelerator Middleware and eventually Sunrise EPR.
Equality & Diversity
Has the impact of redesign been subject to an Equality Impact Assessment?
No impact
Are any of the 9 protected characteristics likely to be negatively impacted? (If so, please attach the Equality Impact Assessment)
No impact
Has any negative impact been added to the departmental risk register and a review date set?
No negative impact
Service
What is the overall impact on service quality? – please tick one box

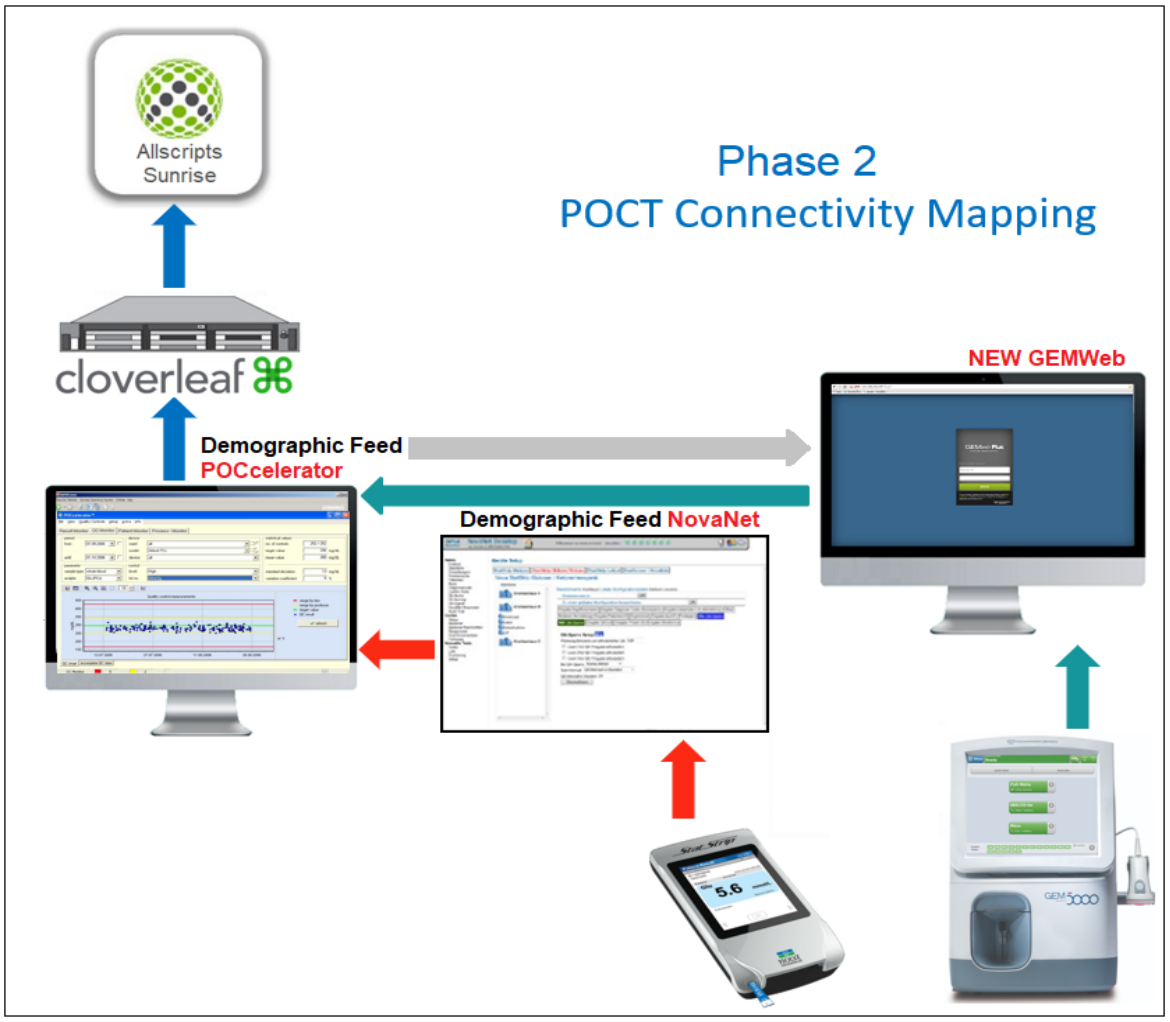
Improves quality	√	Maintains quality		Reduces quality	

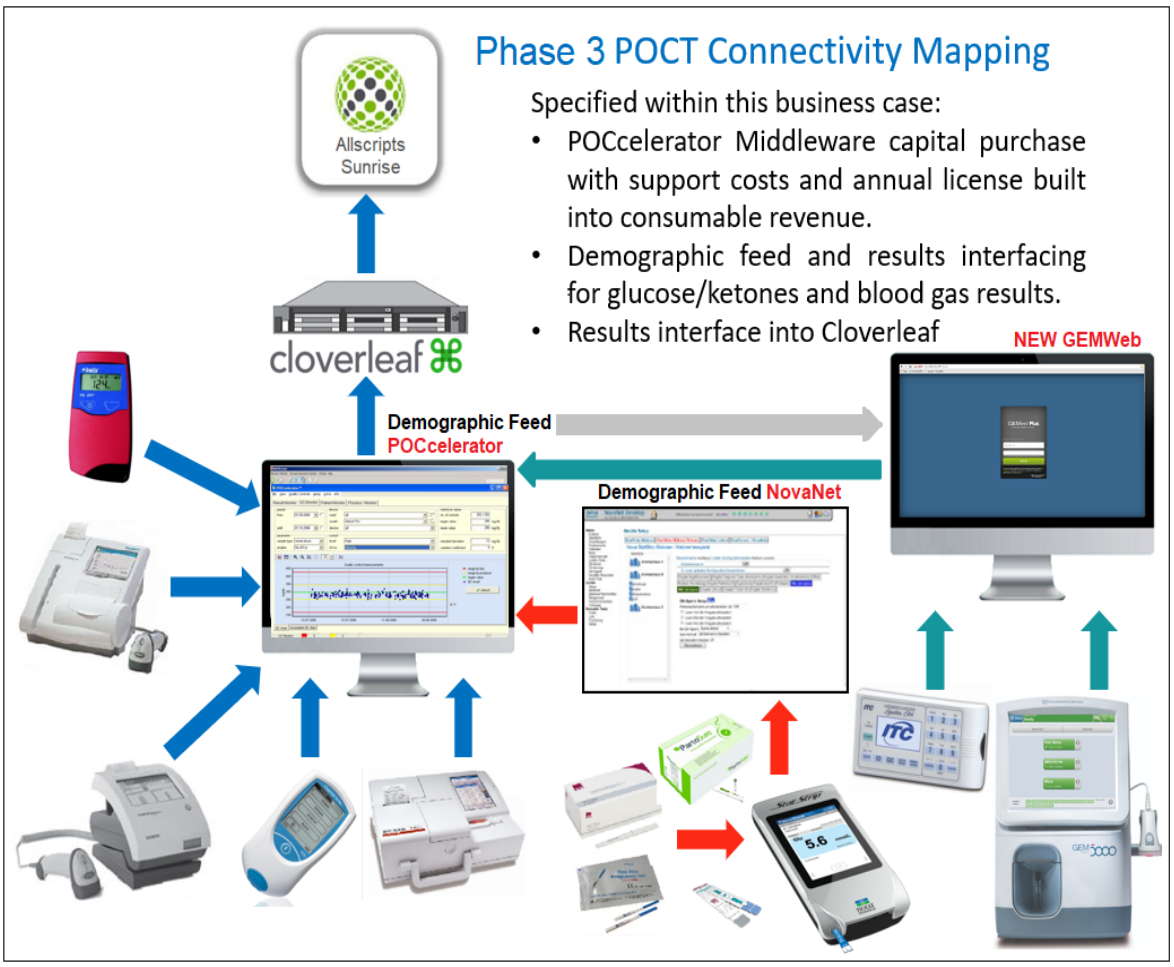
Clinical lead comments
This business case provides MTW with the tools necessary to provide a safe and high-quality point of care service to its patients.

Timetable

ID	Task Name	Type	Duration in days	Start Date	Completion Date	Forecast Completion Date	Actual Completion Date	Status	% Comp.	RAG
Phase 1										
POCT-01	POCT - Compliant POCT Service for MTW via Managed Service Contract	Task	2341	17/09/2018	13/02/2025	13/02/2025		Open	0	Green
POCT-02	Submit Outline Business Case for POCT	Milestone	0	31/10/2018	31/10/2018		31/10/2018	Closed	100	Blue
POCT-03	Commence invitation to tender for MES	Task	57	04/03/2019	30/04/2019		04/05/2018	Closed	100	Blue
POCT-04	Open discussions with direct supplier to negotiate contract	Task	25	03/06/2019	28/06/2019		21/06/2019	Closed	100	Blue
POCT-05	Finalise contract negotiations	Milestone	0	31/07/2019	31/07/2019	01/07/2020		Open	0	Amber
POCT-06	submit QIA and obtain approval	Task	52	02/07/2019	23/08/2019		16/09/2019	Closed	100	Blue
POCT-07	Write and Submit Full Business Case with accurate financial information	Task	182	01/04/2019	30/09/2019	13/06/2020		Open	0	Amber
POCT-08	Present Full Business Case to F&P committee for approval	Milestone	0	31/10/2019	31/10/2019	31/06/2020		Open	0	Amber
POCT-09	Appoint direct supplier for MES Contract	Task	0	31/07/2019	31/07/2019	17/07/2020		Open	0	Amber
POCT-10	Agree preferred supplier for Glucose / Ketone meters	Milestone	0	07/11/2019	07/11/2019	17/07/2020		Open	0	Amber
POCT-11	Install and test NovaNet including demographic feed	Milestone IT Stop/Go	43	17/02/2020	31/03/2020	31/08/2020		Open	0	Amber
POCT-12	Phase replacement of Glucose / Ketone equipments	Milestone	53	06/04/2020	29/05/2020	29/10/2020		Open	0	Green
POCT-13	Standardise Operating Procedures and guidelines	Task	0	29/05/2020	29/05/2020	29/10/2020		Open	0	Green
POCT-14	Glucose / Ketone staff training of relevant clinical staff	Task	60	30/03/2020	29/05/2020	29/10/2020		Open	0	Green
POCT-15	Recruit Band 4 staff	Task	102	17/02/2020	29/05/2020	15/10/2020		Open	0	Green
POCT-16	Install and test stock management systems	Task	49	17/02/2020	06/04/2020			Open	0	Green
Phase 2										
POCT-17	Firm up project timeline for replacement of blood gas analysers	Task	107	17/02/2020	03/06/2020			Open	0	Green
POCT-18	Install and test POCcelerator including demographic feed	Task	135	17/02/2020	01/07/2020			Open	0	Green
POCT-19	Install and test interface from POCcelerator to Cloverleaf/Sunrise	Task	164	17/02/2020	30/07/2020			Open	0	Green
POCT-20	Install and test new instance of GEMWeb linked to POCcelerator for clean data only	Milestone IT Stop/Go	164	17/02/2020	30/07/2020			Open	0	Green
POCT-21	Phased replacement of blood gas analysers	Task	92	10/08/2020	10/11/2020			Open	0	Green
POCT-22	Archive old instance of GEMWeb	Task	30	10/11/2020	10/12/2020			Open	0	Green
Phase 3										
POCT-23	Ongong replacements of other POCT analysers linking into POCcelerator	Task	1716	03/06/2020	13/02/2025			Open	0	Green




Allscripts
Sunrise
Phase 2
POCT Connectivity Mapping
cloverleaf
NEW GEMWeb
Demographic Feed
POCcelerator
Demographic Feed NovaNet


Allscripts
Sunrise
Phase 3 POCT Connectivity Mapping
Specified within this business case:
• POCcelerator Middleware capital purchase with support costs and annual license built into consumable revenue.
• Demographic feed and results interfacing for glucose/ketones and blood gas results.
• Results interface into Cloverleaf
cloverleaf
NEW GEMWeb
Demographic Feed
POCcelerator
Demographic Feed NovaNet

Business assurance and benefits realisation arrangements

Benefit	Baseline value	Target Value	Measure	Timing	Responsibility
Fewer POCT Datix and SI	30 in 12 Months	80% reduction	Calculation of events directly related to blood gas/glucose/ketones	12 Months	POCT Team
Electronic recording of glucose and ketone results	0%	100%	100% Abbott Neo H meters removed from clinical areas. Results in Novanet.	6 Months	POCT Team
Increased compliance to MTW diabetes testing protocols	Not available	70% - 100%	Audit and re-audit of connectivity results to evidence patients requiring a blood ketone test after a glucose result are tested in a timely fashion. Local training re-applied to reach target values.	12 Months	POCT Team DISN Team
Analyser quality checks and access by trained user only via automatic lockdown	50% (Blood Gas)	100% inc. (**Glucose/Ketones)**	All devices configured to 24hr and failed quality check lockdown. Operator lists under monthly review to remove leavers and notify staff if code expiry due. Recertification options available.	6 Months	POCT Team
Automated alerts for critical results sent to specialists	0%	100%	Available via POCcelerator on installation. Audit and re-audit of frequency and outcome.	18 Months	POCT Team Trust IT Team
Blood Gas failed pack credit NOT reclaimed	22%	0%	Audit of failed packs eligible for refund to identify if any not claimed.	12 Months	POCT Team

Risk Management and Contingency plans

							Pre-mitigation scoring			Post-mitigation scoring				
Risk ID	Status	Description	Date opened	Priority	RAG	Risk owner	Rating (A*B*C)	Probability (B)	Severity (C)	Rating	Probability	Severity	Mitigation plan	Contingency plan
POCT-01	Open	Delay in getting IT infrastructure in place may change delivery timeline	07/05/19	Med-Low	Amber-Green	Sue O'brien - Wheeler	12	4	3	4	2	2	Originally glucose/ketone meter implementation planned for Q4 2019. Specific server requirements provided to Darren Twort in July and he confirmed Trust IT has capacity to implement new servers in Oct 2019. This timeline is dependant upon negotiations with Chrystal Consulting Ltd. and Trust acceptance of the POCT MSC business case. Slow progress with Chrystal and anticipated winter pressures means meter implementation is likely to be postponed to Q1 2020. If MSC is signed off the server implementation can proceed for upload of Middleware and testing prior to launch Q1.	Only NovaNet server with demographic feed required in Phase 1 negotiate a new Trust IT capacity window once MSC signed off.
POCT-02	Open	Release time for staff training will need to be agreed by ward managers which will impact on staff availability on wards	07/05/19	Med-Low	Amber-Green	Sue O'brien - Wheeler	12	3	4	4	2	2	Arrange meetings in central locations to allow ward managers to send 1 or 2 staff over at a time.	
POCT-03	Open	Staff competency evidenced by bar code access is required. Printed onto staff ID badges is desirable to minimise risk of code sharing. Affixing sticky bar code labels is inefficient, and replacing damaged labels impacts ongoing management.	07/05/19	Low	Green	Sue O'brien - Wheeler	3	1	3	2	1	2	Requirement raised to Trust IT manager. Sticky lables could be used as an interim measure during project launch.	

9. Arrangements for post project evaluation (PPE) *Management Case*

The following template will be used after the project is completed, to assess issues and lessons learned with the planning for the investment and to what extent the expected benefits were achieved.

Complete the following section now

Name of Division/Directorate: Diagnostic and Clinical Support Services/Pathology
Evaluation manager: POCT Coordinator
Project Title & Reference: A Compliant POCT Service for MTW via Managed Service Contract. Ref:
Total **Reduced** Costs over 7 Years £17,062 (1% of current spend)
Start date: 01/07/2021
Completion date: Ongoing
Post project evaluation Due Date 01/07/2022

Complete this section by PPE due date

Section 1 INTRODUCTION

Background (a brief description of the project and its objectives)
Please give details of commencement of scheme, when staff were appointed and when full capacity was achieved.

SECTION 2: PROJECT PROCESS EVALUATION

Project documentation issues
Project execution issues
Project governance issues
Project funding issues
Human resource issues
Information issues
What worked well in developing case?
What could be improved in developing a case?
Summary of recommendations for developing a case

SECTION 3: ACHEIVEMENT OF OBJECTIVES

Did this Investment meet objectives?
Objective 1
Objective 2
Objective 3 How were they achieved?

SECTION 4: BENEFITS

Benefits planned in original Business Case (See benefits profile – attached below)
Benefit 1
Benefit 2
Benefit 3
Actual Outcome
(Please comment on variances or delays etc.)
How were benefits and outcomes evidenced? Please give details of such.

SECTION 5: VALUE FOR MONEY

What methodology was used to assess quality, funding and affordability and value for money of service provided? What were the conclusions?

SECTION 6: RECOMMENDATIONS AND LESSONS LEARNED

What problems were encountered during implementation of the project, and how where such resolved?
What was learned, how has this been disseminated, and to whom? Please provide supporting evidence.

10. Appendices

Add any additional supporting information here. Include detail of activity and financial information as appropriate. Please do not embed files into this document.

Version history

Version	Issue date	Brief Summary of Change	Owner's Name
1.0	09/12/2019	First pathology circulated draft	Sue O'Brien-Wheeler
1.1	11/12/2019	Second pathology circulated draft	Sue O'Brien-Wheeler
1.2	17/12/2019	First general circulated draft	Sue O'Brien-Wheeler
2.0	06/01/2020	First divisional circulated draft	Sue O'Brien-Wheeler
2.1	10/01/2020	Updated draft sent to JM & SJ	Sue O'Brien-Wheeler
2.2	17/01/2020	Updated draft sent to SJ	Sue O'Brien-Wheeler
2.4	20/01/2020	Updated draft sent to GP	Sue O'Brien-Wheeler
2.5	21/01/2020	Final draft sent to SJ, NB, PS, MH, JC, GP	Sue O'Brien-Wheeler
2.6	05/02/2020	Draft sent to NB and SJ – March timeline	Sue O'Brien-Wheeler
2.7	06/02/2020	Draft sent to NB and SJ – Feb timeline	Sue O'Brien-Wheeler
2.8	12/02/2020	Sent to NB and SJ	Sue O'Brien-Wheeler
Final	14/02/2020	Updated for financials and commentary	Amended by Gemma Paling
2.9	07/06/2020	Updated Post Covid BC suspension	Sue O'Brien-Wheeler
3.0	15/06/2020	Updated for financials and commentary	Amended by: Stuart Doyle, Gemma Paling and Sue O'Brien-Wheeler

Summary report from Workforce Committee (Incl. Quarterly Report from the Guardian of Safe Working Hours), 15/05/20	**Committee Chair (Non-Exec. Director)**

The Workforce Committee met on 15th May 2020.

- **The key matters considered at the meeting were as follows:**
  - The **actions** from previous meetings were reviewed and a plan of action submitted to the outcome of the investigation of the staff members from the same accommodation block that had tested positive for COVID-19
  - Under **to agree a proposed amendment to the Workforce Committee's Membership** it was agreed that the Trust Secretary and Chair of the Workforce Committee should Arrange for the Trust Board to Approve the change to the membership of the workforce Committees Terms of Reference that was agreed at the committee meeting on 15th May (To Replace the membership of the Chief Operating Officer with the Chief Finance Officer) *(N.B. the Trust Board on 21st May approved the amendment)*
  - The Committee reviewed the **Workforce Key Performance Indicators (KPIs)** and it was agreed that the Director Workforce should ensure that future "Review of the Workforce Key Performance Indicators (KPIs) reports included COVID-19 KPI data.
  - Under the **Staff Welfare during COVID-19** it was agreed that the Associate Director of Organisational Development should ensure the "Staff Welfare during COVID-19" update submitted to the July 2020 meeting included the Employee Assistance Programme (EAP) data if published, the usage data for the Improving Access to Psychological Therapies (IAPT) service and an update on the recruitment of an additional mental health practitioner to occupational health. It was also agreed that the Director of Workforce should provide an update to the July 2020 meeting on the recruitment of a support role for the Head of Staff Engagement & Equality.
  - The Committee received an **Update on the COVID-19 Staff Pulse Survey** wherein it was requested that the Associate Director of Organisational Development should develop and circulate the timeline for future staff pulse surveys (incl. the dates the surveys would be undertaken and when the results would be disseminated across the Trust).
  - The Director of Workforce reported the key **Workforce implications of COVID-19 (Incl. staff sickness)** including details of the distribution of COVID-19 positive staff across the Trust and the work that had been undertaken to develop a revised risk assessment for Black Asian and Ethnic Minorities (BAME) staff. It was agreed that the Director of Workforce and Associate Director of Organisational Development should submit the outcome from the COVID-19 BAME risk assessments to the July 2020 meeting as part of the "Staff Welfare during COVID-19" update.
  - The Committee received details of the **Transition plan to post COVID-19** including the various work streams that would be implemented and the areas that would be addressed within the work streams.
  - The Committee was informed of **The national NHS Staff Survey 2019 - Findings & Key Implications.** it was subsequently agreed following the meeting that an extraordinary meeting of the Workforce Committee should be scheduled for July to further review the NHS Staff Survey action plans in response to the findings.
  - Under the **Quarterly update from the Guardian of Safe Working Hours** (appendix 1) it was agreed that the Director of Workforce should Liaise with the Guardian of Safe Working Hours, the Medical Director and the Chief of Service for Surgery to review and provide a solution to the exception reports received from surgical FY1s as a result of expectations to write reports for governance meetings during clinical time.
  - Under the **Quarterly report from the Freedom to Speak Up Guardian** it was agreed that the Trust Secretary should Liaise with the Freedom to Speak up Guardian to seek their views on the order and method by which the Quarterly report from the Freedom to Speak Up Guardian should be submitted to the Trust Board and Workforce Committee (however, this

action was then closed later on in the meeting, when it was agreed that Quarterly report from the Freedom to Speak Up Guardian should be submitted to the Trust Board as the primary audience and then subsequently submitted to the Workforce Committee with the Freedom To Speak Up Guardian in attendance. It was also agreed that the Trust Secretary and Assistant Trust Secretary should Update the Committee's forward programme to reflect the decision regarding the scheduling of the Quarterly report from the Freedom to Speak up Guardian, with the Freedom to Speak Up Guardian to be in attendance)

- The Committee received an **Update from the Director of Medical Education (DME)** wherein the revised training approached for Medical students were discussed and the importance of resuming the education schedule was noted.
- Under the **Review of the relevant aspects of the Risk Register** it was agreed that the Director of Workforce should ensure that the next "Review of the relevant aspects of the Risk Register" included specific risks associated to COVID-19
- The Committee undertook a **Review of the Internal Audit Plan 2020/21** wherein it was noted that in future scheduling the Committee would receive the Internal Audit Plan prior to approval by the Audit and Governance Committee, however amendments to the plan could still be requested. It was agreed that the Trust Secretary should schedule a review of the Internal Audit Plan 2020/21 for the July 2020 meeting.
- The Committee received the **summary report from the Health & Safety Committee** during which it was agreed that the Chief Nurse should investigate the nine RIDDOR reportable staff falls and provide a plan of action to the July 2020 meeting.
- It subsequently agreed following the meeting that the Committee should receive a quarterly review of internal communications with the Director of Strategy, Planning and Partnerships to attend for this item

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

- The Quarterly Report from the Guardian of Safe Working Hours has been enclosed in appendix 1
- An extraordinary Workforce Committee meeting has been schedule for July to review the action plans in response to the national NHS Staff Survey 2019 findings.

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

WORKFORCE COMMITTEE – MAY 2020

QUARTERLY UPDATE FROM THE GUARDIAN OF SAFE WORKING HOURS	**GUARDIAN FOR SAFE WORKING HOURS**

The enclosed report covers quarter 4 of 2019/20.

Reason for submission to the Workforce Committee
Review and Assurance

Guardian for Safe Working Report
Quarter 4 January – March 2020

Reporting Period: January – March 2020

This report covers the period January – March 2020 in which time a total of 122 exception reports were raised.

Summary:

- Total of 122 exception reports received in this period.
- 58 in medicine, 64 surgery.
- Exception Reports were raised by 95 FY1 and 27 FY2
- 40 exception reports coming from 5 trainees
- Meeting held with BMA IRO to discuss exception report activity in last few months.

High level data: January – March 2020

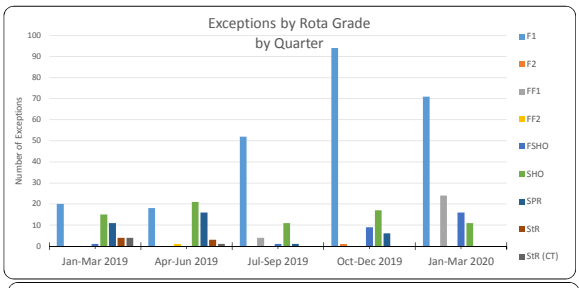
- Number of doctors in training on 2016 TCS (total): 346

In total for this period 122 Exception Reports were raised by foundation level doctors.

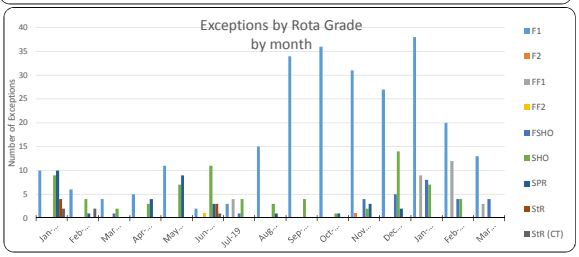
Exception reports (with regard to working hours)

Exception reports by department: January – March 2020				
Specialty	Carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Medicine	1	58	58	0
Surgery	3	64	64	0
Total	**4**	**122**	**122**	**0**
Exception reports by grade: January – March 2020				
Grade	Carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	4	95	95	0
F2	0	27	27	0
Total	**4**	**122**	**122**	**0**
Exception reports (response time) January – March 2020				
Grade	48 hours	Within 7 days	longer than 7 days	Still open
F1	18	4	73	0
F2	1	2	24	0
Total	**19**	**6**	**97**	**0**

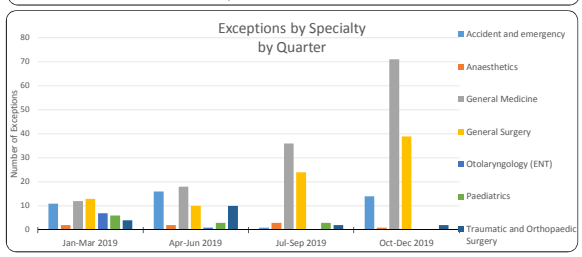
a) **Work Schedule reviews January – March 2020 None in period.**



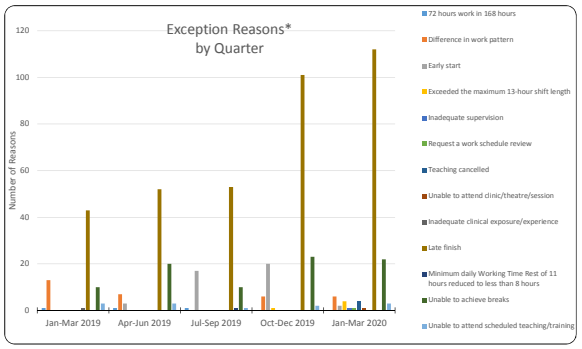
Rota Type	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Total	%
F1	20	18	52	94	71	**255**	**58.9%**
F2				1		**1**	**0.2%**
FF1			4		24	**28**	**6.5%**
FF2		1				**1**	**0.2%**
FSHO	1		1	9	16	**27**	**6.2%**
SHO	15	21	11	17	11	**75**	**17.3%**
SPR	11	16	1	6		**34**	**7.9%**
StR	4	3				**7**	**1.6%**
StR (CT)	4	1				**5**	**1.2%**
Total	**55**	**60**	**69**	**127**	**122**	**433**	**100.0%**



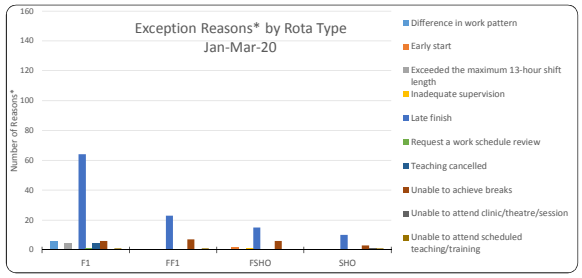
	Months										
Rota Type	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**
F1	10	6	4	5	11	2	3	15	34	36	31
F2											1
FF1							4				
FF2						1					
FSHO			1				1				4
SHO	9	4	2	3	7	11	4	3	4	1	2
SPR	10	1		4	9	3		1		1	3
StR	4					3					
StR (CT)	2	2				1					
Total	**35**	**13**	**7**	**12**	**27**	**21**	**12**	**19**	**38**	**38**	**41**



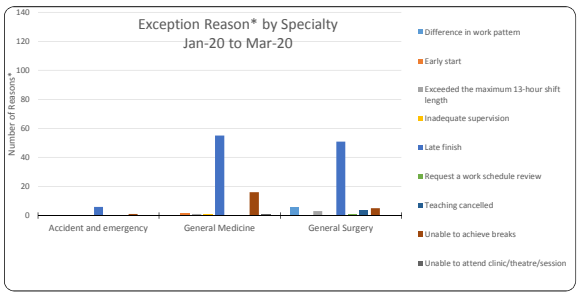
Specialty	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Total	%
Accident and emergency	11	16	1	14	6	**48**	**11.1%**
Anaesthetics	2	2	3	1		**8**	**1.8%**
General Medicine	12	18	36	71	58	**195**	**45.0%**
General Surgery	13	10	24	39	58	**144**	**33.3%**
Otolaryngology (ENT)	7	1				**8**	**1.8%**
Paediatrics	6	3	3			**12**	**2.8%**
Traumatic and Orthopaedic Surgery	4	10	2	2		**18**	**4.2%**
Total	**55**	**60**	**69**	**127**	**122**	**433**	**100.0%**



Exception Reasons*	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Total	%
72 hours work in 168 hours	1	1	1		0	**3**	**0.5%**
Difference in work pattern	13	7		6	6	**32**	**5.8%**
Early start		3	17	20	2	**42**	**7.7%**
Exceeded the maximum 13-hour shift length				1	4	**5**	**0.9%**
Inadequate supervision					1	**1**	**0.2%**
Request a work schedule review					1	**1**	**0.2%**
Teaching cancelled					4	**4**	**0.7%**
Unable to attend clinic/theatre/session					1	**1**	**0.2%**
Inadequate clinical exposure/experience	1				0	**1**	**0.2%**
Late finish	43	52	53	101	112	**361**	**65.8%**
Minimum daily Working Time Rest of 11 hours reduced to less than 8 hours			1		0	**1**	**0.2%**
Unable to achieve breaks	10	20	10	23	22	**85**	**15.5%**
Unable to attend scheduled teaching/training	3	3	1	2	3	**12**	**2.2%**
Total	**71**	**86**	**83**	**153**	**156**	**549**	**100%**



	Rota Grade				
Exception Reasons*	**F1**	**FF1**	**FSHO**	**SHO**	**Total**
Difference in work pattern	6				**6**
Early start			2		**2**
Exceeded the maximum 13-hour shift length	4				**4**
Inadequate supervision			1		**1**
Late finish	64	23	15	10	**112**
Request a work schedule review	1				**1**
Teaching cancelled	4				**4**
Unable to achieve breaks	6	7	6	3	**22**
Unable to attend clinic/theatre/session				1	**1**
Unable to attend scheduled teaching/training	1	1		1	**3**
Total	**86**	**31**	**24**	**15**	**156**



	Specialty			
Exception Reasons*	**Accident and emergency**	**General Medicine**	**General Surgery**	**Total**
Difference in work pattern			6	**6**
Early start		2		**2**
Exceeded the maximum 13-hour shift length		1	3	**4**
Inadequate supervision		1		**1**
Late finish	6	55	51	**112**
Request a work schedule review			1	**1**
Teaching cancelled			4	**4**
Unable to achieve breaks	1	16	5	**22**
Unable to attend clinic/theatre/session		1		**1**
Unable to attend scheduled teaching/training		2	1	**3**
Total	**7**	**78**	**71**	**156**

*** Note that some exceptions give more than one reason.**

Summary report from Quality Committee, 02/06/20 Committee Chair (Non-Exec. Director)

The Quality Committee met (virtually, via webconference) on 2nd June 2020 (a Quality Committee 'deep dive' meeting).

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

- The Chief of Service for Women's, Children's & Sexual Health and Divisional Director of Midwifery, Nursing & Quality attended to present a **review of maternity services**. The presentation gave considerable assurance on the processes in place, and on the further work required. It was acknowledged that some of the issues, such as the documentation of a contemporaneous record of any telephone conversations with consultants, needed further discussion and debate within the Division. The allocation of a lead Non-Executive Director for maternity services was also discussed and it was agreed that the Committee's Chair would liaise with the Chair of the Trust Board to discuss whether such a lead could be assigned, and if so, to determine which Non-Executive Director that should be. It was also agreed to schedule a "Review of maternity services – update" item at the Quality Committee 'deep dive' meeting on 16/10/20.
- The Deputy Chief Nurse, Lead Nurse, Tissue Viability and Tissue Viability Nurse then attended to give a presentation on **pressure ulcers.** The presentation again gave assurance on the action that had been, and would be, taken on the key issues, but it was noted that liaison would continue to be required with the clinical areas, as there were only two members of the Tissue Viability Nurse team.
- A discussion was then held on the **items that should be scheduled for scrutiny at future Quality Committee 'deep dive' meetings**, and it was firstly agreed to schedule a "Review of complaints during the COVID-19 period" at the 'main' Quality Committee on 08/07/20 (instead of the Quality Committee 'deep dive' meeting in August). It was also agreed that the Chief Nurse, Medical Director, Deputy Director of Quality Governance and Deputy Medical Director should liaise to consider and confirm the priority and scheduling of the following items at future Quality Committee 'deep dive' meeting meetings: "COVID-19 and harm reviews of patients who had waited a long time"; "The mortality review process"; "The effectiveness of divisional clinical governance arrangements"; and "Outcome of the review of the Never Events that had occurred at the Trust (in light of the seeming common themes involved in some of the Events)". Finally, it was agreed to remove the "Update on the plans for the strategic development of Ophthalmology Service" and "Follow-up review of quality/clinical outcomes within the Urology service" items from the Quality Committee's forward programme, as the priority of the items had waned as a result of COVID-19.

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

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

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

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

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

Summary report from the Patient Experience Committee, 11/06/20	**Committee Chair (Non-Executive Director)**

The Patient Experience Committee (PEC) met on 11th June 2020.

The key matters considered at the meeting were as follows:

- Under **to note the progress with previous actions** it was agreed that the General Manager for Facilities, Deputy Chief Nurse and Divisional Director of Quality governance should provide an update to the September 2020 meeting on the "Red Tray Process", including details of compliance with the process.
- The Committee received a **Notification regarding review of the Terms of Reference**
- Under **To agree the name and content of the framework to ensure we are working together in the most effective way** it was agreed that the Assistant Trust Secretary should amend the "framework to ensure we are working together in the most effective way" to remove the "Ensure that when I am representing…" statement and rename the document as "Principles for Working Together". The Committee agreed the document subject to the amendment discussed.
- The Deputy Chief Nurse gave an update on the **Patient Feedback** work across the Trust wherein it was agreed that the Deputy Chief Nurse should circulate the updated Friends and Family Test (FFT) questions to Committee members for review. It was also agreed that the Deputy Chief Nurse should investigate the ability to provide the provision of a freepost option for the postal return of Friends and Family Test (FFT) forms.
- The Lead Nurse of Palliative and End of Life Care and End of Life Care Clinical Nurse Specialist provided a report of the **Findings from the bereaved carers survey** wherein the Committee agreed that the Assistant Trust Secretary should obtain the Bereavement Services Letter from the Lead Nurse for Palliative and End of Life Care and circulate the letter to Committee members for comment and that the Communications Manager, Healthwatch Kent should Arrange for Kent Healthwatch members to comment on the Bereavement Services Letter, once received from the Assistant Trust Secretary. It was subsequently agreed that the Divisional Director of Midwifery, Nursing & Quality should liaise with the Lead Nurse for Palliative and End of Life Care to investigate the production of a Bereavement Services Letter for the carers of Children.
- The Committee reviewed the **Complaints Annual report 2019/20** and it was agreed that the Deputy Complaints & Pals Manager should submit a report to the September 2020 meeting providing more detailed analysis on the complaints related to communications
- The Chair of the Committee that All Committee members read the **"Feedback during the COVID-19 period"** report and provide comments (to the Assistant Trust Secretary) ahead of the September 2020 meeting
- The Chief Nurse gave a report on the **Recovery from the COVID-19 period** which included details of the pathways that had been implemented, the support that had been provided for staff in terms of social distancing and working from home, and the antibody testing that would be initiated across the Trust, however noted the limitations of antibody testing due to the evidence available.
- The **Review of the relevant aspects of the Board Assurance Framework (BAF)** was noted
- Under **To consider the Forward Programme** it was agreed that the Chief Nurse should submit an update on "The Patient and Carer Strategy ("Making it Personal")" to the September 2020 meeting. It was also agreed that the Deputy Chief Nurse should submit an update on the plans for development of Patient Feedback to the September 2020 meeting.
- Under **To consider any other business**, it was agreed that the Trust Secretary should circulate the web address of the Trust's YouTube Channel to Committee members to enable viewing of Trust Board meetings. It was also agreed that the Chief Nurse should provide an update on the operational contact for League of Friends queries and Liaise with the representative from The League of Friends of Tunbridge Wells Hospital regarding the resumption of their "Table Sales". It was subsequently agreed that the Assistant Trust Secretary should schedule an informal

meeting of Committee members for six weeks on from the June 2020 meeting.

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

The issues that need to be drawn to the attention of the Board are as follows: N/A

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Trust Board meeting – 25th June 2020

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the Audit and Governance Committee, 18/06/19	**Committee Chair (Non-Executive Director)**

The Audit and Governance Committee met on 18th June 2020. A verbal update on the meeting was given at the Trust Board held later the same day, but this written report has been submitted for completeness.

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

- The final draft Annual Report and Annual Accounts for 2019/20 (including the Governance Statement) was reviewed, and the Committee agreed to recommend that these be approved by the Trust Board. Trust Board Members will be aware that these were duly approved on 18/06/20
- The Audit Findings Report ('Report to those charged with governance') from the External Auditors was reviewed and no significant issues were raised
- The 2019/20 Draft Management Representation Letter was reviewed, and the Committee agreed to recommend that this be approved by the Trust Board. The letter was subsequently approved by the Trust Board on 18/06/20.
- Under **to note the forward programme** it was agreed that the Chair of the Audit and Governance Committee should liaise with the Trust Secretary to develop some proposals regarding the committee's role in governance (including whether additional items need to be considered) following the discussion at the meeting on the 18th June 2020.

2. The Committee agreed that (in addition to any actions noted above): N/A

3. The issues that need to be drawn to the attention of the Board are as follows: N/A

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for 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