Maidstone and Tunbridge Wells NHS Trust

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

24 September 2020, 09:45 to 13:00
Virtual meeting, via webconference

Agenda

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

09-1
To receive apologies for absence

David Highton

09-2
To declare interests relevant to agenda items

David Highton

09-3
To approve the minutes of the 'Part 1' Trust Board meeting of 23rd July 2020

David Highton

Board minutes 23.07.20 (Part 1).pdf (8 pages)

09-4
To note progress with previous actions

David Highton

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

09-5
Report from the Chair of the Trust Board

David Highton

Chair's report.pdf (1 pages)

09-6
Report from the Chief Executive

Miles Scott

Chief Executive's report.pdf (3 pages)

09-7
Integrated Performance Report (IPR) for August 2020 (incl. planned and actual ward staffing for July and August 2020)

Miles Scott and colleagues

Integrated Performance Report (IPR) for August 2020 (incl. planned and actual ward staffing for July and August 2020).pdf (34 pages)

Quality items

09-8
Quarterly mortality data

Peter Maskell

Quarterly mortality data.pdf (16 pages)

09-9

Update on progress against the CNST maternity incentive scheme standards

This item has been scheduled for 10.40am

Sarah Blanchard-Stow

Update on progress against the CNST maternity incentive scheme standards.pdf (3 pages)

Reset and recovery

09-10

The Trust's Phase three (of NHS response to COVID-19) planning; plan for the forthcoming winter; contingencies for a second wave of COVID-19 cases; lessons learned from the first COVID-19 wave; and the latest position re overseas nursing recruitment

The item has been scheduled for 10.50pm

Amanjit Jhund / Sean Briggs / Lynn Gray / Cheryl Lee / Claire O'Brien

Planning (cover report).pdf (1 pages)

09-11

The allocation of resources and funding as part of the 'reset and recovery' programme

Steve Orpin / Sean Briggs

Reset and Recovery resources.pdf (4 pages)

Assurance and policy

09-12

Responsible Officer's Annual Report 2019/20

Peter Maskell

Responsible Officer's Annual Report 201920.pdf (23 pages)

09-13

Health & Safety Annual Report, 2019/20 and agreement of the 2020/21 programme (incl. Trust Board annual refresher training on health & safety, fire safety, and moving & handling)

This item has been scheduled for 12pm

Rob Parsons

H&S Annual Report 2019-20 and work programme 2020-21.pdf (34 pages)

Reports from Trust Board sub-committees

09-14

Workforce Committee, 17/07/20 (incl. quarterly report from the Guardian of Safe Working Hours) and 18/09/20

Please note that the meeting on 18/09/20 will be covered via a verbal report

Emma Pettitt-Mitchell / Richard Finn

Summary of Workforce Cttee, 17.07.20 (incl. Guardian of SWH report).pdf (7 pages)

09-15

Charitable Funds Committee, 21/07/20

David Morgan

Summary of Charitable Funds Cttee, 21.07.20.pdf (1 pages)

09-16

Audit and Governance Committee, 30/07/20 (incl. the Annual Audit Letter for 2019/20)

David Morgan

Summary of Audit and Governance Committee, 30.07.20 (incl. Annual Audit Letter 2019-20).pdf (15 pages)

09-17
Quality Committee, 13/08/20 and 16/09/20

Sarah Dunnett

Summary of Quality C'ttee, 13.08.20.pdf (1 pages)

Summary of Quality C'ttee, 16.09.20.pdf (2 pages)

09-18
Finance and Performance Committee, 25/08/20 (incl. approval of revised Terms of Reference) and 22/09/20

N.B. The report of the meeting on 22/09/20 will be issued after the meeting.

Neil Griffiths

Summary of Finance and Performance C'ttee 25.08.20 (incl. revised ToR).pdf (6 pages)

09-19
Patient Experience Committee, 03/09/20

Maureen Choong

Summary report of Patient Experience Cttee, 03.09.20.pdf (1 pages)

09-20
To consider any other business

David Highton

09-21
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 23rd JULY 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)
	David Morgan	Non-Executive Director	(DM)
	Claire O'Brien	Chief Nurse	(COB)
	Steve Orpin	Chief Finance Officer	(SO)
	Emma Pettitt-Mitchell	Non-Executive Director	(EPM)
	Miles Scott	Chief Executive	(MS)
In attendance:	Karen Cox	Associate Non-Executive Director	(KC)
	Richard Finn	Associate Non-Executive Director	(RF)
	Simon Hart	Director of Workforce	(SH)
	Amanjit Jhund	Director of Strategy, Planning & Partnerships	(AJ)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Jo Webber	Associate Non-Executive Director	(JW)
	Kevin Rowan	Trust Secretary	(KR)
	Aoife Cavanagh	Deputy Director of Quality Governance (for items 07-7.1 and 07-8 to 07-10)	(AC)
	Judy Durrant	Deputy Chief Nurse (for items 07-7.1 and 07-8 to 07-10)	(JD)
	Christian Lippiatt	Freedom to Speak Up Guardian (for items 07-7.1 and 07-8 to 07-11)	(CL)
Observing:	The meeting was livestreamed on the Trust's YouTube channel.		

07-1 To receive apologies for absence

Apologies were received from Peter Maskell (PM), Medical Director.

07-2 To declare interests relevant to agenda items

No interests were declared.

07-3 To approve the minutes of the 'Part 1' Trust Board meeting of 25th June 2020

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

07-4 To note progress with previous actions

The circulated report was noted. The following action was discussed in detail:

- **06-14.4a ("Update the "Board Checklist - workforce risk factors linked to COVID-19" to include reference to the evidence underlying the statements in the report (and provide assurance that the associated risks had been mitigated and reduced")).** SH reported that the document was in the process of being updated, as per the discussion at the Trust Board, and in accordance with a revised guidance document from NHS England (NHSE)/NHS Improvement (NHSI).

07-5 Report from the Chair of the Trust Board

DH stated that much of what he would have reported would be covered in MS' report under item 07-6. DH did however note that the number of COVID-19 cases at the Trust had reduced dramatically and paid tribute to the staff's continued efforts, including social distancing.

DH then referred to the relevant attachment and stated that he had been very pleased to appoint Dr Graham Wallace as a Care of the Elderly consultant with an interest in stroke, which would address consultant gaps in two important specialties.

07-6 Report from the Chief Executive

MS referred to the relevant attachment and highlighted the key points therein, which included that the 'reset and recovery' programme had continued to make good progress. MS added that although the Trust would aim to return to pre-COVID-19 levels of activity, that did not mean a return to pre-COVID-19 levels of productivity, given the additional clinical time that was now required under the 'new normal'. MS continued that only two areas would struggle to return to pre-COVID-19 levels of activity. MS then elaborated on the position for outpatients and noted that significant progress had been made, but there was more to be done.

MS then highlighted that Emergency Department (ED) attendances had already reached 85% of pre-COVID-19 levels over the past month, which was the largest return of any of the acute Trusts in Kent, but patient flow through the Trust's hospitals was still very good, so there had not been an accumulation of 'Medically Fit For Discharge' patients.

MS then noted that all patient-facing staff were being tested for COVID-19 on a weekly basis; and also thanked those who participated in the "Going the distance" fundraising campaign, particularly RF, who joined MS on his recent marathon run between the Trust's sites. MS stated that the Trust Board needed to consider what should be done with the charitable funds that had been raised for staff, including those at the Paddock Wood and Kent and Canterbury Hospital sites.

MS then highlighted that the work for the Trust to become 'outstanding' continued and COB would update the Quality Committee and Trust Board in due course.

MS then noted that revised objectives had been developed, and the Integrated Performance Report (IPR) report contained a working draft of such objectives, although further work was required on the Key Performance Indicators (KPIs), so MS proposed that comments be provided over the next month. DH noted that the Trust Board would not meet in August, so he was reluctant to wait until September before the Board Assurance Framework (BAF) was developed. DH therefore instead proposed that the Trust Board approve some form of objectives, to enable the BAF to be developed, under item 07-7. MS agreed. DH continued that the BAF contained 12 objectives in 2019/20 and he would like fewer objectives for 2020/21, to enable the Trust Board to focus on key priorities. DH therefore proposed that the Trust Board selected 10 objectives to enable the BAF to be developed, and the Finance and Performance Committee meeting in August could consider the refined metrics. MS agreed.

07-7 Integrated Performance Report (IPR) for June 2020, incorporating an update on the Trust's 'reset and recovery' programme and approval of revised objectives for 2020/21

SO firstly referred to the relevant attachment and explained the new reporting format, which included that the focus should be on areas of variation. SO did however acknowledge that further work was required, as several areas had "No data" at the present time. SO added that it was the first time the new IPR had been shared, so comments were welcome, and although the previous-style appendices had been included, it was, in time, intended to remove those from the IPR.

DM asked for further explanation of how the 'spider graphs' were scored and how they should be interpreted. SO explained that the intention was to indicate the assurance rating under Statistical Process Control (SPC), i.e. whether there was confidence that the actions being taken would enable the objective to be met. SO went on to explain the differences between the three levels of assurance i.e. "Favourable Assurance", "Common Cause Assurance" and "Adverse Assurance", and added that the best outcome would be to have universal "Favourable Assurance" ratings.

NG noted that the new IPR had been reviewed by the Finance and Performance Committee on 21/07/20, and had been well received, although it had been agreed that a 'refresher' session on SPC should be held for the Non-Executive Directors.

MC asked about the timeline for having a fully populated IPR, given the number of indicators that reported “No data”. SO replied that many of the indicators were related to the ‘reset and recovery’ programme, and it was intended to have a more populated IPR in August, at the Finance and Performance Committee, and then again by the time of the Trust Board meeting in September.

EPM asked whether the new format had led to time being saved by the relevant staff, and whether the main ‘at a glance’ page was still intended to be the “Executive Summary” page. SO answered that the new IPR had not saved any time, as a dual-running approach was being taken at present, although it was intended to adopt the new format throughout the organisation in due course. SO then explained that the readers’ main area of focus should be the special cause variations and any exceptions that were reported. EPM asked whether the methodology in the new IPR was similar to that used at Western Sussex Hospitals NHS Foundation Trust. SO confirmed there were some differences, as Western Sussex Hospitals NHS Foundation Trust did not use SPC, but the underlying structure of the reports was similar.

RF commended the improved report but asked for further explanation of the assurance ratings. SO gave the requested explanation and noted that further supplementary information could be shared if required.

DH summarised that the Trust Board was pleased with the new format, so thanked SO and his team for its production and noted that the Non-Executive Directors looked forward to receiving the aforementioned ‘refresher’ session.

MS then referred to the content of the IPR and stated that it was pleasing to see the 62-day cancer waiting time target performance being achieved again. MS added that there was a new mean for pressure ulcers, so that indicator was on the cusp of having an adverse assurance rating. MS noted the other areas of special cause variation and adverse variation, noting that the latter included agency expenditure, and that had been discussed at the Executive Team Meeting on 21/07/20, and further work had been agreed to explore the causes.

COB then referred to the “Safe” domain and highlighted that an emerging issue had already been recognised for pressure ulcers, which was one of the reasons she had recommended that pressure ulcers be the subject of a recent Quality Committee ‘deep dive’ meeting, although the actual numbers of pressure ulcers were small. COB then described the actions that had been taken, or were planned, to address the issue, and achieve the required reduction.

SM then also referred to the “Safe” domain and reported the latest position for infection prevention and control, which included SM’s concern at the continuing number of E.Coli bacteraemia infections. SM added that she had asked a doctor to take on the issue as a specific project, as although the situation had not worsened, it had not improved as intended.

SM then referred to the “Effective” domain and reported that mortality rates remained low, and the main challenge was in relation to stroke. SM noted that the Trust’s Sentinel Stroke National Audit Programme rating had deteriorated from a “B” to a “C” and was now a “D”. SM explained the factors involved, which included higher-acuity patients, therapy staffing, increased sickness absence and an issue in relation to data submission. SM added that the Stroke Programme Director had however developed a plan to achieve a “B” rating.

JW asked how the therapies staffing issue would be addressed. SM explained the actions that would be taken and gave assurance that a plan was in place. COB added that eight Allied Health Professionals (AHPs) would soon start with the Trust, while MS stated that he understood circa four AHPs intended to join the Trust from Medway NHS Foundation Trust.

COB then referred to the “Caring” domain and noted that it was intended to reintroduce the Friends and Family Test.

SB then referred to the “Responsive” domain and reported that much of the work was linked to the ‘reset and recovery’ programme, but elective care was the main area of challenge. SB continued that great progress had been made on outpatients and gave thanks to Katie Goodwin, Alice Farrell

and Charlotte Wadey. SB noted that the issue had been discussed briefly by the Finance and Performance Committee on 21/07/20 and NG had agreed to schedule a more detailed outpatients item at the Committee's meeting in August.

SB also noted that he and SO were liaising to discuss the resourcing requirements of the 'reset and recovery' programme workstreams, noting that no additional funding had been made available to the Trust, so the focus was on ensuring the optimum return for any resources allocated. SB added that there had been challenges in theatre productivity, and although the Trust's performance compared very well to others, it would be difficult to return to pre-COVID-19 levels of productivity.

SB noted that the Trust was the second best performing Trust in the country for the ED 4-hour waiting time target, and was only behind Sheffield Children's NHS Foundation Trust; while the 62-day cancer waiting time target backlog of circa 30 patients was the lowest it had ever been. SB added that although the data for June would not be finalised until w/c 27/07/20, it was already known that the Trust would achieve the target for that month, which would mean it had been achieved for twelve months in a row. SB also noted that the Trust's performance on that target was second only to Frimley Health NHS Foundation Trust.

SB then reported on the 28-day faster diagnosis target for cancer, and stated that although implementation had been delayed by COVID-19, the Trust decided to proceed with its plans, and had achieved the target in May and June 2020. SB did however note that the target had been achieved at the cost of increased financial expenditure.

MS then asked SB to report on the progress with winter planning. SB reported that the first winter planning meeting had been held, and good progress was being made. SB added that the Trust had good relationships with its community partners and was working closely with Independent Sector Providers to maximise available opportunities. SO noted that the TeleTracking system would support the Trust's efforts, and added that an update on the winter plan would be given at the next Finance and Performance Committee meeting.

DH referred to page 15 of 48, noted that the number of patients waiting over 40 weeks was at circa 1200 and asked what happened when a patient refused an appointment that the Trust had offered. DH also asked what the relationship was between the patients waiting over 40 weeks and the harm review process. SB acknowledged that far more patients now waited longer for treatment and explained that the access policy whereby patients who refused treatment could be referred back to their GP had been suspended during the COVID-19 period, but discussions were taking place with the Clinical Commissioning Group (CCG) as to whether that policy should be reinstated. SB then noted that patients waiting a long time were triaged for clinical urgency and meetings to review patients took place every week. MC asked how patients were being kept informed of their situation, given the longer waiting times, and the likelihood that such patients were anxious. SB explained the approach being taken. JW noted that there were likely to be significant numbers of patients who had not yet even been referred. The point was acknowledged.

SDu asked about the preparations for a second wave of COVID-19 cases and asked whether metrics could be reported to monitor the situation. MS instead proposed that an agenda item be scheduled at the next Trust Board meeting on the winter plan, as he believed that SDu's question would be best addressed by giving assurance on the Trust's plans. This was agreed, but DH asked that the item include winter planning, the contingencies for a second wave of COVID-19 cases, and any lessons learned from the first wave. DH also stated that the report needed to include the latest situation regarding overseas nursing recruitment. This was also agreed.

Action: Submit a report to the Trust Board in September 2020 that covered a) the Trust's plan for the forthcoming winter, b) the contingencies for a second wave of COVID-19 cases, c) lessons learned from the first wave of COVID-19 cases, and d) the latest situation regarding overseas nursing recruitment (Chief Operating Officer / Chief Nurse / Director of Workforce, September 2020)

MS then continued and reported that the Trust's Incident Command Centre was still in operation and the Trust had been able to avoid some of the Personal Protective Equipment (PPE) availability issues that had affected other Trusts.

COB then referred back to the harm review process and pointed out that a report on harm reviews would be considered at the Executive Team Meeting on 28/07/20 and the issue would also be discussed at the Quality Committee 'deep dive' meeting in August. The point was acknowledged.

MS then referred to the "Well Led" domain and highlighted the main issues for workforce, which included recruitment. SH added further context. EPM asked for an explanation of the reporting of the recruitment metric in the IPR and SO obliged. DH noted that the number of job offers made was higher than the number of nurses actually recruited by the Trust, so asked how many job offers had been made. SH confirmed that only a small number of offers had not been accepted.

SO then referred to the "Well Led" domain and gave details of the 'top up' payment the Trust received under the current financial regime. SO continued that it was understood that the current regime would be extended to at least August, and possibly until September, which meant that the new regime would not start until October 2020. SO added that no details had yet been confirmed, but he expected the new regime to be similar to current regime, with some minor differences. SO also highlighted that he understood that no direct additional funding had been allocated, so the Trust had to make best use of its own funding environment. SO then reported the latest position on cash, which included that the Trust continued to comply with the national guidance to pay suppliers within seven days rather than the usual 30 days.

SO then reported details of the funding at the Sustainability and Transformation Partnership (STP) level, but it was noted that the situation had not yet been finalised. SO suggested that the details of the STP's proposed plan be submitted to the Finance and Performance Committee and Trust Board in due course. DH acknowledged the large number of imponderables and stated that he hoped that HM Treasury provided some clarity in the coming weeks.

The "Planned Vs Actual staffing data" was noted.

AJ then referred to the proposed objectives, from page 35 of 48 onwards, and explained the background to the development of the objectives, and the relationship with the 'reset and recovery' programme. AJ then specifically highlighted the content of page 48, which showed the KPIs that were included in the IPR. AJ added that further work was required to identify, and refine, the metrics, and also fully reflect the interdependences, as well as identify the Trust Board sub-committees that would oversee each programme of work.

DH referred back to the comments he made under item 07-6 and suggested that one simple solution would be to include each the 10 objectives, but suggested that the Trust Board also consider merging the "OD/EPOC" and "Workforce" sections, and thereby only have nine objectives. MS replied that it may be useful to merge the categories as DH suggested, but stated that the "Project Aim" should be the main area of focus, so asked for any comments on that in particular. DH clarified that his proposal related to the production of the BAF. The point was acknowledged.

RF remarked that he did not consider the content of the "Expected benefits" section to be benefits, as they were not very outcome orientated. The point was acknowledged. EPM remarked that there was a lot of KPIs. AJ acknowledged the point but explained that the KPIs marked in bold where those that had been agreed as the most pertinent, although further work was required.

JW opined that it would be helpful to include some content regarding communication with patients reflected in the workstreams, so that there was an outwards, and not just an inwards, focus, particularly given the potential impact of any forthcoming recession on the local community. AJ agreed to address this within the "ICP/External" workstream. MS added that the Trust Board Seminar in September 2020 would be focused on sustainability, which was pertinent to JW's point.

[Post-meeting note: The Trust Board Seminar on sustainability issues is actually scheduled for October 2020, not September]

KC asked why the Trust's efforts on education were only focused on the Kent and Medway Medical School. AJ acknowledged the challenge but noted that other aspects of education and research had been included in other workstreams.

NG suggested that the overarching narrative should reflect the fact that the Trust was performing very well at the present time. The suggestion was acknowledged.

DH asked for any further comments to be relayed to AJ, to enable him to update the document.

Action: Update the "Organisational Objectives 2020/21" to reflect the comments made at the Trust Board meeting on 23/07/20, and any comments received from Trust Board members after that meeting (Director of Strategy, Planning and Partnerships, July 2020 onwards)

07-7.1 Update on Black, Asian, and Minority Ethnic (BAME) staff risk assessments

SH referred to the relevant attachment and highlighted the key points therein, which included that the compliance rate for BAME staff risk assessments had increased markedly, but NHSE had now asked all Trusts to focus on risk assessments for all 'at risk' staff, which included all male staff, although the particular focus was on staff who were shielding. SH added that some staff were anxious about returning to work, but there were also some staff who were anxious about not returning to work.

EPM asked for confirmation that the deadline for completion was 24/07/20. SH explained that the deadline had been extended to 31/07/20 for all 'at risk' staff. EPM asked whether 100% would be achieved. SH replied that that was unlikely, given the inclusion of all male staff.

Quality items

07-8 Approval of Quality Accounts, 2019/20

AC referred to the relevant attachment and highlighted the key points therein, which included the "Quality Improvement Priorities for 2020/21" that were described from page 10 of 129 onwards.

DH commended the document and thanked AC for the hard work that had led to its production.

RF asked whether there was sufficient emphasis on working within the wider system. COB agreed to consider the point, noting that the Quality Accounts would ordinarily have been published by now, but had been delayed due to the COVID-19 period.

Action: Consider amending the Quality Accounts for 2019/20 to reflect the comment made at the Trust Board meeting on 23/07/20 regarding the Trust's involvement in the wider healthcare system (Chief Nurse, July 2020 onwards)

AJ noted that further discussion of the wider system would take place at the Trust Board Seminar that afternoon. The point was acknowledged.

The Trust Board approved the Quality Accounts, 2019/20 subject to the potential amendment in response to RF's comment regarding working within the wider system.

07-9 Findings of the national inpatient survey 2019

COB referred to the relevant attachment and highlighted the key points therein, which included that further discussion would be required at the Patient Experience Committee and COB would therefore arrange for the survey to be discussed at the Committee's next meeting.

JW noted that the Trust was close to the "worst performing trusts" rating on a number of areas. COB acknowledged that further work was needed.

07-10 Safeguarding Adults and Children update (Annual Report to Board, including Trust Board annual refresher training)

COB referred to the relevant attachment and noted that it was the first joint safeguarding report, and it had been considered by the 'main' Quality Committee on 08/07/20. JD then highlighted the key points in the report, which included the details of training.

DH asked for further details of how future training would be affected by the impact of COVID-19. JD gave assurance that plans had been put in place to ensure that training compliance was maintained, which included making training available online.

Assurance and policy

07-11 Quarterly report from the Freedom to Speak Up Guardian

CL referred to the relevant attachment and highlighted the key points therein, which included that the Business Case Review Panel would consider a Business Case for additional support for the Freedom to Speak Up Guardian (FTSUG) function on 24/07/20; and the Trust's Freedom to Speak Up policy would be updated once the national template policy had been published. CL added that bullying and harassment remained the main subject of the issues reported to him, and elaborated on the factors involved.

EPM stated that she thought the Business Case would be considered earlier than 24/07/20, so asked why there had been a delay. CL stated that he believed the Case had just missed the deadline for submission to the previous Business Case Review Panel, which only met monthly, and had been paused during the COVID-19 period. SH added that the Business Case had been developed pre-COVID-19, and therefore had to be amended to reflect the changed arrangements.

RF stated that the situation felt urgent, so waiting for the appointment caused him some concern. RF also asked whether CL was liaising with the Organisational Development team, as the issues raised should be important to them. CL noted that in addition to being FTSUG, he was also the Head of Occupational Health and worked closely with the Associate Director for Organisational Development.

EPM asked whether one of the lessons learned from the COVID-19 period was to ensure that there was a process for considering decisions in the event of committee meetings being cancelled. AJ clarified that a process for escalating any urgent Business Cases to him had been in place during the COVID-19 period.

Reports from Trust Board sub-committees

07-12 Workforce Committee, 02/07/20 and 17/07/20

EPM referred to the relevant attachment and confirmed she had no issues to report from the meeting on 17/07/20. Questions were invited. None were received.

07-13 Quality Committee, 08/07/20

SDu referred to the relevant attachment and noted that it had been agreed to draw the Trust Board's attention to the issue of therapy staffing within the stroke service, but that had already been raised under item 07-7, and assurance had been given that there was a plan.

07-14 Finance and Performance Committee, 21/07/20

NG referred to the relevant attachment and noted that the Committee had approved an extension to the laundry contract, that was due to expire, while the longer-term issues with the service were being addressed.

07-15 Charitable Funds Committee, 21/07/20

DM reported that the Committee had approved the management and administration fee of circa £83k, which was a slight reduction on the fee for 2019/20, and far below 10% of income. DM also

reported that the Charity Management Committee had started to meet, and would consider how the charitable funds should be spent.

07-16 To consider any other business

SO noted that the Trust Board did not meet again until September 2020, but the Trust's current Managed Laboratory Service (MLS) contract was due to expire at the end of August, and the size of the contract required any extension to be approved by the Trust Board. SO therefore proposed that the Trust Board delegate the authority to consider a proposal to extend the contract to the Finance and Performance Committee, which would meet in August. The requested authorisation was duly granted.

Action: Arrange for the Finance and Performance Committee meeting on 25/08/20 to consider a proposal to extend the Trust's current Managed Laboratory Service contract (Trust Secretary, July 2020 onwards)

07-17 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.

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]
N/A	N/A	N/A	N/A	N/A
				N/A

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
06-14.4a	Update the "Board Checklist - workforce risk factors linked to COVID-19" to include reference to the evidence underlying the statements in the report (and provide assurance that the associated risks had been mitigated and reduced)	Director of Workforce	September 2020	It is now intended that the work regarding risk factors linked to COVID-19 will be addressed through the Trust's response to the recently-issued NHS People Plan (which will be primarily channelled via the Workforce Committee).
07-7a	Submit a report to the Trust Board in September 2020 that covered a) the Trust's plan for the forthcoming winter, b) the contingencies for a second wave of COVID-19 cases, c) lessons learned from the first wave of COVID-19 cases, and d) the latest situation regarding overseas nursing recruitment	Chief Operating Officer / Chief Nurse / Director of Workforce	September 2020	A report has been submitted to the September 2020 Trust Board meeting.
07-7b	Update the "Organisational Objectives 2020/21" to reflect the comments made at the Trust Board meeting on 23/07/20, and any comments received from Trust Board members after that meeting	Director of Strategy, Planning and Partnerships	September 2020	Updates were made incorporating both changes suggested by the Trust Board and by email (i.e. combining the workforce and Organisational Objectives).
07-8	Consider amending the Quality Accounts for 2019/20 to reflect the comment made at the Trust Board meeting on 23/07/20 regarding the Trust's involvement in the wider	Chief Nurse	July 2020	The suggested amendment was considered. It was determined that the primary focus of the Quality Account was to report on the Trust's own performance regarding quality, rather than on its

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	healthcare system			wider involvement in the healthcare system. Demonstrating the Trust's wider involvement in the healthcare system will form part of the Quality Account for 2020/21.
07-16	Arrange for the Finance and Performance Committee meeting on 25/08/20 to consider a proposal to extend the Trust's current Managed Laboratory Service contract	Trust Secretary	July 2020	The item was scheduled for the Finance and Performance Committee's meeting on 25/08/20 (and the contract extension was approved)

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**

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
19/08/2020	Consultant AMU	Katherine	Smith	Acute Medicine	To be confirmed
09/09/2020	Consultant Emergency Surgery	Syed	Moosvi	Colorectal Surgery	To be confirmed

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. Our cancer patients are now receiving some of the fastest access to treatment in England after the Trust hit the national standard for treating patients within 62 days for twelve months in a row. This means that at least 85% of all patients referred by a GP for suspected cancer were treated promptly and within the required timeframe. This is a huge turnaround in performance for MTW, which until August 2019 had not hit the target for five years and was the worst performing trust. MTW is now one of only four trusts in the country to meet this standard. The Trust has also met the two week wait referral target for eleven consecutive months – meaning even more patients are being seen within 14 days of being referred by their GP.

   To support our turnaround, we have introduced a raft of changes to improve cancer waiting times and respond to the rise in demand, including investing in more staff and upskilling more nurses to be able to deliver chemotherapy treatment. MTW has also improved diagnostic equipment and facilities; introduced new treatment pathways; and implemented innovative best practice to streamline systems and processes.

   Thank you to all staff for helping the trust consistently achieve the national standard. We'll now be building on this work so our patients can continue to access world-leading, high quality cancer care and treatment.

2. Congratulations to our Finance and Transformation teams who received highly commended accolades this month in the Health Service Journal's (HSJ) prestigious Values Awards. MTW's Finance Team was recognised by judges for transforming the traditional role of finance to integrate and add value to the whole patient pathway through quality improvements and cost savings. While the West Kent Alliance (WKA) Musculoskeletal (MSK) Pathway Transformation Team, which MTW's Transformation Team is part of, was acknowledged for its work in improving waiting times for MSK patients. This was done by creating a single point of access and clinical decision making unit all of which has resulted in good patient and staff feedback.

3. MTW's Endoscopy team has been awarded the prestigious Joint Advisory Group (JAG) accreditation for high quality gastrointestinal endoscopy services. The JAG review particularly commended the Trust for its positive approach, investment in delivering improvements to the endoscopy service and commitment to providing a high quality service for patients. Congratulations to the team for achieving this outstanding quality mark.

4. Young people with cancer who are being treated at MTW can now access specialist care and support from a new Teenage Cancer Trust nurse. Sarah Trollope, who is based at Maidstone Hospital, will provide age-appropriate advice, care and extra emotional support for those aged 17-24 receiving cancer treatment. Sarah's role has been funded by global financial services firm Morgan Stanley as part of a two-year charity partnership with Teenage Cancer Trust. Her role will also cover Darenth Valley Hospital and Medway Maritime Hospital.

5. MTW's Cultural and Ethnic Minorities Network (CEMN) is undertaking a number of actions to deliver positive change and reduce inequalities in health provision, career development and discrimination in our Trust. MTW is committed to being a fully inclusive organisation and over the next 12 months is focusing on:
   - Introducing a reverse mentoring scheme which will, in the first phase, see 16 pairs of senior staff buddy up to listen, learn and understand their BAME colleague's experiences.
   - Appointing an additional Freedom to Speak Up Guardian for BAME staff, who will provide dedicated support to individuals affected by discrimination, inequality or bullying and harassment.
   - Rolling out the Recruiting for Difference scheme to other services - it's currently being piloted

by the Medicine and Emergency Care Division and has taken positive steps to improve our commitment to equality and diversity. We're also looking at ensuring interview questions ask candidates about equality and include BAME staff on interview panels.
- Implementing an explicit element to our current talent management and succession planning programme to support BAME colleagues reach their potential. This also includes career development for network members and support to BAME students on placements in our hospitals.
- Hosting events about the CEMN, such as a conference in September, and developing activities to support Black History Month in October.

6. An 18-month project to improve the experience of our emergency surgical patients has been held up as an example of national best practice. The Same Day Emergency Care (SDEC) surgical ambulatory emergency care service was set up to overhaul the trust's approach to seeing and treating surgical patients and introduced a raft of improvements from investing in additional senior staff and introducing new roles to support the service, to reconfiguring the unit and extending its opening hours. As a result, people attending our emergency departments are now being seen, assessed and undergoing investigations quicker, with patients getting prompt access to the surgical treatment they need. Congratulations and well done to our Surgery teams.

7. Following the change to national guidelines in August that clinically vulnerable people no longer need to shield, the trust has been working hard to support our shielding staff return to work. We have put support mechanisms in place to ensure they continue to feel a valued part of our MTW community and carefully help them back to the workplace safely. We had 226 staff that were shielding and, with the exception of 14 people, all have either returned to their previous roles, subject to stringent occupational health risk assessments, or have been found alternative roles within their divisions to ensure they are protected from infection. Those who are not currently able to return to work continue to support teams by working from home or are awaiting additional assessments from our occupational health team.

8. Our Annual General Meeting (AGM) took place this month which gave us the opportunity to highlight some of our key achievements from the past year and look ahead to our priorities for the next 12 months. Our Trust has made huge progress since last September and that's been down to our staff working together to implement quality improvements in the services we run and the care we give our patients.

   Last year we set out to deliver a number of goals to help us on our journey to become and be recognised as an outstanding organisation. These included meeting the national cancer access standard of ensuring at least 85% of our patients were treated within 62 days of being referred; addressing unprecedented demand on our services while maintaining quality of care; working with our partners to create integrated models of care; and ensuring we have enough staff in key speciality and clinical areas by implementing a proactive recruitment campaign and introducing new roles to help us deliver clinical care.

   Some of our priorities for the year ahead include: continuing to respond to the Covid-19 pandemic and ensuring we keep patients and staff safe; increasing our surgical theatre and outpatient capacity to reduce the number of patients waiting over 18 weeks for a planned procedure or appointment; improving the flow of patients through our hospitals to minimise admission and discharge waiting times; and supporting staff welfare. You can view a recording of the AGM via our website.

9. This month saw the first cohort of students starting at the new Kent and Medway Medical School. This is an extremely important step forwards for the healthcare system in the county. Our medics have been working closely with the school to support development of the curriculum and medical education and training opportunities. MTW will be offering placements to these students in their third year (starting in two years' time) and we are working hard to ensure their training programme and accommodation is in place.

10. The contribution of the Project Wingman team – furloughed airline cabin crew – to our staff

welfare and wellbeing throughout the pandemic was recently acknowledged in a special, socially distanced, thank you ceremony. Project Wingman has been running our staff breakout areas over the past few months to provide them with some rest and relaxation, and first-class cabin service. Members of the team were presented with appreciation badges and certificates.

11. While cases of coronavirus nationally may be rising, we are not seeing this translate into an increase in admissions of patients who have tested positive for Covid-19. We have cared for a very small handful of patients with coronavirus over the past month and the numbers of suspected cases remains extremely low. Our hospitals are safe to visit with stringent safety measures in place to protect patients and staff from the spread of infection. We would strongly encourage people not to delay getting the healthcare help they need.

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 August 2020 (incl. planned and actual ward staffing for July and August 2020)	**Chief Executive / Members of the Executive Team**

The IPR for month 5, 2020/21, is enclosed, along with the monthly finance report and the latest 'planned vs actual' nurse staffing data.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 22/09/20 (IPR)
- Finance and Performance Committee, 22/09/20 (IPR)

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

Review and discussion of the IPR and Planned V Actual nurse staffing

[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

August 2020

MTW
exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells NHS Trust

Contents

Appendices (Page 23 onwards)

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

MTW
exceptional people, outstanding care

Key to KPI Variation and Assurance Icons

Variation			Assurance			
						
Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or higher pressure due to (H)igher or (L)ower values	Common cause - no significant change	Variation Indicates inconsistently (P)assing of the target	Variation Indicates inconsistently passing and falling short of the target	Variation Indicates inconsistently (F)alling short of the target	Data Currently Unavailable

Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in an adverse direction. Low (L) special cause concern indicates that variation is downward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is upwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

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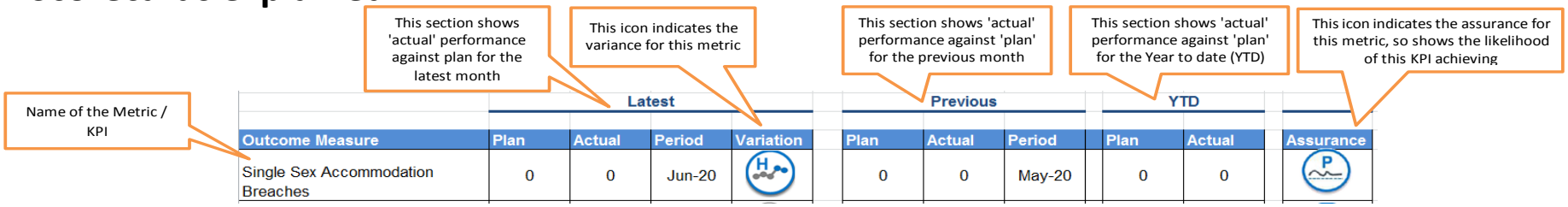
Maidstone and Tunbridge Wells NHS Trust

Escalation Rules:

Areas are escalated for reporting if:

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

Scorecards explained



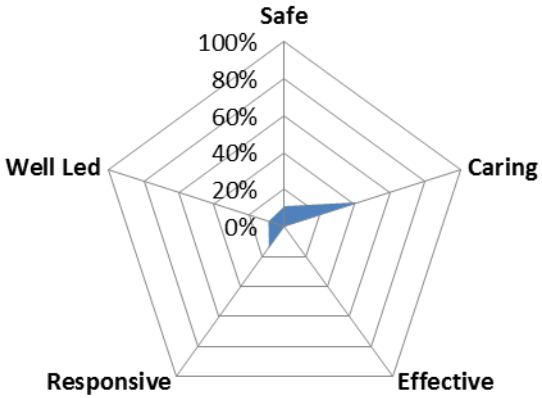
Further Reading / other resources

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

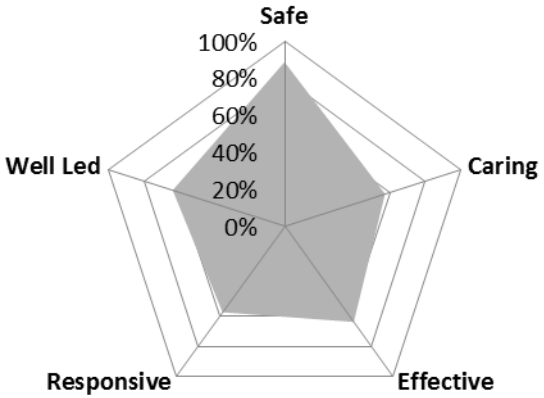
MTW exceptional people, outstanding care

Executive Summary

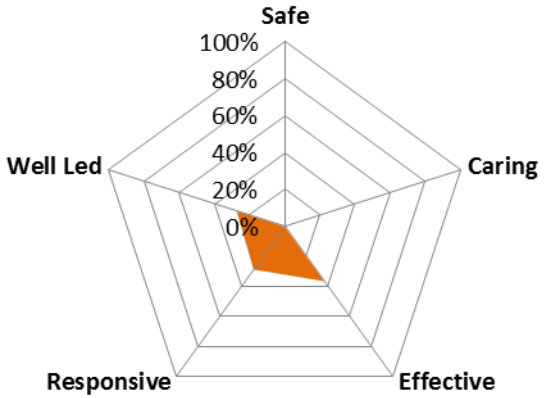
Favourable Assurance



Common Cause Assurance



Adverse Assurance



Favourable Assurance:
Trust Mortality (HMSR), Mixed Sex Accommodation Compliance, Rate of Complaints, VTE Risk Assessment and Mandatory Training Compliance are consistently passing the target. The Cancer Waiting Times 2 week wait and 62 Day indicators are also now consistently passing the target.

Common Cause Assurance:
All of the Safe and Caring Indicators are experiencing common cause variation and inconsistency (passing or falling short of target) indicating that the indicators are not stable with the exception of Mortality (HMSR), Mixed Sex Accommodation Compliance, Rate of Complaints and VTE Risk Assessment. The number of overdue complaints and the percentage of complaints responded to within target are both now experiencing special cause variation of an improving nature.
The majority of the Urgent Care and Flow Workstream indicators continue to experience special cause variation – data outside of control limits (in a positive way) and inconsistency (passing or falling short of target) due to the COVID-19 Pandemic, however both A&E Attendances and Bed Occupancy have now increased enough in August to now be experiencing common cause variation.

The majority of the Workforce Indicators are experiencing common cause variation and inconsistency (passing or falling short of target) indicating that the indicators are not stable with the exception of Mandatory Training compliance (which is consistently achieving the target) and those metrics highlighted below (as Adverse). Readmissions within 30 Days of discharge indicators and the Stroke Best Practice Indicator are experiencing common cause variation and inconsistency (passing or falling short of target).

Adverse Assurance:
In the Well Led domain, Agency Staff used, Agency Spend and the Appraisal rate are failing the target. The majority of the efficiency indicators for the outpatient workstream are showing as consistently failing the target with the exception of the DNA Rates and Hospital Cancellations, however the percentage of outpatient that is non face to face (virtual) and the number of calls answered within 1 minute are experiencing special cause variation of an improving nature. The majority of the Elective Care workstream indicators are experiencing special cause variation – data outside of control limits (in a negative way) and consistently failing the target due to the COVID-19 Pandemic.

Executive Summary Scorecard

Current Month Overview of KPI Variation and Assurance Icons

	Variation					Assurance				Total
Trust Domains		L	H	L	H	P	F	?	No data	
CQC Domain Safe										
Infection Control	3							3	1	4
Harm Free Care	2							2		2
Incident Reporting	2							2		2
Safe Staffing	1							1	1	2
Mortality	1					1				1
Safe Total	***9***	***0***	***0***	***0***	***0***	***1***	***0***	***8***	***2***	***11***
CQC Domain Effective										
Outpatients	3	1			3		4	3		7
Quality & CQC	4							4		4
EPR									5	5
Strategy - Estates									5	5
Strategy - ICP / External									5	5
Effective Total	***7***	***1***	***0***	***0***	***3***	***0***	***4***	***7***	***15***	***26***
CQC Domain Caring										
Complaints	1			1		1		1		2
Admitted Care	3					2		1	1	4
ED Care									2	2
Maternity Care	1							1	1	2
Outpatient Care	1							1		1
Caring Total	***6***	***0***	***0***	***1***	***0***	***3***	***0***	***4***	***4***	***11***
CQC Domain Responsive										
Elective Access	2	1	2				4	1		5
Acute and Urgent Access				2	1			3	2	5
Cancer Access	4					2		2	1	5
Diagnostics Access		1						1		1
Bed Management				1				1		1
Responsive Total	***6***	***2***	***2***	***3***	***1***	***2***	***4***	***8***	***3***	***17***
CQC Domain Well-Led										
Staff Welfare									10	10
Finance and Contracts	2				1		1	2	3	6
Leadership and Education		1			1			2	6	8
Strategy - Clinical and ICC									9	9
Workforce	4	1		1		1	2	3		6
Well-Led Total	***6***	***2***	***0***	***1***	***2***	***1***	***3***	***7***	***28***	***39***
Trust Total	***34***	***5***	***2***	***5***	***6***	***7***	***11***	***34***	***52***	***104***

Corporate Scorecard by CQC Domain

Safe

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
S2	Number of cases C.Difficile (Hospital)	5	1		
S6	Rate of Total Patient Falls	5.80	7.28		
S7	Number of Never Events	0	0		
S8	Number of New SIs in month	11	7		
S10	Overall Safe staffing fill rate - Estimate	93.5%	91.3%		

Effective

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
E2	Standardised Mortality HSMR	Lower conf <100	96.0		
E3	% Total Readmissions	14.6%	15.9%		
E6	Stroke: Best Practice (BPT) Overall %	50.0%	46.6%		
R11	Average LOS Non-Elective	6.70	5.81		
R12	Theatre Utilisation	90.0%	78.2%		

Caring

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
C1	Single Sex Accommodation Breaches	0	0		
C3	% complaints responded to within target	75.0%	96.8%		
C5	IP Friends & Family (FFT) % Positive	95.0%	97.3%		
C7	A&E Friends & Family (FFT) % Positive	87.0%	No data due to COVID-19	No Data	No Data
C10	OP Friends & Family (FFT) % Positive	84.0%	81.7%		

Responsive

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
R1	Emergency A&E 4hr Wait	90.0%	97.2%		
R4	RTT Incomplete Pathway	84.1%	57.8%		
R6	% Diagnostics Tests WTimes <6wks	99.0%	74.0%		
R7	Cancer two week wait	93.0%	98.8%		
R10	Cancer 62 day wait - First Definitive	85.0%	87.4%		

Well-Led

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
W1	Surplus (Deficit) against B/E Duty	No data	No data	No Data	No Data
W2	CIP Savings	Suspended due to COVID-19		No Data	No Data
W7	Vacancy Rate (%)	9.0%	8.9%		
W8	Total Agency Spend	745	1,304		
W10	Sickness Absence	3.3%	3.3%		

Variation			Assurance			
Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or higher pressure due to (H)igher or (L)ower values	Common cause - no significant change	Variation Indicates inconsistently (P)assing of the target	Variation Indicates inconsistently passing and falling short of the target	Variation Indicates inconsistently (F)alling short of the target	Data Currently Unavailable

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Safe - CQC Domain Scorecard

Reset and Recovery Programme: Patient and Staff Safety

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Safe Staffing Levels	93.5%	91.3%	Aug-20		93.5%	91.9%	Jul-20	93.5%	90.0%	
Sickness Rate - Covid / Non-Covid	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
Infection Control - Number of Hospital acquired Covid	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
Infection Control - Rate of Hospital C.Difficile per 100,000 occupied beddays	24.6	6.4	Aug-20		24.6	44.6	Jul-20	24.6	22.7	
Infection Control - Number of Hospital acquired MRSA	0	0	Aug-20		0	0	Jul-20	0	3	
Infection Control - Rate of Hospital E. Coli Bacteraemia	34.5	19.3	Aug-20		34.5	7.4	Jul-20	26.6	27.5	
Number of New SIs in month	11.0	7.0	Aug-20		11	17	Jul-20	55	45	
Rate of Total Patient Falls per 100,000 occupied beddays	5.8	7.3	Aug-20		5.8	7.2	Jul-20	5.8	7.6	
Rate of Hospital Acquired Pressure Ulcers per 1,000 admissions	2.3	1.4	Aug-20		2.3	2.0	Jul-20	2.3	2.3	
Standardised Mortality HSMR	100.0	96.0	Aug-20		100.0	96.0	Jul-20	100.0	96.0	P
Never Events	0	0	Aug-20		0	0	Jul-20	0	0	

Effective - CQC Domain Scorecard

Reset and Recovery Programme: Outpatients

	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Percentage of Non-face to face OP activity / Total activity	75.0%	45.5%	Aug-20	H	75.0%	52.2%	Jul-20	75.0%	51.7%	F
OP Utilisation	85.0%	50.5%	Aug-20	L	85.0%	52.6%	Jul-20	85.0%	47.3%	F
Outpatient DNA Rate	5.0%	5.5%	Aug-20		5.0%	4.9%	Jul-20	5.0%	5.0%	?
Outpatient Hospital Cancellation	20.0%	21.7%	Aug-20		20.0%	20.0%	Jul-20	20.0%	29.8%	?
Outpatient Cancellations < 6 weeks	10.0%	16.4%	Aug-20		10.0%	16.4%	Aug-20	10.0%	21.7%	?
Calls Answereed in under 1 min	75.0%	39.0%	Aug-20	H	75.0%	39.0%	Aug-20	75.0%	47.0%	F
Calls Answereed in under 3 min	100.0%	63.0%	Aug-20	H	100.0%	63.0%	Aug-20	100.0%	72.2%	F

Organisational Objectives: Quality and CQC

	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Total Readmissions <30 days	14.6%	15.9%	Jul-20		14.6%	10.5%	Jun-20	14.6%	14.6%	?
Non-Elective Readmissions <30 days	15.2%	16.2%	Jul-20		15.2%	10.7%	Jun-20	15.2%	15.2%	?
Elective Readmissions < 30 Days	7.8%	10.2%	Jul-20		7.8%	7.0%	Jun-20	7.8%	7.8%	?
Stroke Best Practice Tariff	50.0%	46.6%	Aug-20		50.0%	48.9%	Jul-20	50.0%	39.4%	?

Effective - CQC Domain Scorecard

Organisational Objectives: EPR

	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Paper notes storage capacity (sqm)	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
Adverse drug events	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
Data protection incidents	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
Print costs	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
Duplicate tests	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data

Organisational Objectives: Strategy - Estates

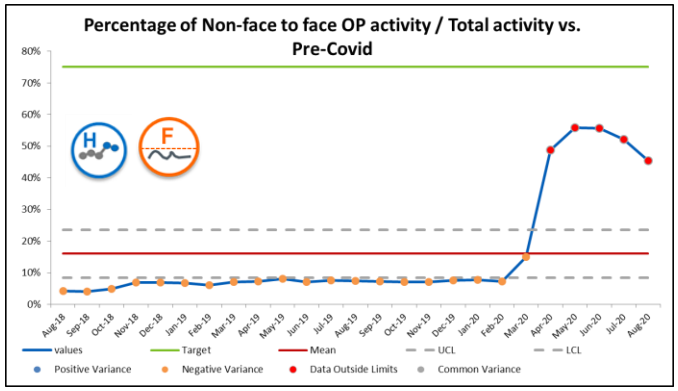
	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Utilised and unutilised space ratio	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
Footprint devoted to clinical care vs non clinical care ratio	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
Admin and clerical office space in (sqm)	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
Number of people without allocated office space (excludes those allocated to hot desking space)	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
Aggregated cost per sqm of estate	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data

Effective - CQC Domain Scorecard

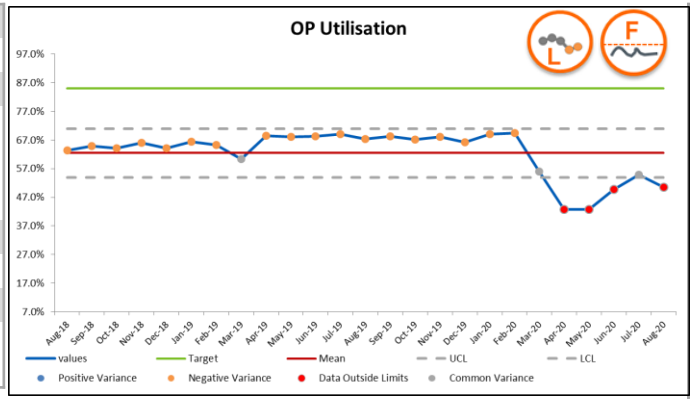
Organisational Objectives: Strategy – ICP/External

	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Dementia rate	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
Mental health – Children – Hospital admissions as a result of self harm (age 10-24)	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
Frailty – Admissions due to falls	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
System financial performance (£)	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
West Kent estates footprint (sqm)	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data

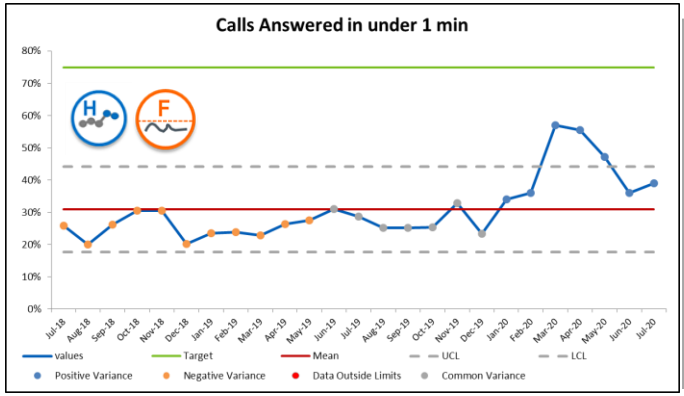
Effective- Reset and Recovery Programme: Outpatients



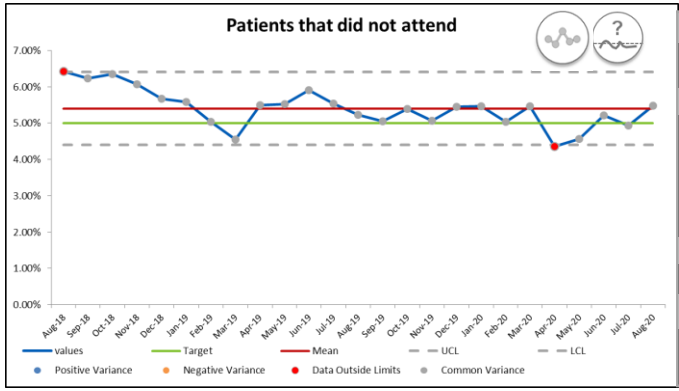
Aug-20
45.5%
Variance Type
Metric is currently experiencing special cause variation – positive performance outside limit
Max Target (Internal)
75%
Target Achievement
Metric is constantly failing the target



Aug-20
50.5%
Variance Type
Metric is currently experiencing special cause variation – negative performance outside limit
Max Target (Internal)
85%
Target Achievement
Metric is constantly failing the target



Aug-20
39%
Variance Type
Metric is currently experiencing special cause variation - positive
Max Target (Internal)
75%
Target Achievement
Metric is constantly failing the target



Aug-20
5.5%
Variance Type
Metric is currently experiencing common cause variation
Max Target (Internal)
5%
Target Achievement
Metric is experiencing variable achievement

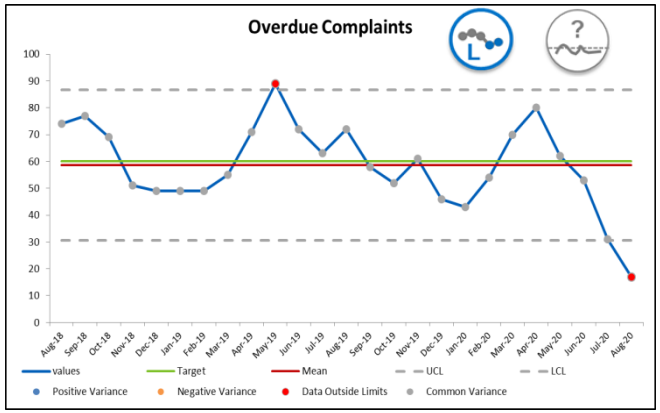
Summary:	Actions:	Assurance:
As expected due to the COVID-19 pandemic outpatient utilisation levels have decreased., this began to increase however due to annual leave in august has fallen again. The number of calls that is answered within 1 minute is constantly failing the target , this has started to increase however is still far off the target. DNA rates remain consistent but are experiencing variable achievement of the target.	Outpatient attendances have been impacted by COVID-19 but where clinically appropriate appointments have been moved to either a telephone or virtual appointment to avoid cancellations & DNAs. The Trust is reviewing the demand and capacity as part of the Reset and Recovery Programme for Outpatients.	Outpatient recovery plan is being considered with the different speciality teams and will be implemented with support from PMO. The demand and capacity remodelling has been completed and shared with the divisions. This is being reviewed to ensure we are aiming to achieve the phase 3 targets.

Caring - CQC Domain Scorecard

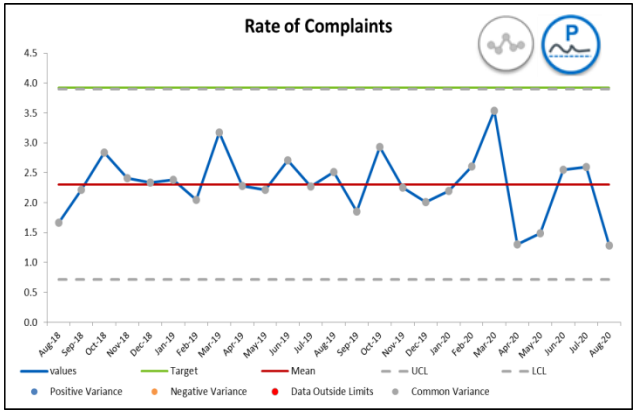
Organisational Objectives – Quality & CQC

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Single Sex Accommodation Breaches	0	0	Aug-20		0	0	Jul-20	0	0	P
Rate of New Complaints	3.9	1.3	Aug-20		3.9	2.6	Jul-20	3.0	1.9	P
% complaints responded to within target	75%	96.8%	Aug-20	L	75%	78.1%	Jul-20	75%	75.7%	?
IP Resp Rate Recmd to Friends & Family	25%	No data	Aug-20	No data	25%	No data	Jul-20	25%	No data	No data
IP Friends & Family (FFT) % Positive	95%	97.3%	Aug-20		95%	95.7%	Jul-20	95%	No data	?
A&E Resp Rate Recmd to Friends & Family	15%	No data due to COVID-19	Aug-20	No data	15%	No data due to COVID-19	Jul-20	15%	No data due to COVID-19	No data
A&E Friends & Family (FFT) % Positive	87%		Aug-20	No data	87%		Jul-20	87%		No data
Mat Resp Rate Recmd to Friends & Family	25%	30.9%	Aug-20	No data	25%	40.0%	Jul-20	25%	No data	No data
Maternity Combined FFT % Positive	95%	99.3%	Aug-20		95%	98.5%	Jul-20	95%	No data	?
OP Friends & Family (FFT) % Positive	84%	81.7%	Aug-20		84%	81.2%	Jul-20	84%	No data	?
% VTE Risk Assessment	95%	96.7%	Aug-20		95%	96.7%	Jul-20	95%	No data	P

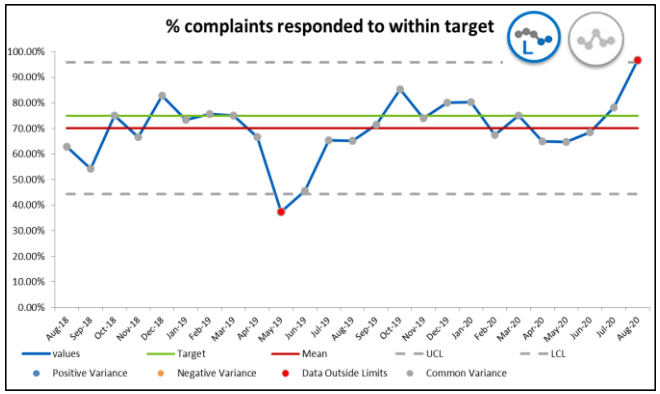
Caring- Organisational Objective: Quality and CQC



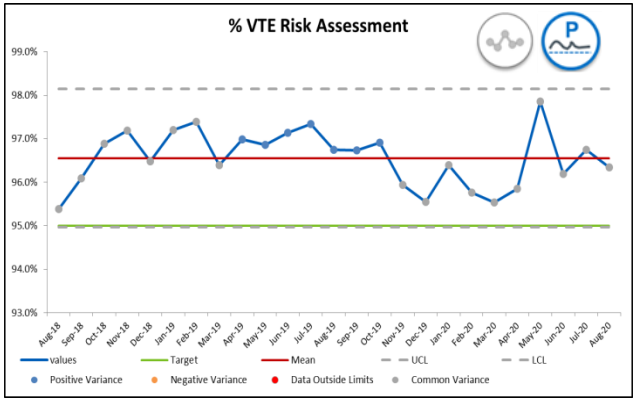
Aug-20
17
Variance Type
Metric is currently experiencing special cause variation - positive performance outside limit
Max Target (Internal)
60
Target Achievement
Metric is experiencing variable achievement



Aug-20
1.3
Variance Type
Metric is currently experiencing common cause variation
Max Target (Internal)
3.9
Target Achievement
Metric is consistently achieving the target



Aug-20
96.8%
Variance Type
Metric is currently experiencing special cause variation - positive performance outside limit
Target
75%
Target Achievement
Metric is experiencing variable achievement



Aug-20
96.3%
Variance Type
Metric is currently experiencing Common Cause Variation
Target (National)
95%
Target Achievement
Metric is consistently achieving the target

Summary:	Actions:	Assurance:
The number of new complaints received in August decreased to 20. Performance for the percentage of complaints responded to within their target date increased significantly to 96.8% which is therefore above the target of 75%. YTD compliance is now achieving the target at 75.7%. The number of overdue complaints and the percentage of complaints responded to within target are both now experiencing special cause variation of an improving nature. The rate of new complaints is now consistently achieving the target. The number of open complaints is also showing a downward trend and is at it lowest level for the last two years. VTE Risk Assessment Performance is consistently achieving the target.	Regular meetings with key divisional staff reinstated to monitor progress on open complaints. New format weekly reports issued with particular emphasis on overdue cases.	Continued regular monitoring of all open complaints with reports to CN. Learning and key messages published in the Governance Gazette.

Responsive- CQC Domain Scorecard

Reset and Recovery Programme - Elective Care

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
RTT (Incomplete Pathways) performance against trajectory	84.1%	57.8%	Aug-20	L	84.1%	49.1%	Jul-20	84.1%	57.8%	F
Number of patients waiting over 40 weeks	0	1799	Aug-20	H	0	1413	Jul-20	0	6212	F
52 week breaches (new in month)	8	144	Aug-20	H	8	166	Jul-20	40	610	F
Average for new appointment	10.0	10.1	Aug-20		10.0	10.8	Jul-20	10.0	10.1	F
Theatre Utilisation	90.0%	78.2%	Aug-20		90.0%	79.6%	Jul-20	90.0%	77.9%	?

Reset and Recovery Programme – Acute & Urgent Care

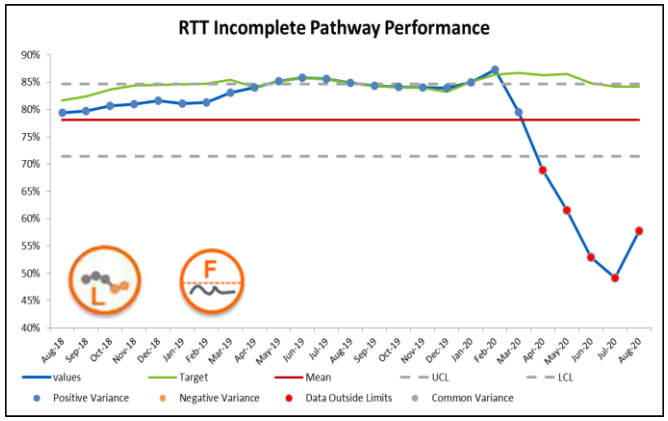
	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Referrals to ED from NHS 111	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
A&E 4 hr Performance	90.0%	97.2%	Aug-20	H	90.0%	98.0%	Jul-20	90.0%	97.8%	?
Super Stranded Patients	80	54	Aug-20	L	80	54	Jul-20	80	54	?
Delayed Transfers of Care	3.6%	No data	Aug-20	No data	3.6%	No data	Jul-20	3.5%	0.0%	No data
Bed Occupancy	90.0%	80.3%	Aug-20	L	90.0%	70.9%	Jul-20	90.0%	62.3%	?
NE LOS	6.7	5.8	Aug-20	L	6.7	5.4	Jul-20	6.7	5.7	?

Responsive - CQC Domain Scorecard

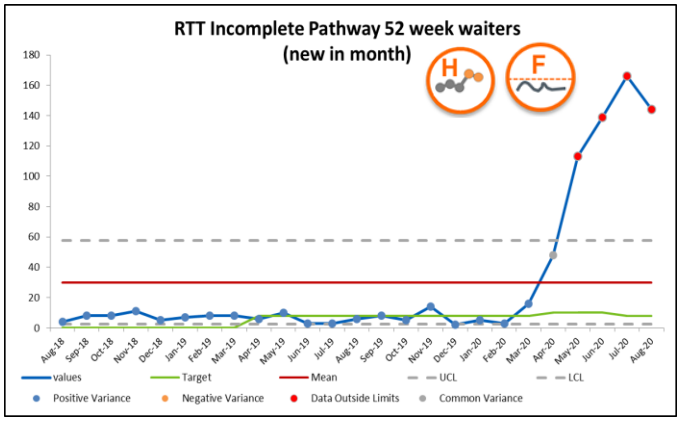
Reset and Recovery Programme – Cancer Services

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Cancer - 2 Week Wait	93.0%	98.8%	Jul-20		93.0%	98.8%	May-20	93.0%	98.8%	P
Cancer - 31 Day	96.0%	98.3%	Jul-20		96.0%	98.3%	May-20	96.0%	98.3%	?
Cancer - 62 Day	85.0%	87.4%	Jul-20		85.0%	87.4%	May-20	85.0%	87.4%	P
Size of backlog	30	35	Jul-20		30	35	May-20	30	35	?
Access to Diagnostics (<6weeks standard)	99.0%	74.0%	Aug-20	L	99.0%	74.0%	Jun-20	99.0%	74.0%	?
28 day Target	Coming Soon		Jul-20	No data	Coming Soon		May-20	Coming Soon		No data

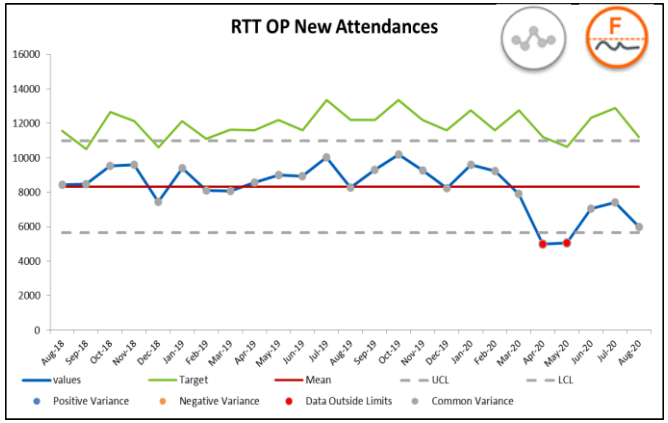
Responsive - Reset and Recovery Programme: Elective



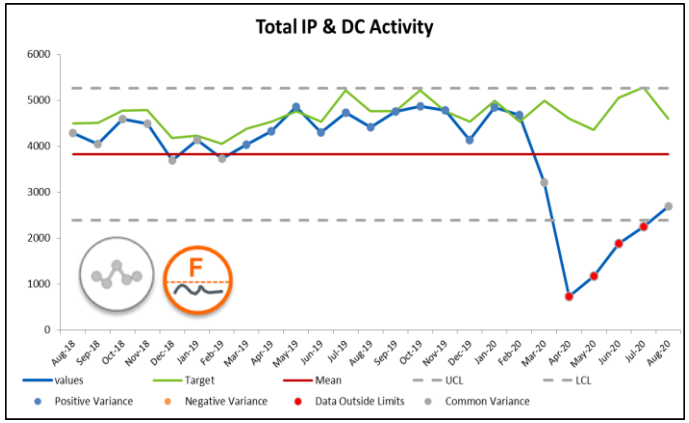
Aug-20
57.8%
Variance Type
Metric is currently experiencing special cause variation – negative performance outside limit
Max Target (Internal)
86.3%
Target Achievement
Metric is consistently failing the target



Aug-20
144
Variance Type
Metric is currently experiencing special cause variation – negative performance outside limit
Max Target (Internal)
8
Target Achievement
Metric is consistently failing the target



Aug-20
6,003
Variance Type
Metric is currently experiencing Common Cause Variation
Max Target (Internal)
11,213
Target Achievement
Metric is consistently failing the target



Aug-20
2,693
Variance Type
Metric is currently experiencing Common cause variation – negative performance outside limit
Max Target (Internal)
4,596
Target Achievement
Metric is consistently failing the target

Summary:

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. However the August performance has improved for the first time since the COVID-19 pandemic to 57.8%.

The elective activity levels have increased by 27% (excluding IS activity) in August compared to July. Large scale cancellations of elective activity has resulted in admitted electives & daycases reducing by 67% on normal levels YTD but with an improvement in August 2020.

The OP New activity levels remained similar in August compared with July (based on working days to allow for the Bank Holiday). New Outpatient activity has reduced by around 39% & follow up by around 20% YTD on normal activity levels, OP FUP activity levels decreased by 3% in August compared to July (based on working days to allow for the Bank Holiday).

Actions:

Due to the COVID response most of the elective activity ceased for 3 weeks apart from cancer and urgent cases. The Independent Sector were procured by NHSE to facilitate and assist with NHS activity.

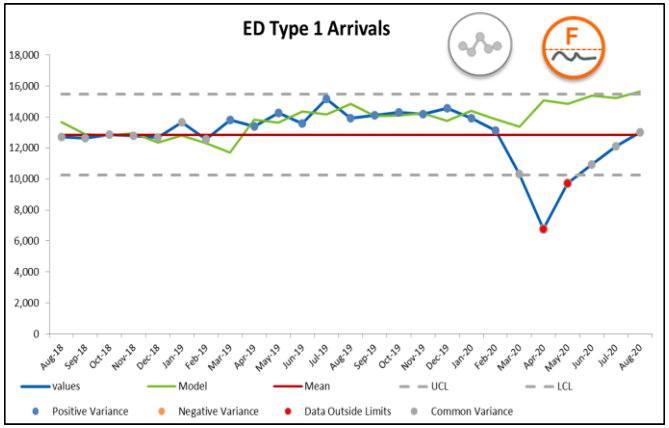
To decrease the 52 week breaches

Assurance:

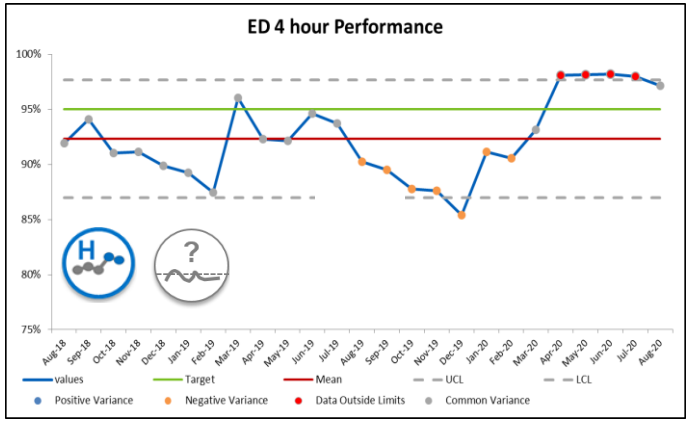
Phase 3 has been deployed which means that with the de-escalation of intensive care provision, the Trust has opened all theatres to allow increased activity for cancer, urgent and long waiting patients following guidance from NHSE. The Short Stay Surgical Unit has opened at TWH in order to increase the internal day case activity. Plans for Phase 3 include increasing the activity sent to the IS by sending whole patient pathways.

The speciality teams are planning treatment dates for these patients as well as those at 40+ weeks in order to stop patients tipping over in to 52 weeks before treatment.

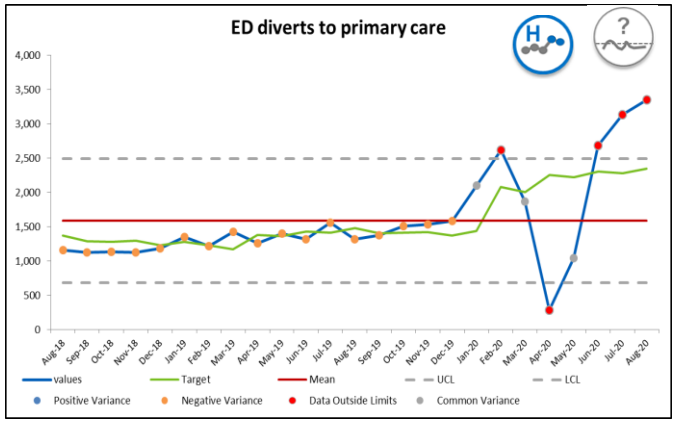
Responsive - Reset and Recovery Programme: Emergency Care



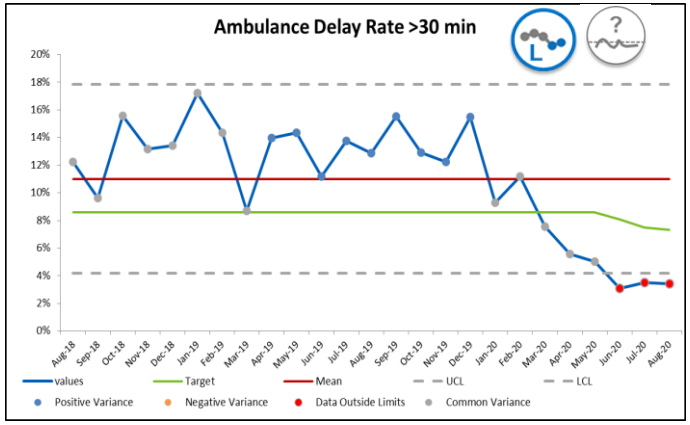
Aug-20
13,030
Variance Type
Metric is currently experiencing Common Cause Variation
Model
15,634
Target Achievement
Metric is consistently below model



Aug-20
97.16%
Variance Type
Metric is currently experiencing special cause variation – positive performance outside limit
Target
95.00%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail



Jul-20
3,135
Variance Type
Metric is currently experiencing special cause variation – positive performance outside limit
Target
2,346
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)



Aug-20
3.4%
Variance Type
Metric is currently experiencing special cause variation – positive performance outside limit
Target
7.3%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Summary:

- ED arrivals (Type 1) dropped by 55-60% at the height of the pandemic. August came in at 12.3% below model
- ED 4hr performance (inc MIU) had been above 98.0% for 4 months, but dipped to 97.16% in Aug
- Diverts to Primary Care hit another new high in Aug of 3,135, New MIUs came online in Jan to work alongside the GP service. This shut down during the pandemic. But is back running.
- Ambulance delays have been generally improving since New Year, with 3.4% of all handovers delayed 30 mins or longer in Aug

Actions:

SDEC running 7 days per week. Continued Improvement seen in handover performance with 'at the time' reporting to get a full picture of the issues

Introduction of First Contact Practitioner (FCP) at front door to assist appropriate streaming of patients

Trail of Flow Co-Ordinator at MGH to assist with Ambulance Handover and departmental flow

COVID 19 Discharge P3 allowed rapid discharge, however this group of patients are still within the health economy , but are in care homes etc. This has significantly benefitted TWH. Reset requires conversation with social services and CCG

Assurance:

Continuous work to ensure all departments within Trust feel a part of the 4Hour Access Standard –

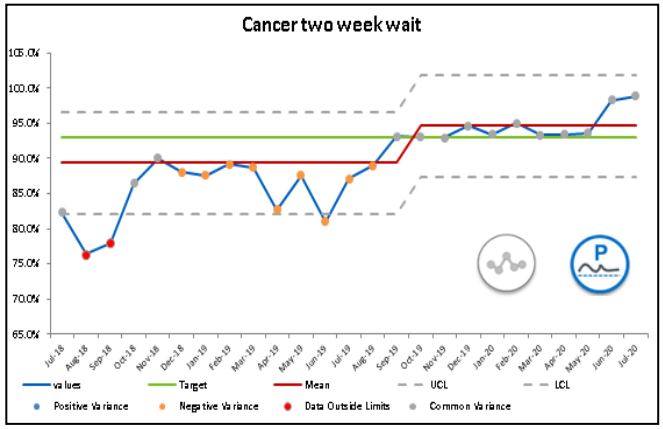
Increased profile on ambulance handovers.

Focused bed meetings on actions. System call put in on a daily basis where required when system is tight.

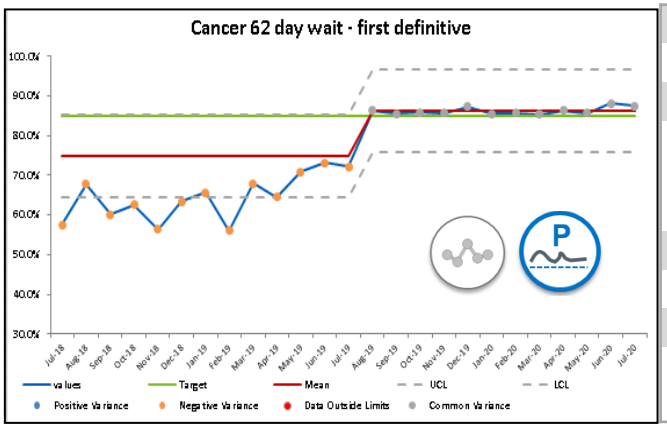
New escalation document developed to raise awareness of required actions to better deal with unexpected demand increase and departmental issue

Daily review of 21+ numbers . MFFD dramatically reduced and being carefully monitored. DTOC suspended.

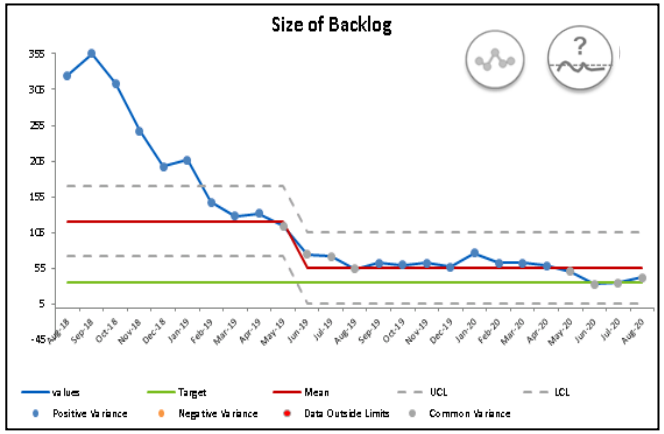
Responsive - Reset and Recovery Programme: Cancer



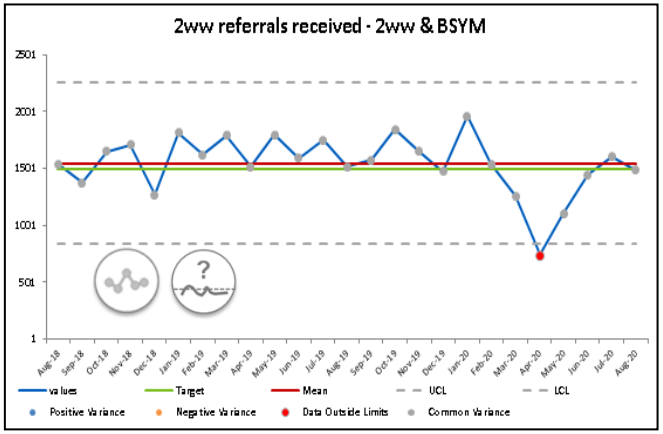
Jul-20
98.8%
Variance Type
Metric is currently experiencing Common Cause Variation
Max Target (Internal)
93%
Target Achievement
Metric is currently achieving the target



Jul-20
87.4%
Variance Type
Metric is currently experiencing Common Cause Variation
Max Target (Internal)
85%
Target Achievement
Metric is currently achieving the target



Aug-20
42
Variance Type
Metric is currently experiencing Common Cause Variation
Max Target
35
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)



Aug-20
1487
Variance Type
Metric is currently experiencing Common Cause Variation
Max Target (Internal)
1500
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Summary:	Actions:	Assurance:
Both the 2ww and the 62d standards are showing as currently achieving the targets, with the 62d target being achieved for 12 consecutive months, from August 2019 with 86% and reporting 87.4% in July 2020 and the 2ww target has been consistently achieving for 11 months from September 2019 The number of incoming 2ww referrals has continued to rise and August referral numbers are currently an average of 97% of pre-Covid-19 numbers The overall size of the backlog is being maintained with an average of 42 patients in August (3.7% of the total PTL)	In previous months we have developed Green pathways to fit the Covid-19 requirements and these have been integrated to achieve the 28 day Faster Diagnosis and the 62 day targets. This is ongoing work continues to need further engagement with all services, to ensure that both the 28day FDS and the 62d performance targets can be met Services that were stopped during Covid-19 have recommenced (e.g. endoscopy and major surgery) and we continue to see increased activity Following initial delays due to Covid-19, we are continuing with recruitment to nursing roles to support the new pathways that have been developed	The ongoing daily huddles with each tumour site team are in place and monitoring the growth in the PTL as referral numbers return to pre-Covid levels. Management of the daily PTLs continues to give oversight and hold services to account for patient next steps. Diagnostic services attend these huddles to escalate booking or reporting delays on the day The weekly performance meetings continue to oversee the cancer performance and include funding initiatives and quality assurance i.e. 104 day clinical harm reviews .

Well Led - CQC Domain Scorecard

Reset and Recovery Programme: Staff Welfare

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Climate Survey - Engagement: Number of people completing the Climate survey	Improving Quarterly	738	Jun-20	No data	Improving Quarterly	850	Apr-20	Improving Quarterly	738	No data
Climate Survey - Percentage of staff who feel fully supported in their role		72.0%	Jun-20	No data		69.0%	Apr-20		72.0%	No data
Climate Survey - Percentage of staff who feel the Trust has a genuine concern for their safety		71.0%	Jun-20	No data		67.0%	Apr-20		71.0%	No data
Climate Survey - Percentage of staff who feel able to cope with the demands that are being		76.0%	Jun-20	No data		70.0%	Apr-20		76.0%	No data
Health and Wellbeing metrics	Coming Nov-20		Aug-20	No data	Coming Nov-20		Apr-20	Coming Nov-20		No data

Organisational Objectives: Workforce

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Sickness	3.3%	3.3%	Aug-20		3.3%	3.9%	Jul-20	3.3%	4.8%	?
Turnover	10.0%	11.6%	Aug-20	L	10.0%	10.9%	Jul-20	10.0%	11.2%	?
Vacancy Rates	9.0%	8.9%	Aug-20		9.0%	8.0%	Jul-20	9.0%	8.9%	?
Use of Agency	80	166	Aug-20		80	187	Jul-20	80	166	F
Appraisal Completeness	95.0%	43.2%	Aug-20	L	95.0%	48.8%	Jul-20	95.0%	30.8%	F
Stat and Mandatory Training	85.0%	87.9%	Aug-20		85.0%	87.3%	Jul-20	85.0%	85.9%	P

Well Led - CQC Domain Scorecard

Reset and Recovery Programme: Finance & Contracts

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Surplus (Deficit) against B/E Duty	No data		Aug-20	No data	No data		Jul-20	No data		No data
CIP Savings	Suspended		Aug-20	No data	Suspended		Jul-20	Suspended		No data
Cash Balance	34,102	64,408	Aug-20	H	34,102	58,608	Jul-20	34,102	64,408	?
Capital Expenditure	897	1,265	Aug-20		897	282	Jul-20	4,586	3,524	?
Agency Spend	745,180	1,303,663	Aug-20		745,180	1,333,724	Jul-20	3,865,590	6,277,880	F
Use of Financial Resources	3	No data	Aug-20	No data	3	No data	Jul-20	No data		No data

Reset and Recovery Programme: Social Distancing / Home Working

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Number of staff home working against plan	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
Staff swabbing compliance against guidelines	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
Compliance with risk assessments e.g. BAME / at-risk staff / VDU	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
Use of associated technology e.g. MS Teams	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
Staff reporting having the equipment they need to comply with rules	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data

Well Led - CQC Domain Scorecard

Reset and Recovery Programme: ICC

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Implementation of Teletracking	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
PPE availability	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
Nursing vacancies	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
Covid Positive - number of patients	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data

Reset and Recovery Programme - Education / KMMS

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Number of medical students at Trust	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
Number of clinical academic posts	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
Number of non-medical educators	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
% of students reporting a good or better educational experience	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
% of medical students retained as FY1s	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data

Well Led - CQC Domain Scorecard

Organisational Objectives - Strategy – Clinical

	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Number of specialist services per directorate	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
Volume of activity being sent to London	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
Service contribution by division	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
Research grants (£)	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data
Number of advanced practitioners	Coming Soon		Aug-20	No data	Coming Soon		Jul-20	Coming Soon		No data

Organisational Objectives – Exceptional People

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Staff Friends and Family % recommended work	57.0%	72.2%	Aug-20	L	57.0%	72.2%	Jul-20	57.0%	72.2%	?
Staff Friends and Family % recommended care	80.0%	77.8%	Aug-20	H	80.0%	77.8%	Jul-20	80.0%	77.8%	?
Equality, Diversity and Inclusion reducing inequalities metrics / dashboard	Coming April 21		Aug-20	No data	Coming April 21		Jul-20	Coming April 21		No data

Appendices

Supporting Narrative

Executive Summary

The Trust has achieved the National Cancer 62 Day FDT Standard of 85% each month for a whole year at 87.4%. The 2 week wait cancer waiting time target remained above target for the eleventh consecutive month with Breast Symptoms also achieving the target. In addition, August performance remained high at 97.16% for the A&E 4hr standard, with the Trust remaining one of the best performing Trusts in the UK and the RTT performance increased for the first time since the COVID-19 Pandemic as we start to implement the Trust's Reset and Recovery Programme. Performance for the Diagnostics Waiting Times target also increased further in August. Whilst the activity levels remained lower than usual in August elective activity has increased (+27% compared to July) and first outpatient activity as remained similar to July (based on working days). The lower activity levels continue to adversely impact the RTT performance and of the constitutional standards the RTT and Diagnostics standards are most at risk in future months due to the decrease in capacity (with the impact of social distancing and use of PPE) and the uncertainty as to the likely level of demand.

Key Performance Items:

- **Infection Control:** There was 1 case of C.Diff reported in August and the Trust remains on trajectory. Both the rate of C.Difficile and E.Coli are experiencing common cause variation and variable achievement of the target. Cases of Gram Negative Bacteraemia and MSSA have remained slightly lower than last year.

- **Falls:** The rate of Falls for the Trust has remained similar in August with both Maidstone and Tunbridge Wells levels just above the mean. The level of occupied bed days remained lower in August due to COVID-19 but saw a 15% increase on July and is now at 76% of the level in August last year). Monitoring of falls incidents reported and also review of measures taken to reduce risk of further falls. Reviews of wards with high falls to identify trends and themes to share with wards.

- **Pressure Ulcers:** The level of hospital acquired pressure ulcers (HAPU) has reduced further in August with 8 reported equating to a rate of 1.4 against a maximum limit of 2.3. Following the decrease seen in the level of admissions due to COVID-19 August was just 0.4% below the level of admissions in August last year and was 8% higher than in July 2020. This metric is now experiencing common cause variation. The rate of all pressure ulcers (including those who already had a pressure ulcer on admission) has reduced to 22.6 and is also now experiencing common cause variation. We continue to triangulate pressure ulcer incidence in COVID positive patients alongside our requirements for data collection from NHS England.

- **Stroke:** Performance for August remained similar to July and was slightly below the 50% target at 46.6%. All of the stroke indicators are experiencing common cause variation and inconsistency.

- **A&E 4 hour Standard:** Performance in August reduced slightly to 97.16% but remains high 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 been steadily increasing to around 88% of normal levels in August. Minor attendances have been reduced more than major attendances and ambulance arrivals are now around 5% lower than normal. Emergency Admissions are now only 5% lower than normal levels, despite ED attendances still being 10-15% lower than normal. The total bed occupancy has increased from 42% in April to 80.3% in August.

- **Ambulance Handover Delays**: The ambulance handover scores improved significantly in the weeks before the pandemic, and although they improved significantly during the pandemic, they have continued to improve as activity has been returning to normal. Ambulance handover delays are now at 3.4% of all handovers delayed 30 mins or longer. This is therefore experiencing special cause variation of an improving nature.

Supporting Narrative 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, however the elective activity has increased (+27% compared to July) and first outpatient attendances have remained similar compared to July (based on working days to allow for the bank holiday). This has adversely impacted the RTT performance. August performance has improved to 57.8%. Diagnostics waiting < 6 weeks performance has increased to 74% in August.

- **Outpatient Activity Face to Face vs Virtual:** As the number of Covid-19 patients has decreased, the number of face to face outpatient appointments has been able to increase again. Additionally from the increased use of Attend Anywhere and telephone appointments the non-face to face activity levels have increased. 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 has successfully completed 12 months of achieving the 62 day standard, from 86.3% in August 2019, achieving over 85% each month up to July 2020, where 87.4% was reported. This remains a significant improvement over last year when only 72.2% of our patients were treated in 62 days in July 2019. Following the decrease in treatments due to Covid-19 pandemic, although the treatment numbers are still lower than the average for last year, numbers are increasing from previous months (77 in May, 85 in June, 100 in July 2020). The current number of treatments is 84% of the average from 2019-20.

- **Cancer 2weeks (2ww):** The Trust has maintained achievement of the 2ww standard for 11 months, from September 2019, reporting 98.8%% for July 2020, and 96.7% for Breast Symptoms. This is a continued improvement over the same period last year where only 87% of patients had their first seen appointment within the 14 day standard

- **Cancer 2weeks (2ww) Referrals:** After the drop in referral numbers at the beginning of April due to COVID-19, the incoming referrals continue to increase weekly and the numbers received in August averaged out to 97% of the average daily referrals from January / February 2020. Through August there have been some days where referral numbers were up to 130% of the average from January / February (e.g. 130% on Friday 28th August where 94 referrals were received)

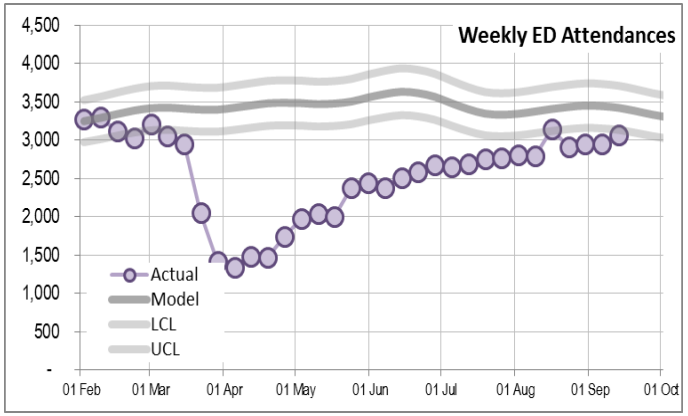
- **Finance:** The Trust has delivered a breakeven financial position which includes £9.2m retrospective top up income support. The Trust has identified financial pressures (increase in costs and reduction in income) due to COVID 19 of £15.7m, the Trust plan assumed £2.4m top up would be required to achieve a balanced position (before COVID costs) therefore underspends within the plan of £8.9m have been made to net down the impact to £9.2m. The key underspends to plan are: Drugs (£3.2m) mainly due to reduction in Oncology and Ophthalmology high cost drugs, pay underspends (£5m) mainly within Nursing (£1.8m), STT (£1.5m) and A&C (£1.3m) staff groups due to higher than planned vacancies, £1.7m underspend within clinical supplies due to reduction in elective activities and £0.4m 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), increase in expected credit loss (£0.1m), income reductions within Diagnostics relating to independent sector activity (£0.3m), increase in reserves(£0.1m) and £0.1m 2019/20 clinical income contract settlement.

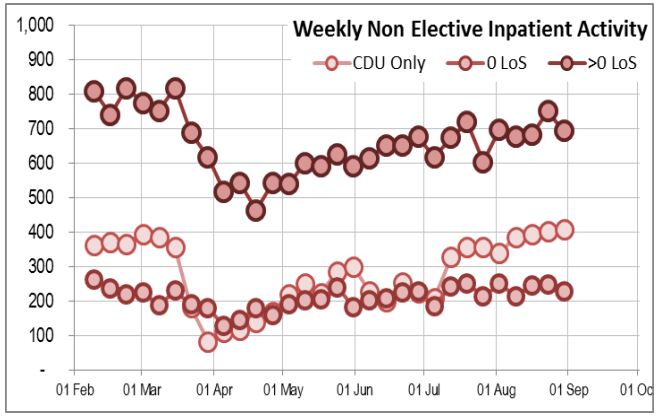
- **Workforce - Various:** The Safe Staffing Nursing Fill Rate remained similar in August but remains below usual levels which has impacted on the overall fill rate, however the overall fill rate is now back to similar levels compared to last year. There has not been any staffing level risk to wards. Agency staff usage has reduced slightly but remains above the desired levels. Sickness levels have reduced in August, achieving the target of 3.3% and this metric is now experiencing common cause variation following the peak outside the control limits in April and May due to COVID-19. The proportion that is due to COVID-19 has also reduced to less than 0.5%. August Vacancy rate increased slightly to 8.9% but continues to achieve the target.

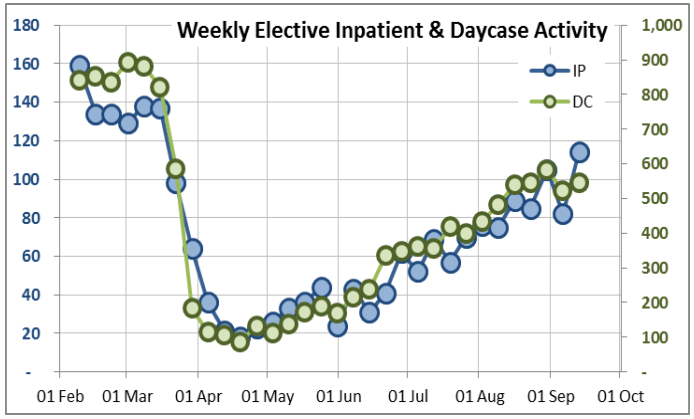
- **Staff and their Families Swabbing:** Capacity is higher than uptake. The drive-through is less utilised than the two PODs at Maidstone and Tunbridge Wells Hospitals which is bringing down the overall utilisation rate.

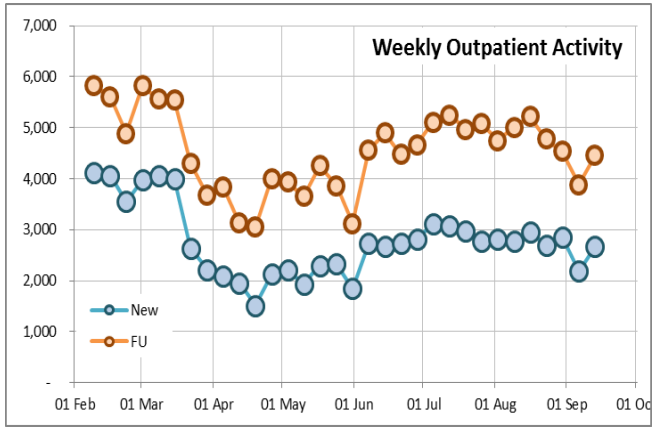
- **COVID-19 Tests:** There has been a gradual increase in the levels of testing and capacity has been increased to support the need. Total tests have now technically exceeded testing capacity, as we are now outsourcing some of our tests. We are currently averaging just under 500 total tests, and over 125 a day on staff. The percentage of tests showing positive has dropped to <1%. The Trust has also been undertaking the antibody test.

Escalation: COVID-19









ED Attendances: Attendances fell by around 60% against model at the height of the pandemic, but have since been recovering steadily. Aug attendance were 12.3% down on model, and the week ending 13-Sep was 10.7% down. Ambulance arrivals dropped by around 30% at the height of the pandemic, and have recovered more strongly, with the last few weeks being only ~5% lower than average, and within normal ranges. Assessment at the door of ED is now occurring, which is preventing much of the lower end of the acuity scale from attending,

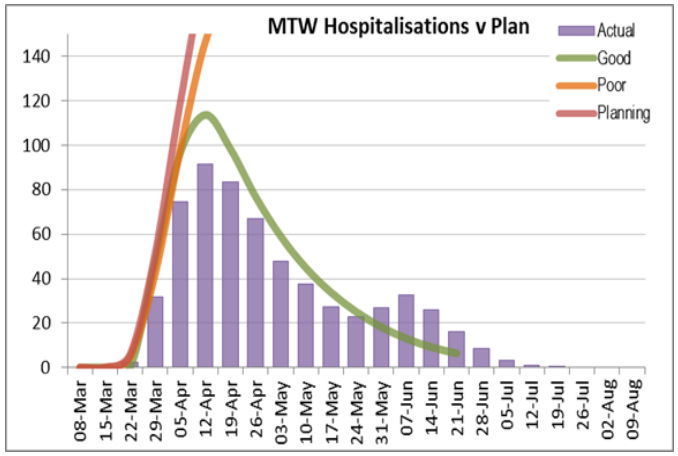
Emergency Admissions: Non-zero emergency admissions have been around 10% down on normal over the past 3 weeks, whilst zero LoS admissions are pretty much back to normal & CDU Only is now higher than normal pre-pandemic levels, despite ED attendances still being 10-15% down.

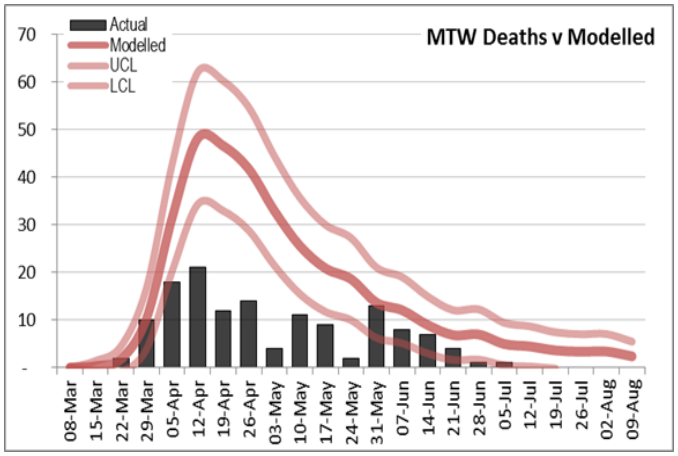
Elective / Daycase Activity: Large scale cancellations of elective activity has resulted in admitted electives reducing by 75-80% on normal levels, and daycases also 80-85%. They have both recovered steadily – elective is around 35-40% down & daycase 35-40% down. Both these are expected to recover more strongly in the next few weeks as the trust restart programmes come into effect.

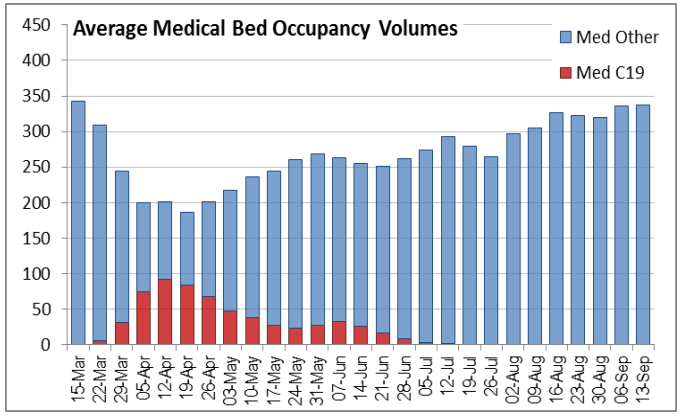
Outpatient Activity: New Outpatient activity seems to have dipped back down, with New now around 35% down, and follow up by around 20-25% down on normal, though some of this may be subject to an undercount, with some uncashed appointments still in the system. As with elective activity, the week-by-week reduction has been slower than seen in emergency activity.

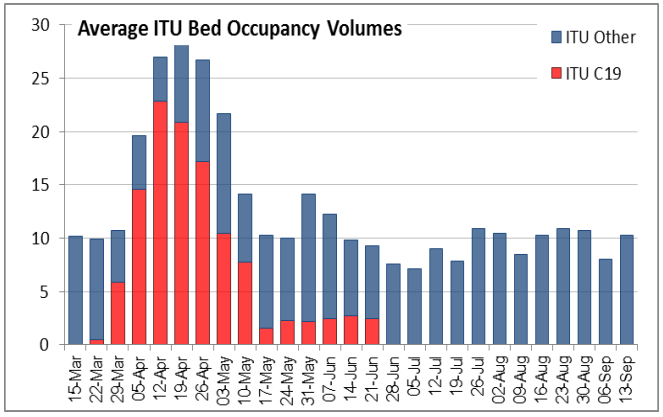
Summary : All activity is down, but recovering steadily
Minor ED attendances now 15-20% down, major down ~5%
Emergency admissions down around 5%
Daycase 35% to 40% down & elective 35-40% down
Total Outpatient activity down 16% with new down a little more than FU

Escalation: COVID-19









Caseload v Planning: The bed planning figures only ran until 21-June. Despite a national surge in cases, national hospitalisations remain at a much lower level, and Kent is lower still. MTW had just one Covid case in July and one in August. The virus is currently affecting a generally younger & more resilient population, but this situation could change in a short timescale, so close monitoring of these indicators is being maintained

Deaths: The national total being quoted daily is hospital deaths. If deaths were spread evenly throughout the country, then by Sun 12-Jul, we would have expected our cumulative total to be 330-340. In reality it was less than half that at 137, and we have not seen a reportable death since 29-Jun

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, went down to 180-220 at the peak in early April, and went above 300 in the week ending 09-Aug, and has remained there since.

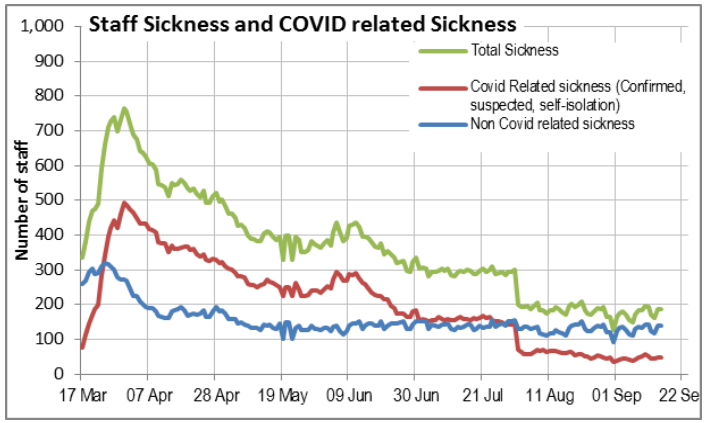
ITU Occupancy: This was around normal levels of 8-12 for the two weeks before the first patients arrived, before rising sharply to 25-30. ITU has now been Covid free for 12 weeks

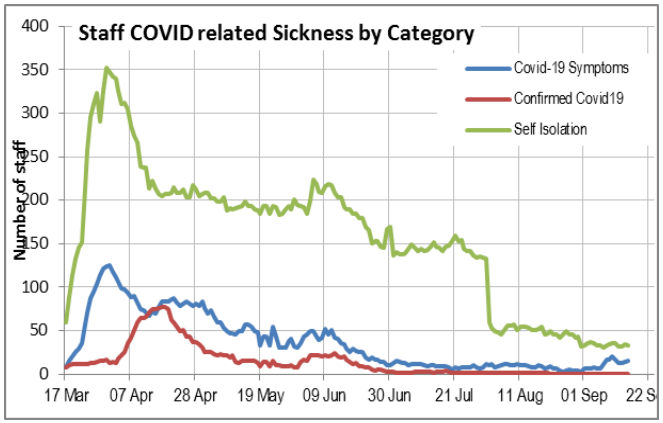
Summary

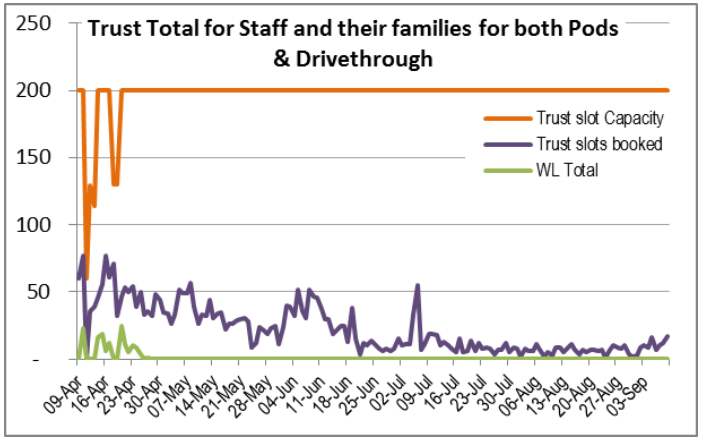
MTW caseloads & deaths have both been tracking well below what we would expect. In the past few weeks, C19 cases & deaths have gone to zero.

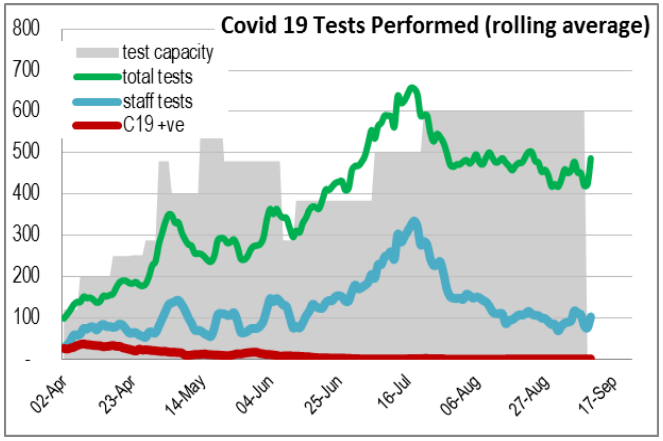
The national surge in cases has yet to affect MTW, but this could change in short timescales

Escalation: COVID-19









Staff Non-Covid related sickness peaked at just over 300 in late March, but is now back at normal levels (average 100-130 per day).

Covid-19 Related Sickness: The COVID-19 related sickness which includes; confirmed cases, suspected cases and self-isolation increased sharply at first, peaking at just under 500 at the end of March but is now back down into the 150-170 range. This is a combination of confirmed & unconfirmed symptomatic & self isolation

Self-Isolation: Similar to Covid related sickness, this peaked in early April (~350), fell & stabilised in May (200-220), increased a little in June when our admissions came back up, and have since fallen back to a steady 140-150 per day. These also step-changed down on 01-Aug to 50-60

Swabbing: Overall Trust slot capacity for staff and their families increased throughout April and is currently at 200 slots available per day (a slot could have 1 to 6 people attending depending how many in the family require swabbing). The number of tests booked has begun to increase over the past few days.

Pathology – COVID-19 Tests Performed: Total tests have now technically exceeded testing capacity, as we are now outsourcing some of our tests. We are currently averaging just around 500 total tests, and around 125 a day on our staff. The percentage of tests showing positive has dropped to zero.

Summary: Summary: Non-Covid related sickness is back to the sort of levels we expect, and both Covid related sickness & self isolation rose in early June along with hospital admissions, indicating a local infection hotspot around that time. Testing has is picking up again, and positive rests are again being seen after dropping to near zero in July

REVIEW OF LATEST FINANCIAL PERFORMANCE

- The Trust delivered the year to date and August's financial position by achieving a breakeven position. In line with national guidance this included retrospective top up income support from NHSE/I (£9.2m YTD, £2.2m in August). 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 £15.7m year to date (£3.1m in August). The Trust plan assumed a £2.4m top up would be required to achieve a balanced position (before COVID costs) therefore underspends within the plan of £8.9m have been made to net down the impact of COVID 19 costs to £9.2m.
- The key year to date variances to plan are as follows:
  - Drugs underspend mainly due to reduction in Oncology and Ophthalmology high cost drugs (£3.2m)
  - Pay underspends mainly within Nursing (£1.8m) A&C (£1.3) and STT (£1.5m) staff groups due to higher than planned vacancies (£5m)
  - Clinical supplies underspend (£1.7m) due to reduction in elective activities.
  - Car Parking lights pressure (£0.3m)
  - Laundry increase in dilapidation reserve (£0.2m)
  - EPR project costs pressure (£0.3m)
  - Income reductions within Diagnostics relating to independent sector activity (£0.3m)
  - 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 £0.5m adverse to plan however this pressure has been included in the COVID impact schedule. The main pressures related to the reduction in catering and car parking income (£0.2m), £0.2m adverse variance relating to private patients and £0.1m reduction in Pathology independent sector charges.
  - Pay budgets adjusted for pass-through items were £0.5m adverse in August, the level of pay spend maintained at last months levels (£25.9m). Nursing staffing was the main staff group which increased spend between months (£0.2m), with the largest increases in Medicine and Emergency Care (£0.1m) and Surgery (£0.1m).
  - Non Pay budgets adjusted for pass through items overspent by £0.8m in August which included £0.9m COVID related costs therefore a net £0.1m underspend within budgets. The key underspends to budget are: Drugs (£0.3m) mainly due to reduction in high cost Ophthalmology and Oncology drugs partly offset by £0.1m costs associated with implementation of Tele tracking and £0.1m HMRC P11D charge.

- The closing cash balance at the end of August 2020 is £64.4m which is similar to the closing cash balance at the end of July (£58.6m). The Slightly higher than normal balance is due to the Trust receiving an advance on SLA income within April from CCG's and NHSE/I. The Trust will continue to receive the same "block" SLA income value for September that it has received for the first five months of 2020/21. The Trust is waiting further details from NHSE/I on the repayments of the SLA advances received in April. On the 21st September the Trust will receive £26.1m in revenue PDC in order to repay on the 23rd September the two working capital loans of £26.1m.
- Capital spend by the end of month five is £3.7m of which £1.8m relates to Covid 19 equipment, ICT and estates costs – these costs have all been submitted to NHSE/I Regional team as part of the funding claims. The main other areas expenditure are £0.7m related to the ongoing EPR programme, £0.7m relating to the IVE Programme and £0.2m related to Estates schemes running across the year end (e.g. the RAP scheme in A&E).
- The Trust has received approval for £190k capital PDC to support the Kent & Medway Care Record system. The Trust has also been notified of its share of the national emergency and urgent care funding, which is £2.8m, plus another £0.5m related to hosting the K&M system for the "Think 111" initiative. The Trust has also received approval for £771k to fund replacement Breast Screening vans and units under phase 2 of the national Diagnostic Fund.

Maidstone and Tunbridge Wells NHS Trust

1. Dashboard

August 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	43.5	42.3	1.2	(0.1)	1.3		214.0	211.5	2.5	(0.7)	3.2	
Expenditure	(41.0)	(39.8)	(1.3)	0.1	(1.3)		(201.6)	(198.6)	(3.1)	0.7	(3.8)	
EBITDA (Income less Expenditure)	2.5	2.5	(0.1)	(0.0)	(0.1)		12.4	12.9	(0.6)	(0.0)	(0.5)	
Financing Costs	(2.5)	(2.5)	0.0	0.0	0.0		(12.6)	(12.9)	0.3	0.0	0.3	
Technical Adjustments	0.0	0.0	0.0	0.0	0.0		0.2	0.0	0.2	0.0	0.2	
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	64.4	34.1	30.3		30.3		64.4	34.1	30.3		30.3	
Capital Expenditure	1.3	0.9	(0.4)		(0.4)		3.7	4.9	1.1		1.1	

Summary Current Month:

- The Trust delivered the financial plan in August by achieving a breakeven position. In line with national guidance this included £2.2m 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 August has identified £3.1m of costs and income reductions associated with COVID 19 . The Trust plan assumed £0.5m top up would be required to achieve a balanced position (before COVID costs) therefore underspends within the plan of £1.4m have been made to net down the impact to £2.2m.

The key underspends against plan are: Pay budgets £1.4m mainly in Nursing (£0.5m) and A&C (£0.4m) , Drugs £0.3m due to reduction in high cost Cancer and Ophthalmology drugs partly offset by £0.3m pressure within non pay budget.

Year to date overview:

- The Trust has delivered a breakeven financial position which includes £9.2m retrospective top up income support.
- The Trust has identified financial pressures (increase in costs and reduction in income) due to COVID 19 of £15.7m, the Trust plan assumed £2.4m top up would be required to achieve a balanced position (before COVID costs) therefore underspends within the plan of £8.9m have been made to net down the impact to £9.2m. The key underspends to plan are: Drugs (£3.2m) mainly due to reduction in Oncology and Ophthalmology high cost drugs, pay underspends (£5m) mainly within Nursing (£1.8m), STT (£1.5m) and A&C (£1.3m) staff groups due to higher than planned vacancies, £1.7m underspend within clinical supplies due to reduction in elective activities and £0.4m 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), increase in expected credit loss (£0.1m), income reductions within Diagnostics relating to independent sector activity (£0.3m), increase in reserves(£0.1m) and £0.1m 2019/20 clinical income contract settlement.

Key Points:

- The Trust received Julys retrospective top-up income from NHSI/E (£1.5m) on the 15th September

Risks:

- The Trust won't be notified by NHSI/E of the final retrospective top up value for August until the mid October.

2. COVID 19 Expenditure and Income Impact

2020/21 Summary of Cost Reimbursement

Total Revenue (£000s):	13,645

Breakdown by Allowable Cost Type	£000s
Expanding medical / nursing / other workforce	871
Sick pay at full pay (all staff types)	178
COVID-19 virus testing (NHS laboratories)	1,844
Remote management of patients	2
Support for stay at home models	12
Direct Provision of Isolation Pod	1
Plans to release bed capacity	0
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	1,452
Segregation of patient pathways	3,544
Enhanced PTS	0
Business Case (SDF) - Ageing Well - Urgent Response Accelerator	0
Existing workforce additional shifts	951
Decontamination	0
Backfill for higher sickness absence	1,416
NHS 111 additional capacity	0
Remote working for non patient activites	279
National procurement areas	1,774
Other	1,322

Summary: Loss of income

Total (£000s):	2,064

Breakdown by income type	£s
Car parking income	1,055
Catering	144
Pathology Trade Income	67
Private Patient Income	300
Injury Recovery Income	54
Research and Development	200
Other	243

Grand Total

Total (£000s):	15,709

Commentary:
The Trust has identified the financial impact relating to COVID to be £15.7m, which includes £13.6m associated with additional expenditure and £2.1m 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 July 2020 retrospective top up funding (£1.5m). The Trust will be notified mid October of the retrospective top up funding for August (£2.2m).

Jul-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	121.9%	84.3%	-	100.0%	115.7%	97.4%	-	-	50.9%	36.5%	196	13.61	26	11.0	3	0		123,824	172,150	(48,326)
MAIDSTONE	Cornwallis (M) - NS959	97.7%	72.9%	-	100.0%	70.0%	90.9%	-	-	6.1%	5.9%	15	0.90	1	16.6	0	1	Reduced fill rate due to lower bed occupancy throughout the month between 0 - 14	80,201	81,356	(1,155)
MAIDSTONE	Culpepper Ward (M) - NS551	91.4%	114.4%	-	-	100.9%	103.3%	-	-	17.9%	26.0%	51	3.59	3	9.1	2	0	1 x fall above threshold	103,769	102,673	1,096
MAIDSTONE	John Day Respiratory Ward (M) - NT151	108.6%	98.8%	-	-	110.7%	102.2%	-	-	30.8%	9.9%	53	3.50	5	8.4	7	1	2 x Falls above threshold. Increased fill rate at night due to enhanced care requirements throughout the month.	143,870	145,853	(1,983)
MAIDSTONE	Intensive Care (M) - NA251	95.5%	92.9%	-	-	92.6%	100.0%	-	-	13.2%	12.6%	138	8.39	42	48.4	0	0		163,807	179,454	(15,647)
MAIDSTONE	Pye Oliver (Medical) - NK259	93.1%	102.9%	-	-	110.0%	105.6%	-	-	20.0%	27.6%	61	4.11	4	7.0	0	0	Increased fill rate at night to support enhanced care requirements.	116,856	113,056	3,800
MAIDSTONE	Chaucer Ward (M) - NS951	75.2%	71.3%	-	-	78.8%	62.5%	-	-	8.6%	25.0%	36	2.57	5	12.8	2	0		104,729	37,499	67,230
MAIDSTONE	Whatman Ward - NK959	87.7%	91.9%	-	100.0%	155.0%	170.0%	-	-	31.1%	33.0%	97	6.66	7	11.7	2	0	Increased fill rate at night with enhanced care and RMN requirements reported. Staffing levels also inclsuive of aspirant nurses.	94,806	111,650	(16,844)
MAIDSTONE	Lord North Ward (M) - NF651	96.2%	102.4%	-	100.0%	82.2%	103.3%	-	-	8.4%	22.6%	14	0.97	2	9.5	3	0	1 x Fall above threshold. Bed ocupancy between 7 - 17 throughout the month	94,903	87,499	7,404
MAIDSTONE	Mercer Ward (M) - NJ251	100.8%	120.1%	-	-	100.0%	103.3%	-	-	10.3%	21.5%	31	1.90	1	7.1	1	0	Increased fill rate supporting aspirant nurses.	106,119	107,526	(1,407)
MAIDSTONE	Edith Cavell (M) - NS459	105.7%	52.7%	-	100.0%	94.4%	96.7%	-	-	49.6%	50.6%	146	10.32	14	14.3	1	0	Staffing in line with reduced bed occupancy.	66,317	69,974	(3,657)
MAIDSTONE	Acute Medical Unit (M) - NG551	97.3%	119.7%	-	-	122.0%	191.2%	-	-	24.6%	25.4%	99	6.46	10	14.9	2	0	Increased fill rate at night to cover escalation. Bed occupancy between 8 -20.	151,755	136,908	14,847
TWH	Ward 22 (TW) - NG332	103.1%	89.2%	-	100.0%	116.8%	101.7%	-	-	30.1%	7.8%	56	3.84	2	7.8	7	0	RMN requirement	101,566	107,551	(5,985)
TWH	Coronary Care Unit (TW) - NP301	105.1%	112.5%	-	-	100.0%	-	-	-	16.8%	2.9%	32	1.96	1	12.7	1	0	1 x fall above threshold. Bed occupancy between 4-8	70,590	64,835	5,755
TWH	Ward 33 (Gynae) (TW) - ND302	95.9%	98.3%	-	-	100.0%	87.1%	-	-	18.0%	3.7%	46	2.99	3	22.8	0	0	Staffing in line with requirements and reduced bed occupancy at times.	112,501	108,500	4,001
TWH	Intensive Care (TW) - NA201	109.9%	105.8%	-	-	102.8%	93.1%	-	-	3.8%	0.0%	33	1.92	4	48.8	0	0		230,298	209,100	21,198
TWH	Acute Medical Unit (TW) - NA901	98.2%	91.7%	-	100.0%	100.6%	102.0%	-	-	20.6%	25.1%	130	8.61	16	12.9	5	0	Staffing levels include supporting aspirant nurses and TNA.	210,313	183,131	27,182
TWH	Surgical Assessment Unit (TW) - NE701	100.0%	95.7%	-	-	100.0%	100.0%	-	-	14.9%	0.0%	13	0.94	0	153.5	0	0	Supporting aspirant nurses within staffing levels	64,955	63,410	1,545
TWH	Ward 32 (TW) - NG130	84.2%	104.0%	-	-	73.3%	76.7%	-	-	6.9%	5.8%	21	1.27	0	8.9	0	0		143,059	112,029	31,030
TWH	Ward 10 (TW) - NG131	86.9%	78.0%	-	100.0%	85.8%	103.3%	-	-	21.5%	6.1%	70	4.71	7	5.5	6	1	2 x Falls above threshold	122,602	117,805	4,797
TWH	Ward 12 (TW) - NG132	105.7%	102.1%	-	100.0%	111.1%	101.7%	-	100.0%	31.6%	33.7%	73	4.92	2	7.2	20	0	14 x falls above threshold.	133,841	146,095	(12,254)
TWH	Ward 20 (TW) - NG230	88.3%	98.6%	-	-	120.2%	90.7%	-	-	34.3%	31.7%	118	7.86	8	5.8	7	1	Increased fill rate at night due to enhanced care requirements and RMN requirements reported.	123,701	144,044	(20,343)
TWH	Ward 21 (TW) - NG231	101.1%	99.0%	-	100.0%	106.7%	108.3%	-	-	31.3%	37.1%	145	9.44	15	10.1	1	0	Bed occupancy levels reported between 9 - 25	137,160	137,232	(72)
TWH	Ward 2 (TW) - NG442	118.3%	111.0%	-	100.0%	107.8%	125.5%	-	-	28.6%	11.8%	75	4.80	10	8.6	13	1	6 x Falls above threshold. Increased fill rate to support enhanced care, increased risk of falls and RMN requirements during the month.	132,182	124,824	7,358
TWH	Ward 30 (TW) - NG330	99.1%	100.7%	-	-	104.4%	98.9%	-	-	20.0%	21.4%	62	3.77	6	8.0	3	3		124,424	125,700	(1,276)
TWH	Ward 31 (TW) - NG331	107.3%	91.9%	-	100.0%	118.3%	101.1%	-	-	24.0%	12.1%	68	4.09	4	7.6	7	1	1 x fall above threshold. MOU staff redeployed to support increased demand on ward managing new COVID pathways. Requirements for enhancced care reported as well.	129,079	145,804	(16,725)
Crowborough	Crowborough Birth Centre (CBC) - NP775	73.9%	104.1%	-	-	101.7%	100.0%	-	-	3.8%	0.0%	12	0.71	0			0	Considered action to prioritise the night with Community teams support during the day.	69,332	78,264	(8,932)
TWH	Midwifery (multiple rosters)	85.4%	57.9%	-	-	99.1%	73.8%	-	-	11.6%	1.6%	479	27.55	55	24.9	0	0	Reduced fill rate due to lack of available temporary staff with 55 unfilled shifts throughout the month. Delivery suite prioritised to ensure safe staffing levels.	702,432	671,502	30,930
TWH	Hedgehog Ward (TW) - ND702	93.9%	223.8%	-	-	85.4%	-	-	-	3.5%	33.8%	24	1.44	5	15.5	0	0		155,237	122,026	33,211
MAIDSTONE	Maidstone Birth Centre - NP751	103.2%	100.0%	-	-	98.2%	90.0%	-	-	7.6%	0.0%	14	0.84	0		0	0		72,755	67,863	4,892
TWH	SCBU (TW) - NA102	75.3%	600.0%	-	-	94.9%	-	-	-	16.1%	0.0%	106	6.16	2	16.3		0	Fill rate in line with bed occupancy which is reported between 7 - 17 throughout the month. 7 x amber, 3 x red and 1 x black days / epsiodes recorded otherwise remained green. Increased CSW fill rate as these numbers are inclusive of B4 Nursery Nurses which increase the fill rate of unregistered hours against a plan of 172.5. Roster to be realigned to reflect unregistered demand.	175,775	179,883	(4,108)
TWH	Short Stay Surgical Unit (TW) - NE901	88.1%	4.5%	-	-	140.9%	9.1%	-	-	0.5%	0.0%	1	0.07	0	5.2	0	0		86,027	53,944	32,083
MAIDSTONE	Accident & Emergency (M) - NA351	107.2%	89.3%	-	-	126.7%	102.1%	-	-	40.3%	35.7%	298	19.49	18		4	0	MH - 4 x falls above threshold. 18 unfilled shifts. Increased fill rate required to support COVID pathways.	209,396	266,051	(56,655)
TWH	Accident & Emergency (TW) - NA301	98.6%	126.2%	-	100.0%	103.5%	166.3%	-	-	37.9%	33.7%	341	23.38	23		3	0	TWH - 3 x falls above threshold. Staffing in line with COVID pathways. 23 unfilled shifts.	332,468	385,286	(52,818)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	52.3%	33.1%	-	-	0.0%	-	-	-	8.8%	29.3%	18	1.22	0	22.5	0	0	MOU open across 9 days - staffing in line with requirements	52,889	21,405	31,484
MAIDSTONE	Peale Ward COVID - ND451	1.6%	2.3%	-	-	0.0%	0.0%	-	-	10.4%	19.7%	29	2.01	10	0.3%	0	0	COVID pathway. Very low bed occupancy during the month and staffing alligned to requirements.	0	38,333	(38,333)
MAIDSTONE	Chronic Pain Escalation - NE959	85.1%	67.9%	-	100.0%	80.0%	53.3%	-	-	2.4%	0.0%	6	0.41	0	24.9	0	0				
MAIDSTONE	Short Stay Surgery Unit (M) - NE751	98.9%	84.2%	-	-	56.8%	-	-	-	2.7%	60.0%	5	0.34	0	141.8	0	0		46,531	44,503	2,028
																		Total Established Wards	5,090,069	5,064,503	25,566
																		Additional Capacity beds Cath Labs	38,844	43,340	(4,496)
																		Whatman	0	0	0
																		Edith Cavell (M) - NS459	0	88,353	(88,353)
																		Ward 32 (Wells Suite) (TW) - PP010	0	0	0
																		Other associated nursing costs	3,619,593	3,415,032	204,561
																			8,748,506	8,611,228	137,278

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

Aug-20		DAY				NIGHT				TEMPORARY STAFFING						Nurse Sensitive Indicators					Financial review		
Hospital Site name	Health Roster Name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Bank/Agency Usage	Agency as a % of Temporary Staffing	Bank / Agency Demand RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand Unfilled -RM/N (number of shifts)	Overall Care Hours per pt day	FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Stroke Unit (M) - NK551	130.8%	101.7%	-	100.0%	188.7%	155.7%	-	100.0%	59.8%	36.7%	247	17.06	42	13.6			7	1	2 x falls above threshold.	121,912	260,188	(138,276)
MAIDSTONE	Cornwallis (M) - NS959	89.6%	96.4%	-	100.0%	76.1%	95.2%	-	-	4.3%	7.0%	12	0.78	1	14.5	38.5%	100.0%	2	0	Staffing in line with bed occupancy reported between 2 - 12	82,427	80,140	2,287
MAIDSTONE	Culpepper Ward (M) - NS551	90.6%	107.9%	-	-	102.4%	119.4%	-	-	28.9%	15.3%	88	6.15	3	8.7	80.6%	100.0%	2	0	1 x fall above threshold.	106,191	125,267	(19,076)
MAIDSTONE	John Day Respiratory Ward (M) - NT151	117.0%	111.2%	-	-	121.4%	154.8%	-	-	44.8%	34.6%	126	8.82	7	8.7	5.0%	100.0%	0	1	Increased fill rate due to RMN and enhanced care requirements throughout the month. Bed occupancy between 25 - 30.	146,096	162,133	(16,037)
MAIDSTONE	Intensive Care (M) - NA251	88.1%	84.5%	-	-	70.1%	77.7%	-	-	10.8%	7.1%	96	5.98	34	67.6			0	0	Reduced fill rate in line with lower bed occupancy. This is also reflected in the increase in CHPPD	166,033	194,833	(28,800)
MAIDSTONE	Pye Oliver (Medical) - NK259	93.1%	96.9%	-	-	104.3%	98.9%	-	-	23.7%	32.3%	117	7.48	18	6.2	7.6%	100.0%	3	1	Bed occupancy between 22 - 28. staff moves to support organisational safe staffing levels.	119,488	113,869	5,619
MAIDSTONE	Chaucer Ward (M) - NS951	1.2%	1.4%	-	-	2.4%	12.9%	-	-	4.2%	13.2%	8	0.60	3	0.6			3	0	Reduced fill rate in line with bed occupancy and supporting stroke pathway	162,784	31,391	131,393
MAIDSTONE	Whatman Ward - NK959	88.6%	103.7%	-	100.0%	150.0%	93.5%	-	-	31.9%	25.8%	82	5.72	5	9.2			4	0	Bed occupancy between 12 -21. Supporting aspirant nurses .	94,806	105,262	(10,456)
MAIDSTONE	Lord North Ward (M) - Nf651	87.8%	103.7%	-	100.0%	86.0%	100.0%	-	-	14.6%	2.1%	35	2.34	6	8.5	44.8%	92.3%	1	0	Reduced fill rate with 6 unfilled shifts due to sickness and vacancy. Enhanced care requirements on 2 episodes	98,164	104,004	(5,840)
MAIDSTONE	Mercer Ward (M) - NJ251	98.6%	93.1%	-	-	103.7%	108.1%	-	-	14.6%	18.3%	39	2.65	12	6.3			1	0		107,103	120,056	(12,953)
MAIDSTONE	Edith Cavell (M) - NS459	87.5%	73.3%	-	100.0%	119.4%	187.1%	-	-	79.1%	42.6%	193	13.63	16	8.8	10.0%	100.0%	3	1	Bed occupancy between 10 - 22. reduced fill rates in the day alligned to patient flow. Staff redeployed to support organisation sattfling levels but aligned to base ward.	0	109,715	(109,715)
MAIDSTONE	Acute Medical Unit (M) - NG551	93.7%	85.3%	-	-	134.4%	177.4%	-	-	27.5%	26.8%	115	7.70	25	14.4	0.5%	100.0%	3	0	Bed occupancy between 6-18 recorded throughout the month. Increased fill rate at night to support escalation.	151,755	141,674	10,081
TWH	Ward 22 (TW) - NG332	91.0%	106.3%	-	100.0%	102.2%	102.4%	-	-	37.6%	20.6%	122	8.65	21	6.6			15	0	8 x falls above threshold. Bed occupancy between 25 - 32. Enhanced care and RMN requiremtns record across 15 days / nights.	145,443	134,853	10,590
TWH	Coronary Care Unit (TW) - NP301	101.5%	102.2%	-	-	98.0%	-	-	-	20.0%	15.4%	47	2.86	2	11.1			2	0	2 x falls above threshold. Bed occupancy between 5-8	71,559	67,674	3,885
TWH	Ward 33 (Gynae) (TW) - ND302	97.6%	94.5%	-	-	100.0%	100.0%	-	-	26.3%	10.6%	85	5.00	8	17.4			0	0		112,501	119,336	(6,835)
TWH	Intensive Care (TW) - NA201	104.7%	150.3%	-	-	102.5%	125.8%	-	-	5.7%	2.5%	46	2.92	5	34.2			0	0	Escaltion reported on 6 episodes. Bed occupancy between 8-10	232,328	231,008	1,320
TWH	Acute Medical Unit (TW) - NA901	86.7%	85.7%	-	100.0%	99.5%	104.1%	-	100.0%	24.8%	27.0%	153	10.72	42	9.4			11	0	5 x falls above threshold. Bed occupancy between 10 -31. 12 episodes recorded of escalation. RMN requirements on 2 occassions. Supporting TNA and aspirant nurses.	221,364	191,377	29,987
TWH	Surgical Assessment Unit (TW) - NE701	100.0%	87.0%	-	-	100.0%	90.3%	-	-	13.4%	0.0%	15	1.06	0	58.0			0	0	Escalated at night x 6. Ward supporting Aspirant Nurses.	69,051	67,001	2,050
TWH	Ward 32 (TW) - NG130	86.7%	97.3%	-	-	71.8%	77.4%	-	-	10.5%	8.0%	26	1.73	3	8.4	64.2%	94.1%	1	0		145,285	125,858	19,427
TWH	Ward 10 (TW) - NG131	103.0%	90.1%	-	100.0%	96.0%	124.2%	-	-	16.3%	8.4%	50	3.25	6	6.5			6	0	2 x falls above threshold.	124,828	129,658	(4,830)
TWH	Ward 11 (TW) Winter Escalation 2019 - NG144	0.0%	0.0%	-	-	0.0%	200.0%	-	-	15.9%	0.0%	No Demand	No Demand	No Demand				2	0	Ward 11 opened temporarily to support opeational demand and capacity therefore increased fill rate as additional to plan.	0	2,073	(2,073)
TWH	Ward 12 (TW) - NG132	106.5%	101.0%	-	100.0%	111.8%	117.1%	-	100.0%	24.7%	20.8%	64	4.24	13	7.2			7	0	1 x fall above threshold. Increased fill rate due to enahnced care requirements recorded for 8 episodes of care	136,263	146,967	(10,704)
TWH	Ward 20 (TW) - NG230	98.8%	123.9%	-	-	106.5%	108.8%	-	-	42.2%	23.1%	138	9.02	15	6.4			8	0	1 x fall above threshold. RMN requirements reported on 10 episodes and enhanced care requirements.	128,047	149,218	(21,171)
TWH	Ward 21 (TW) - NG231	98.7%	87.3%	-	100.0%	99.4%	100.0%	-	-	31.4%	20.4%	133	8.52	15	7.2			5	2	Bed occupancy between 18 - 29	139,367	143,740	(4,373)
TWH	Ward 2 (TW) - NG442	113.1%	109.1%	-	100.0%	112.5%	130.1%	-	-	29.9%	16.5%	81	5.36	16	8.7	12.1%	100.0%	12	0	5 x falls above threshold. Increased fill rate due to RMN and enhanced care requirements.	132,182	139,192	(7,010)
TWH	Ward 30 (TW) - NG330	110.7%	108.7%	-	-	101.1%	97.8%	-	-	21.7%	18.7%	80	4.82	15	7.0			7	1	2 x falls above threshold. Bed occupancy 24 - 30	127,230	134,691	(7,461)
TWH	Ward 31 (TW) - NG331	103.8%	94.6%	-	100.0%	101.0%	97.7%	-	-	29.7%	13.0%	91	5.65	15	7.0			3	1	Reporting enhanced care requirements and increased dependency. Some STS in month. Bed occupancy between 27 - 30.	133,265	149,960	(16,695)
Crowborough	Crowborough Birth Centre (CBC) - NP775	76.2%	81.0%	-	-	102.1%	93.5%	-	-	4.2%	0.0%	18	1.04	3					0	Considered action to prioritise the night with Community teams support during the day.	69,332	84,037	(14,705)
TWH	Midwifery (multiple rosters)	80.7%	49.8%	-	-	92.5%	71.1%	-	-	11.3%	4.8%	489	28.98	114	19.7	23.5%	100.0%	1	0	1 x fall above threshold. Reduced fill rate due to lack of available temporary staff. Delivery suite prioritised to ensure safe staffing levels. Increase in unfilled shifts this month.	707,252	672,852	34,400
TWH	Hedgehog Ward (TW) - ND702	107.0%	31.3%	-	-	111.8%	-	-	-	29.1%	71.7%	158	11.00	11	13.6			0	0		155,237	161,221	(5,984)
MAIDSTONE	Maidstone Birth Centre - NP751	109.4%	96.8%	-	-	96.6%	96.8%	-	-	2.0%	0.0%	2	0.13	0		97.5%	100.0%	0	0		72,755	72,672	83
TWH	SCBU (TW) - NA102	69.6%	508.9%	-	-	91.2%	-	-	-	12.3%	0.0%	89	5.05	4	15.3				0	Fill rate in line with bed occupancy which is reported between 0 - 15 throughout the month. 4 x amber days / episodes recorded otherwise remained green. Increased CSW fill rate as these numbers are inclusive of B4 Nursery Nurses which increase the fill rate of unregistered hours against a plan of 172.5. Roster to be realigned to reflect unregistered demand.	175,775	174,590	1,185
TWH	Short Stay Surgical Unit (TW) - NE901	88.5%	16.6%	-	-	147.6%	71.4%	-	-	29.2%	28.5%	65	4.24	18	4.5			0	0		88,253	45,550	42,703
MAIDSTONE	Accident & Emergency (M) - NA351	112.8%	70.8%	-	-	132.7%	131.3%	-	-	38.9%	35.5%	334	22.21	65				3	0	MH - 3 x falls above threshold.Increased fill rate to support COVID pathways. TWH - 4 x falls above threshold. Increased fill rate reflective of COVID pathways however, 76 unfilled shifts with unavailale temporary staff and sickness reported during the month	209,396	271,785	(62,389)
TWH	Accident & Emergency (TW) - NA301	93.6%	113.3%	-	100.0%	111.0%	179.0%	-	-	45.0%	40.4%	437	30.48	76				4	0		332,468	417,644	(85,176)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	64.5%	56.8%	-	-	79.0%	-	-	-	22.6%	19.4%	51	3.46	3	22.3			0	0	Reduced fill rate with staffing aligned to low bed occupancy.	52,889	52,865	24
MAIDSTONE	Peale Ward COVID - ND451	94.3%	118.7%	-	-	119.4%	117.7%	-	-	21.5%	16.3%	55	3.90	9	34.0			3	0	2 x falls above threshold	0	81,792	(81,792)
MAIDSTONE	Chronic Pain Escalation - NE959	80.5%	82.9%	-	100.0%	87.1%	22.6%	-	-	2.7%	0.0%	9	0.48	0	27.0			0	0		68,543	65,238	3,305
MAIDSTONE	Short Stay Surgery Unit (M) - NE751	85.0%	68.1%	-	-	22.1%	-	-	-	0.6%	100.0%	1	0.07	0	70.6			0	0		46,531	43,834	2,697
																				Total Established Wards	5,253,903	5,626,175	(372,272)
																				Additional Capacity beds Cath Labs	44,549	50,434	(5,885)
																				Whatman	0	0	0
																				Ward 32 (Wells Suite) (TW) - PP010	0	719	(719)
																				Other associated nursing costs	3,655,688	3,501,391	154,297
																					8,954,140	9,178,719	(224,579)

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

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 June 2019 to May 2020.

Which Committees have reviewed the information prior to Board submission?

- Quality Committee, 16/09/20

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 Fig. 1. The 12 months June 2019 to May 2020 show our HSMR to be 96.0, which is higher than last month's figure 94.1.

Figure 1 Rolling 12 Month view

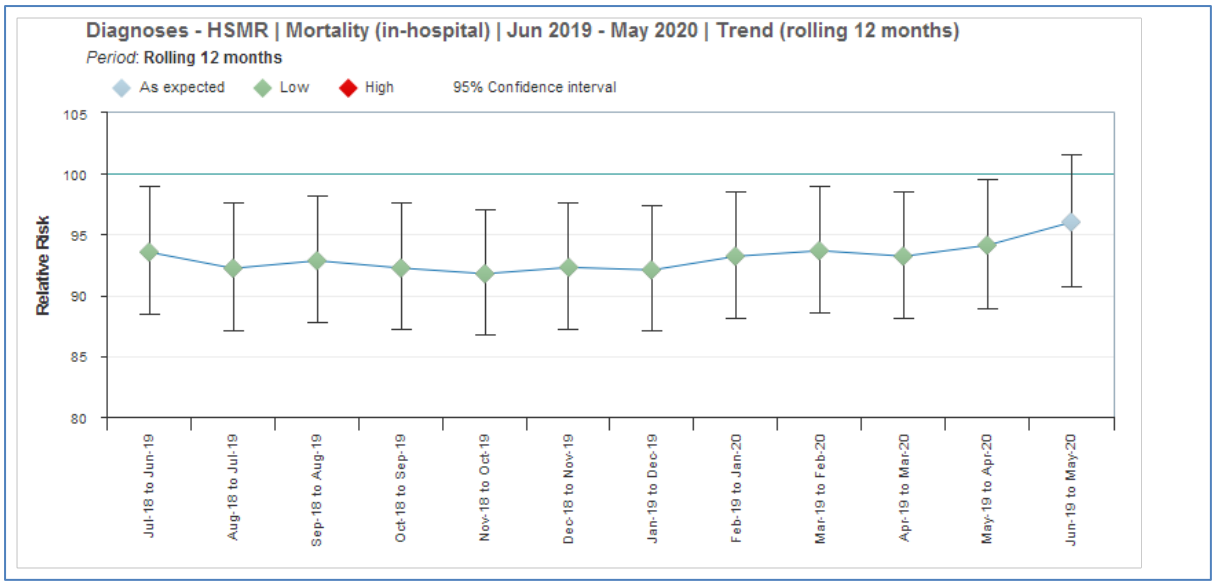
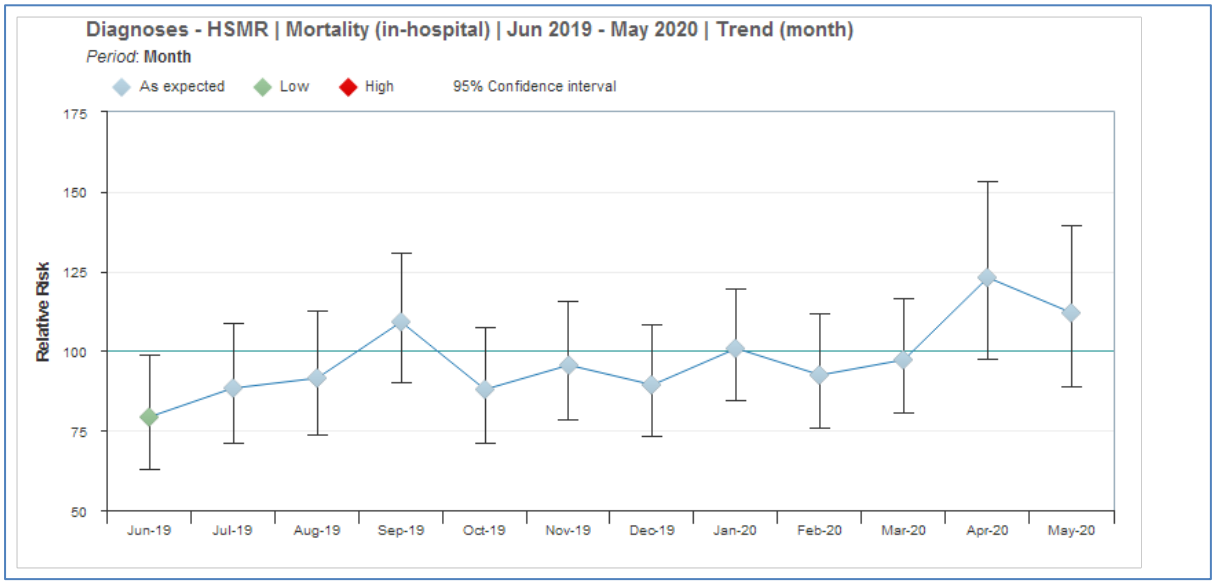


Fig. 2 shows a monthly view of our HSMR performance. The latest month should be viewed with caution as this often shows a false position due to the lag in coding activity. Viewing the previous month, so May 2020 in this case, shows that the Trust's position has decreased to 112.0 from 123.0 in April 2020.

Figure 2 Monthly view



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 (Fig. 3) demonstrates the diagnosis groups where the Trust has received negative alerts when using A 'high' (99%) detection threshold over the past 12 months.

Figure 3 Diagnosis with negative CUSUM Alerts

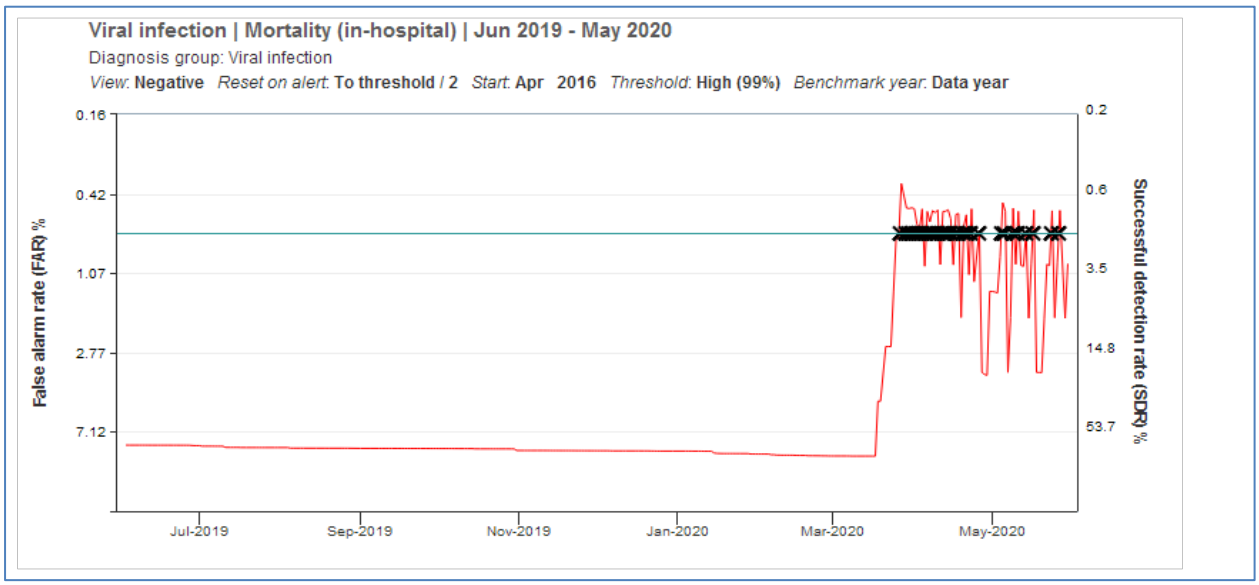
Relative risk & CUSUM alerts

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
All Diagnoses	2 6	108392	1525	1514.8	1.4	100.7				
HSMR (56 diagnosis groups)	3	36120	1200	1249.8	3.3	96.0				
Cancer, other respiratory and intrathoracic	1	11	2	0.7	18.2	269.6				
Multiple sclerosis	1	30	1	0.3	3.3	363.1				
Parkinson's disease	2	87	6	2.0	6.9	299.6				
Residual codes, unclassified	1 1	956	13	7.3	1.4	178.0				
Skin and subcutaneous tissue infections		1947	23	13.8	1.2	166.8				
Sprains and strains	1	65	2	0.3	3.1	698.1				
Viral infection	34	779	107	4.1	13.7	2625.1				
All Procedures	2	70656	1004	1009.5	1.4	99.5				
Rest of Miscellaneous operations	5	3752	50	21.7	1.3	230.4				
Total excision of kidney	1	9	1	0.0	11.1	3684.7				

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 4a shows the CUSUM alert point for Viral infection which has shown as having a red relative risk of 2625.1 in June 2019 to May 2020, the patient level backing data for these alerts is supplied to the coding department to review.



These spikes relate to 779 inpatient spells of which 343 use ICD10 discharge codes for COVID-19 from 1 March to 31 May 2020.

	Discharged	RIP	Total
U07.1 COVID-19, virus detected	197	90	287
U07.2 COVID-10, virus not identified	43	13	56
Dr F Total	243	103	343
ICC Patient Tracker reported numbers	254	114	368

We are aware there is a discrepancy within the reported numbers and this is currently under review by the ICC with assistance from the Coding Department.

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 5a and 5b demonstrate that the Trust is in a good position amongst comparable organisations with Good or Outstanding CQC status.

Figure 5 Benchmarking against good/outstanding acute non-specialist trusts (June 2019 to May 2020)

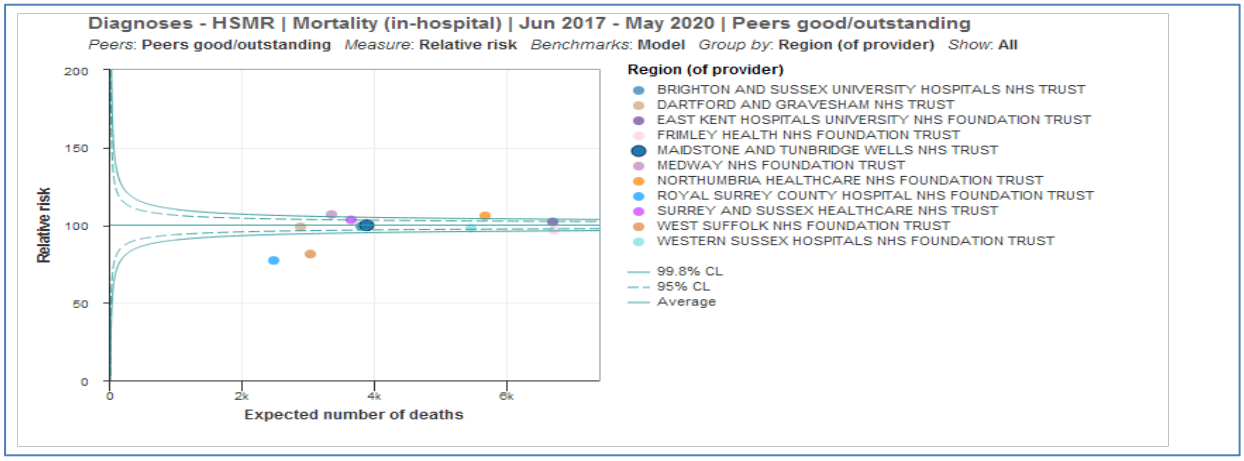


Figure 5a HSMR Peer Comparison

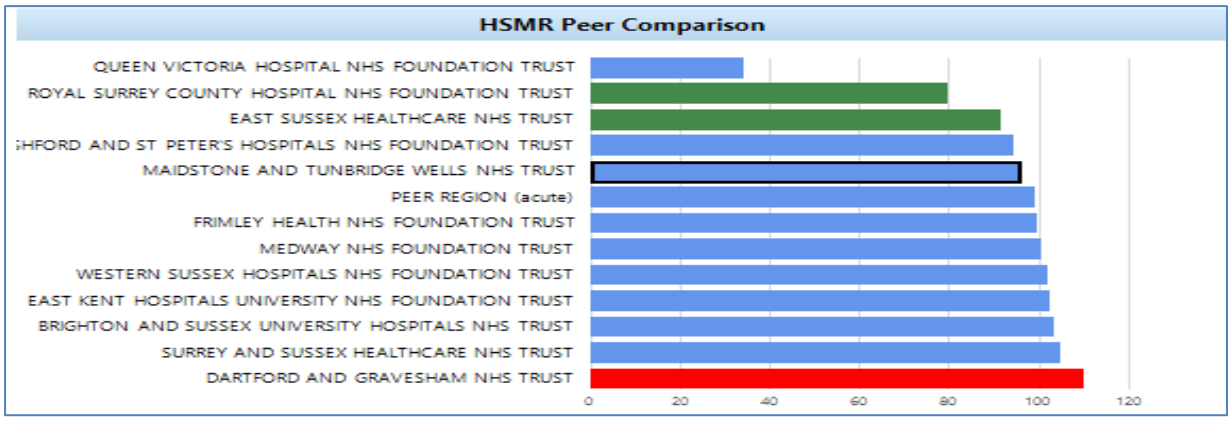


Figure 5b HSMR and Influencers

HSMR and Influencers				
Performance	Site	Trust	Peer	National
HSMR		96.0	99.1	102.7
SMR		100.7	107.4	113.4
Elective (HSMR)		84.8	96.2	109.5
Non-elective (HSMR)		96.1	99.1	102.6
Weekday, non-elective (HSMR)		94.9	97.5	100.7
Weekend, non-elective (HSMR)		99.6	104.0	108.1
Coding / Casemix	Site	Trust	Peer	National
% Deaths in HSMR basket (elective)		75.0%	68.6%	63.9%
% Deaths in HSMR basket (non-elective)		78.7%	77.3%	75.4%
% Non-elective deaths with palliative care		39.6%	37.6%	34.0%
% Non-elective spells with palliative care		4.1%	4.6%	4.3%
% Spells in Symptoms & Signs chapter		8.3%	6.4%	6.2%
% Spells with Charlson comorbidity score = 0		56.0%	49.7%	46.6%
% Spells with Charlson comorbidity score = 20+		7.7%	9.9%	10.0%

HSMR – Supplementary Analysis

The Trust has seen significant improvements in the Relative Risk Rates and the Crude Rates since October 2017, the volume of spells has continued to rise in the same period due to the change in casemix.

a. HSMR Relative Risk v Spells v Crude Rate v Expected Rate

Figure 6 HSMR – Relative Risk

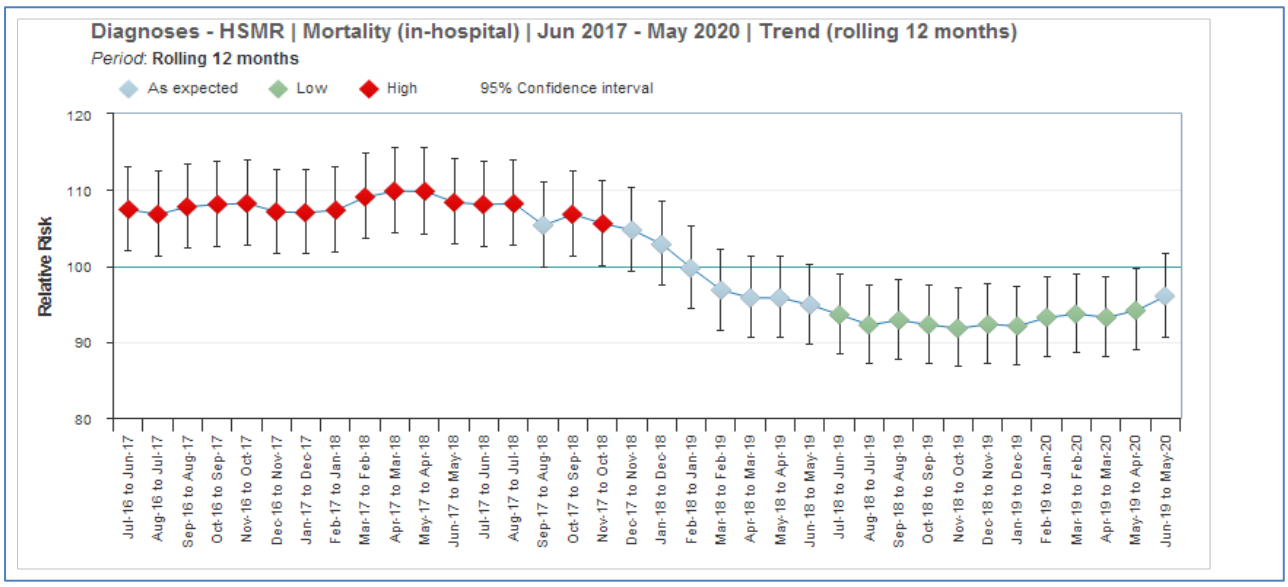
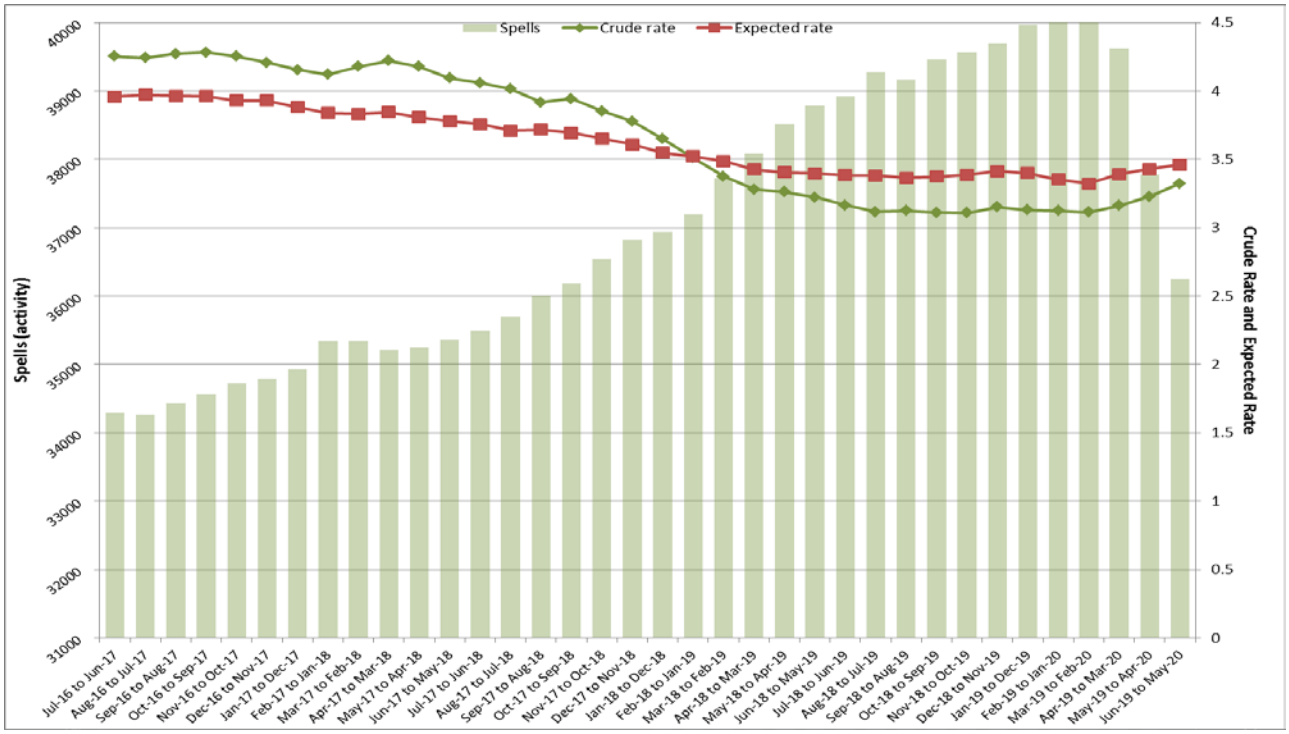


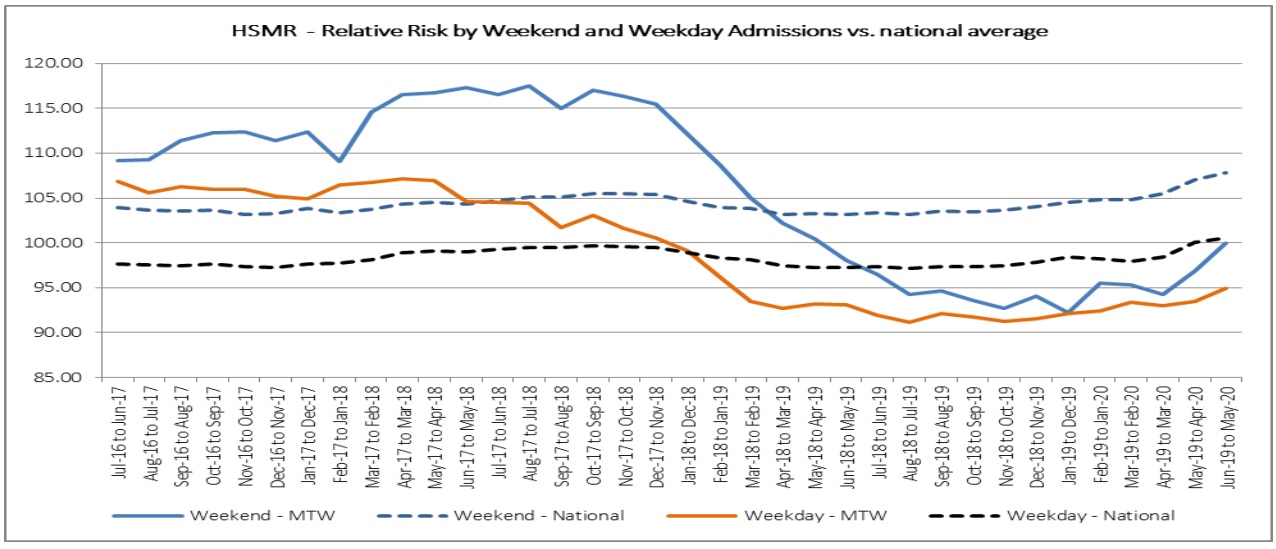
Figure 7 Spells against Crude Rate and Expected Rate



b. 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 100.0 (96.8 last month) for weekends and 94.9 (93.5 last month) for weekday admissions, both the weekday and weekend rates are significantly lower than where the Trust was at the beginning of the year.

Figure 8 HSMR for Weekend & Weekday admissions vs. the National Average (NE Admissions)



The site split of the Weekday deaths for June 2019 to May 2020 is Maidstone – 92.9 (an increase from last month of 92.0) and TWH – 96.6 (a slight decrease from 94.4 last month).

The site split of the Weekend deaths for June 2019 to May 2020 is Maidstone – 98.5 (a decrease from 96.7 last month) and TWH – 101.8 (an increase from 97.4 last 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 had a high relative risk.

c. HSMR – by site

Figure 9 shows the HSMR split by site. The HSMR at the Maidstone site has increased to 94.5 from 93.3 last month; the Tunbridge Wells site has increased to 97.7 from 95.0 last month.

Figure 9 HSMR by site

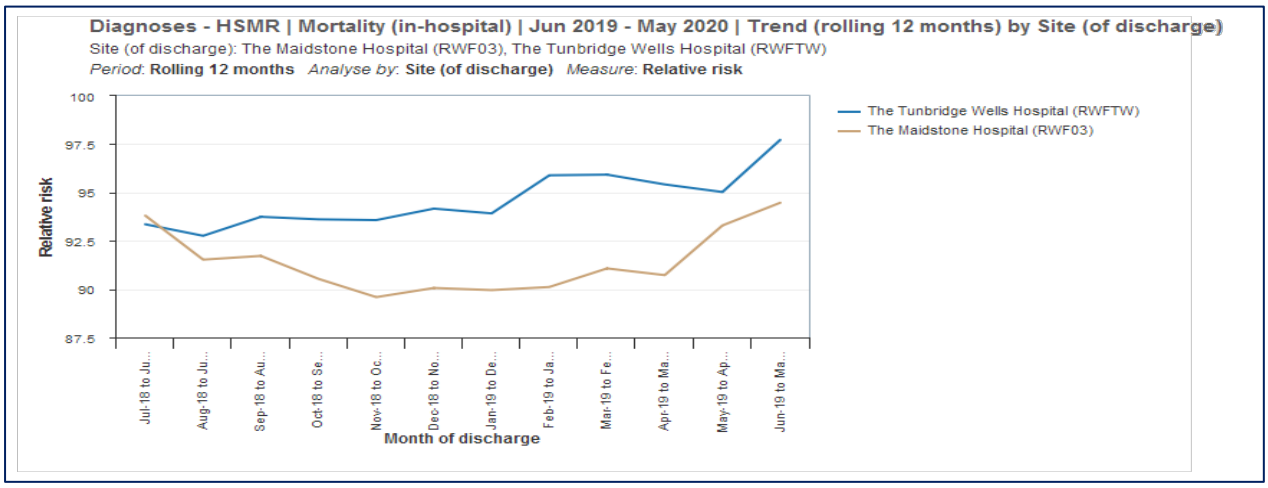
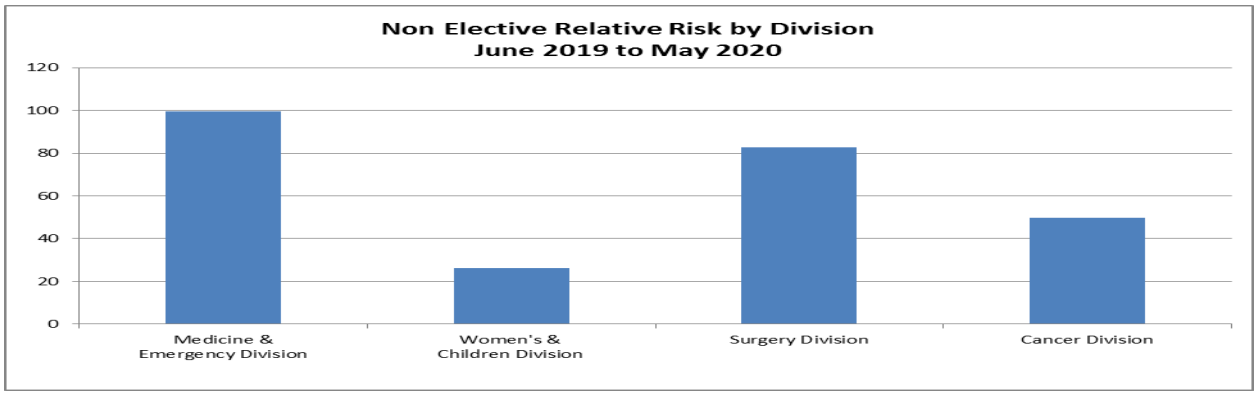


Figure 10 Divisional Non Elective Relative Risk

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



Expected Deaths - Comorbidities

There are various factors that influence the level of 'expected' deaths assigned to a Trust for the purposes of reporting the HSMR these include; Sex, Age, Diagnosis, type, time and month of admission, Socio-economic factors, palliative care and diagnosis/procedure subgroups. One of the key factors is patients Co-morbidities (based on Charlson score) as this informs the Trust's casemix. Of the 1525 deaths recorded in the period June 2019 to May 2020, 213 had no comorbidities recorded (13.96%).

Charlson comorbidity conditions

Charlson comorbidity conditions
Acute myocardial infarction
Cancer
Cerebral vascular accident
Congestive heart disease
Connection tissue disorder
Dementia
Diabetes
Diabetes complications
HIV
Liver disease
Metastatic cancer
paraplegia
Peptic ulcer
Peripheral vascular disease
Pulmonary disease
Renal disease
Severe liver disease

Zero Co-morbidities by Site – All Ages

	Trust	TWH	Maid
Jun-19	11	6	5
Jul-19	14	8	6
Aug-19	20	8	12
Sep-19	14	9	5
Oct-19	17	7	10
Nov-19	13	7	6
Dec-19	25	15	10
Jan-20	27	12	15
Feb-20	24	13	11
Mar-20	23	12	11
Apr-20	17	8	9
May-20	8	7	1
All	**213**	**112**	**101**

Specialties with Zero Comorbidities – All Ages

	Mar-19-Feb-20		Apr-19-Mar-20		May-19-Apr-20		Jun-19-May-20	
Specialty (of discharge)	**Deaths**	**%age**	**Deaths**	**%age**	**Deaths**	**%age**	**Deaths**	**%age**
Geriatric Medicine	71	34%	72	18%	72	33%	71	34%
Respiratory Medicine	39	19%	38	23%	35	0%	34	16%
General Medicine	33	16%	37	18%	37	28%	34	16%
General Surgery	17	8%	18	9%	19	11%	20	10%
Gastroenterology	10	5%	10	5%	9	6%	9	4%
Cardiology	4	2%	5	5%	5	1%	5	2%
Endocrinology	7	3%	6	5%	6	0%	7	3%
Stroke Medicine	12	6%	15	0%	16	6%	16	8%
Clinical Haematology	3	1%	3	14%	3	0%	3	1%
Trauma & Orthopaedics	3	1%	4	5%	3	0%	4	2%
Well Babies	3	1%	3	0%	1	0%	0	1%
Urology	2	1%	2	0%	2	0%	2	1%
Accident & Emergency	2	1%	2	0%	4	11%	4	2%
Neonatology	1	1%	0		0	0%	0	0%
Anaesthetics					1	6%	1	0
All	207		215		213		210	

Figure 11 Deaths with a Charlson score of zero recorded by age

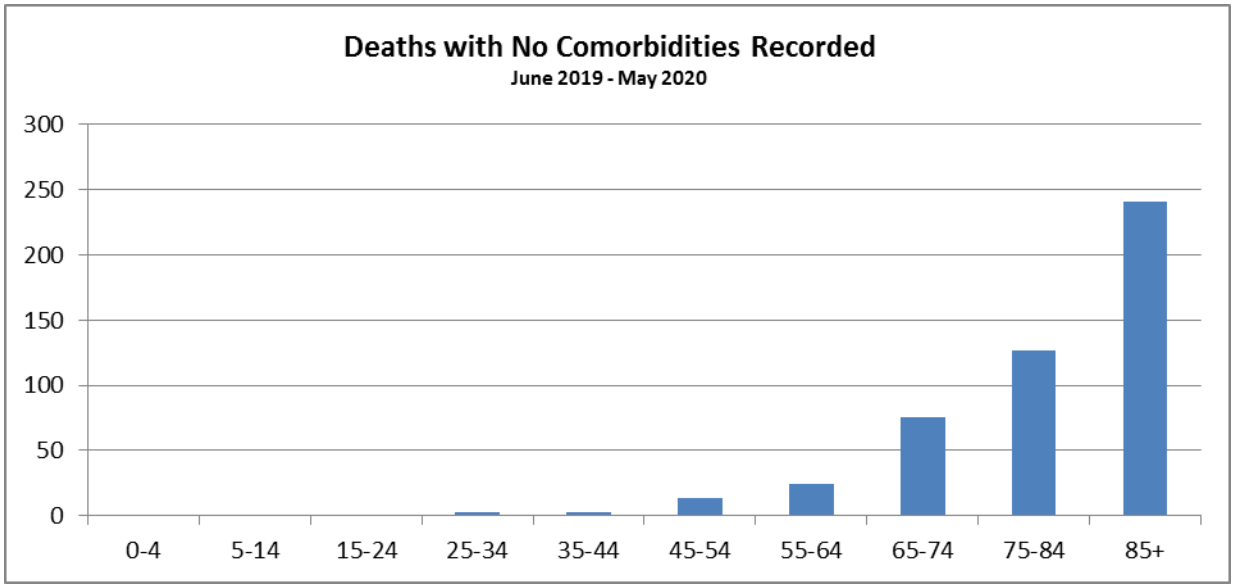
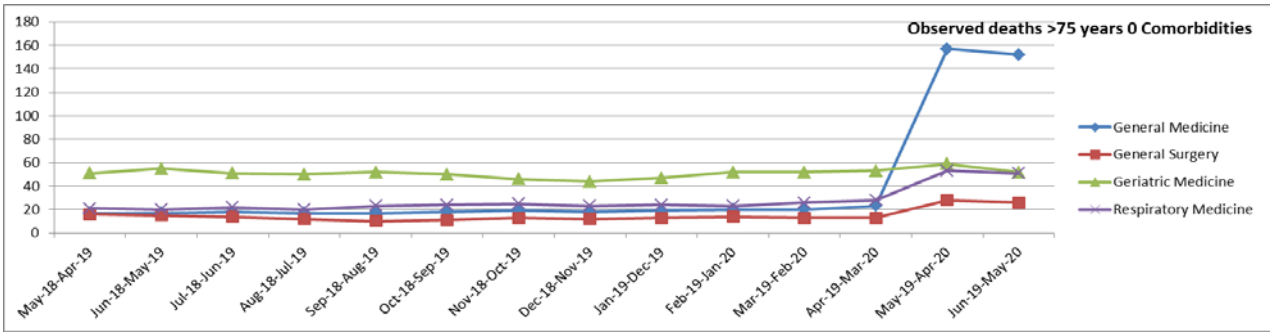
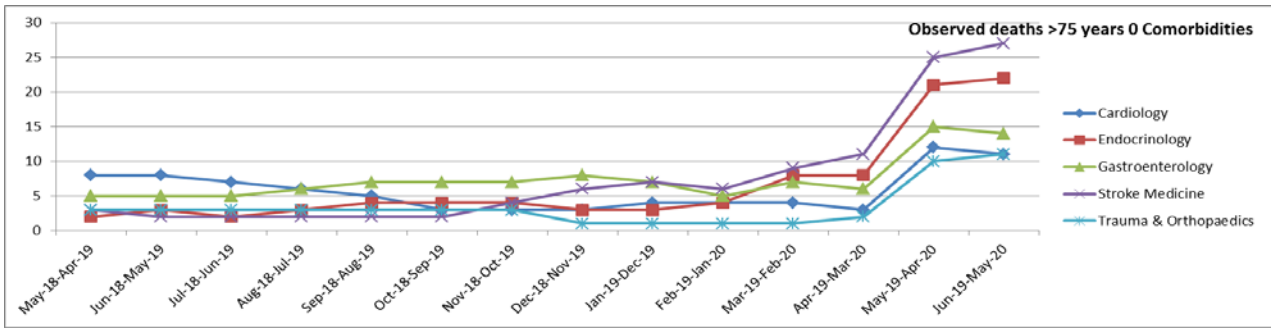


Figure 12 Deaths (>75 years) with a Charlson score of zero recorded by speciality (at discharge) with >10 observed deaths.



All other Specialties that normally have <10 observed deaths



Benchmarking of deaths with Zero Comorbidities - 75 Year +

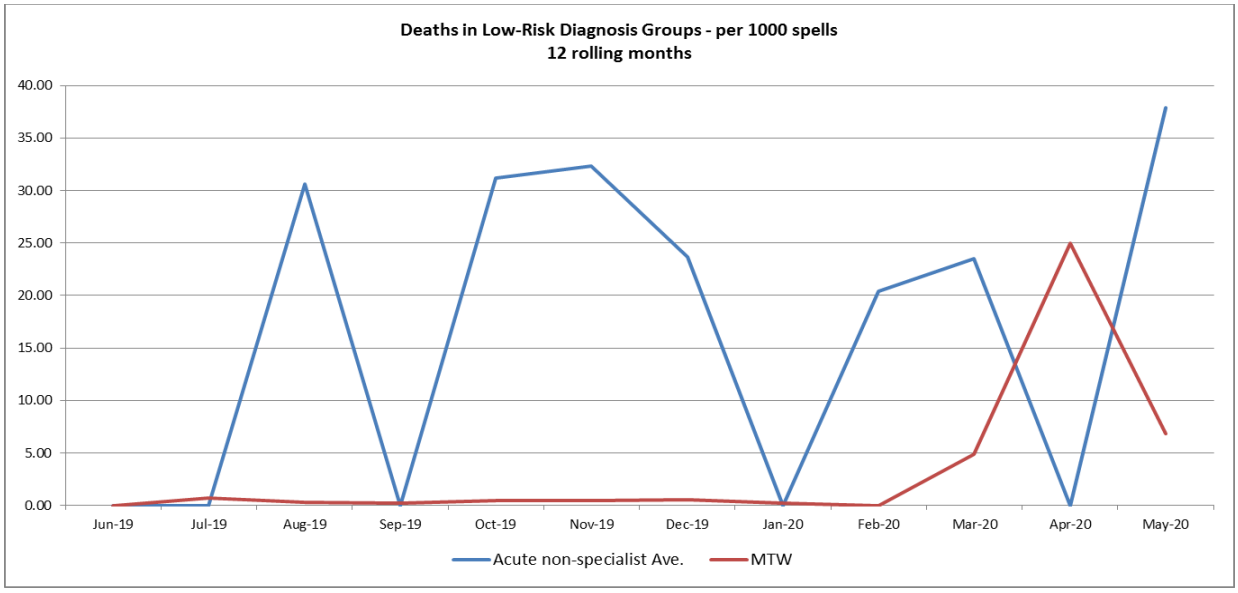
Trust (CQC Good/Outstanding)	All deaths	Zero Comorbidities	%
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	1968	1416	72.0%
ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	659	464	70.4%
SURREY AND SUSSEX HEALTHCARE NHS TRUST	1203	821	68.2%
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	2151	1436	66.8%
WEST SUFFOLK NHS FOUNDATION TRUST	796	510	64.1%

WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST	1753	1100	62.7%
MEDWAY NHS FOUNDATION TRUST	1106	678	61.3%
DARTFORD AND GRAVESHAM NHS TRUST	922	560	60.7%
FRIMLEY HEALTH NHS FOUNDATION TRUST	2063	1236	59.9%
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	1200	712	59.3%
BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	1185	614	51.8%
All	**15006**	**9547**	**63.6%**

Deaths in Low Risk Diagnosis Groups

MTW is now below the Acute, Non Specialist Trusts average when looking at deaths in low risk diagnosis groups. The current average is 6.86 which is below the national average of 37.91. This is a metric used by the CQC in their insight report and MTW was flagged as being consistently worse than average for this measure, hence its inclusion in this report.

Figure 13 Deaths in Low Risk Diagnosis Groups

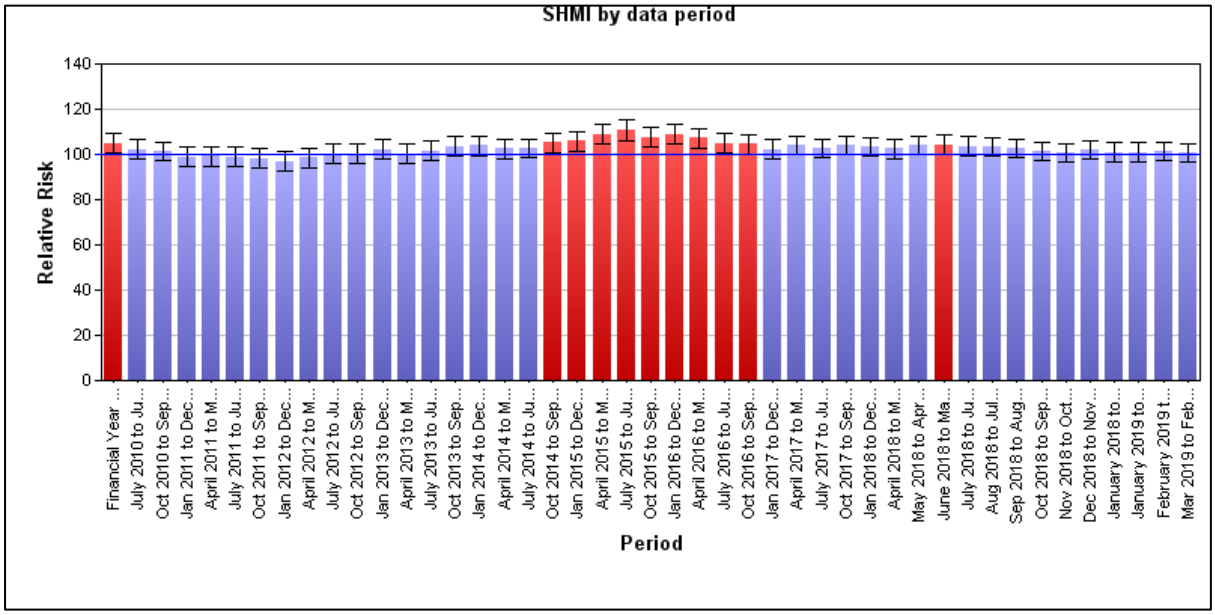


There were 77 deaths in a low risk group in the last 12 months, these deaths breakdown as follows. Those in red are deemed 'significant' by Dr Foster.

Diagnosis group	Total
Viral infection (the majority of these are Covid related)	60
Oesophageal disorders	4
Abdominal hernia	3
Other connective tissue disease	2
Other nervous system disorders	2
Alcohol-related mental disorders	2
Osteoarthritis	1
Rheumatoid arthritis and related disease	1
Other upper respiratory infections	1
Multiple sclerosis	1
Total	**77**

Summary Hospital-Level Mortality Indicator (SHMI)

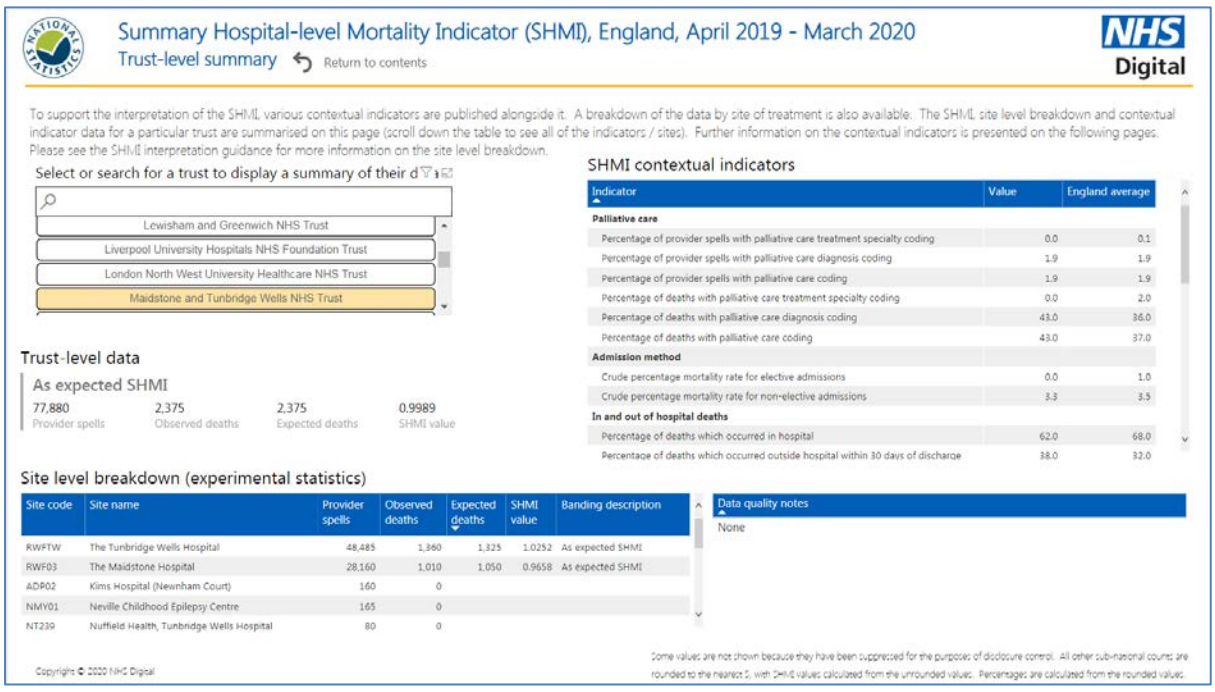
SHMI is a measure of mortality and performance which includes all deaths in hospital regardless of diagnosis, in addition to all those individuals who die within 30 days of discharge from hospital.



SHMI published by HSCIC for the period June 2019 to May 2020 shows SHMI as 0.9989 which is banded as level 2 “as expected”.

SHMI – Breakdown by Site and Contextual Indicators

The information below shows the SHMI broken down by site as well as an overview of the contextual indicators. These are shown in more detail in the following sections. These are all either the same or better that the national average with the exception of the percentage of spells with a primary diagnosis which is a sign or symptom. It is suggested that this is reviewed by the Clinical Coding Team.


Summary Hospital-level Mortality Indicator (SHMI), England, April 2019 - March 2020

Trust-level summary Return to contents

NHS Digital

To support the interpretation of the SHMI, various contextual indicators are published alongside it. A breakdown of the data by site of treatment is also available. The SHMI site level breakdown and contextual indicator data for a particular trust are summarised on this page (scroll down the table to see all of the indicators / sites). Further information on the contextual indicators is presented on the following pages. Please see the SHMI interpretation guidance for more information on the site level breakdown.

Select or search for a trust to display a summary of their d

Lewisham and Greenwich NHS Trust
Liverpool University Hospitals NHS Foundation Trust
London North West University Healthcare NHS Trust
Maidstone and Tunbridge Wells NHS Trust

Trust-level data

As expected SHMI

77,880	2,375	2,375	0.9989
Provider spells	Observed deaths	Expected deaths	SHMI value

SHMI contextual indicators

Indicator	Value	England average
Palliative care		
Percentage of provider spells with palliative care treatment specialty coding	0.0	0.1
Percentage of provider spells with palliative care diagnosis coding	1.9	1.9
Percentage of provider spells with palliative care coding	1.9	1.9
Percentage of deaths with palliative care treatment specialty coding	0.0	2.0
Percentage of deaths with palliative care diagnosis coding	43.0	36.0
Percentage of deaths with palliative care coding	43.0	37.0
Admission method		
Crude percentage mortality rate for elective admissions	0.0	1.0
Crude percentage mortality rate for non-elective admissions	3.3	3.5
In and out of hospital deaths		
Percentage of deaths which occurred in hospital	62.0	68.0
Percentage of deaths which occurred outside hospital within 30 days of discharge	38.0	32.0

Site level breakdown (experimental statistics)

Site code	Site name	Provider spells	Observed deaths	Expected deaths	SHMI value	Banding description
RWFTW	The Tunbridge Wells Hospital	48,485	1,360	1,325	1.0252	As expected SHMI
RWF03	The Maidstone Hospital	28,160	1,010	1,050	0.9658	As expected SHMI
ADP02	Kims Hospital (Newnham Court)	160	0			
NMY01	Neville Childhood Epilepsy Centre	165	0			
NT239	Nuffield Health, Tunbridge Wells Hospital	80	0			

Data quality notes

None

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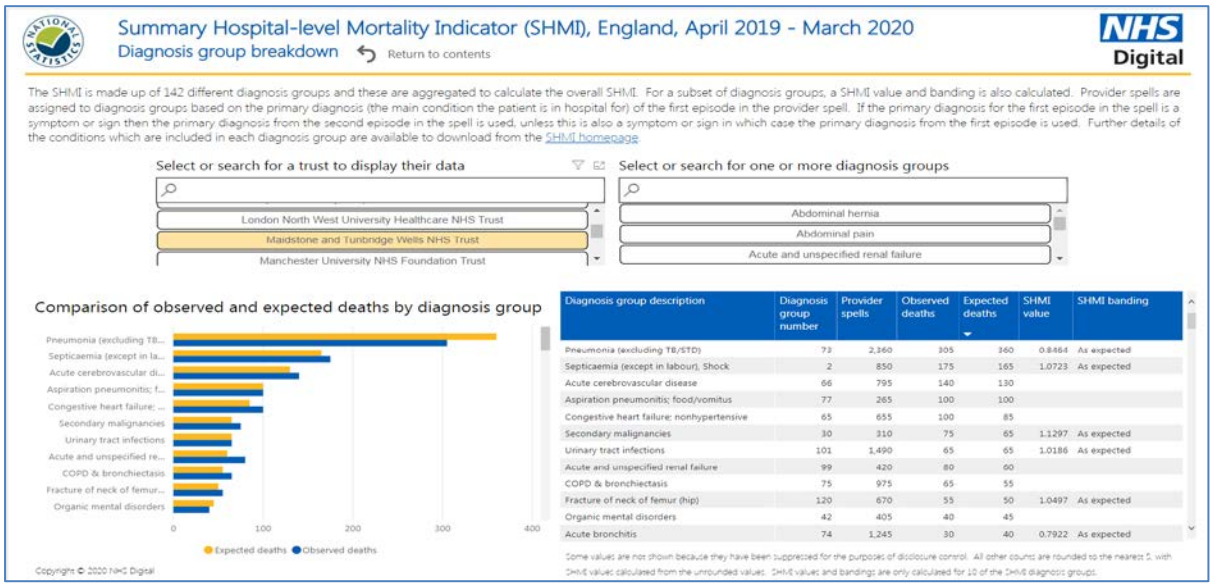
Some values are not shown because they have been suppressed for the purpose of disclosure control. All other sub-national counts are rounded to the nearest 5, with SHMI values calculated from the unrounded values. Percentages are calculated from the rounded values.

SHMI – Breakdown by Diagnosis Group.

As can be seen there are some diagnosis groups where the observed deaths exceeds those expected. There is unsurprisingly some correlation with the HSMR for example Acute Bronchitis and Acute Renal Failure, but others are not highlighted as they fall outside the ten diagnosis groups that inform the SHMI rating and do not have a CUSUM alert in relation to HSMR.



The full range of SHMI data can be found following this link:

https://app.powerbi.com/view?r=eyJrIjoiNmM4NTY0YzAtZTY3NS00MTAxLWI1YWItM2NkY2RkNGNiZDdhIiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9

SHMI - Supplementary information

In the pack of information provided as part of the SHMI release each quarter, there is information included about depth of coding. As can be seen from the table below, MTW's mean depth of coding for non-elective admissions is equal to the national average but is still higher than our local acute peers. This also highlights that our coding of secondary diagnosis is rich as the maximum has been reached.

a. SHMI - Supplementary information: Depth of Coding

Provider name	Mean coding depth for non-elective admissions	Maximum number of secondary diagnosis codes for non-elective admissions
England	5.2	19
DARTFORD AND GRAVESHAM NHS TRUST	3.7	19
FRIMLEY HEALTH NHS FOUNDATION TRUST	4.3	19
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	4.6	19
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	4.8	19
MEDWAY NHS FOUNDATION TRUST	4.9	19
BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	5.0	19
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	5.1	19
WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST	5.7	19
WEST SUFFOLK NHS FOUNDATION TRUST	6.2	19
ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	6.3	19
SURREY AND SUSSEX HEALTHCARE NHS TRUST	6.6	19

b. SHMI - Supplementary information: Palliative Care Coding

Information is also included about our palliative care coding and as can be seen below, the Trust's coding is slightly higher than the England levels. Previously this had been an area where MTW fell below the national average, so this shows an improved position.

Provider name	Observed deaths (c)	Number of deaths with palliative care diagnosis coding (e)	Number of deaths with either palliative care speciality or diagnosis coding (f)	Percentage of deaths with palliative care diagnosis coding (h)	Percentage of deaths with either palliative care speciality or diagnosis coding (i)
ENGLAND	293,659	106,896	107,566	36	37
BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	2,295	925	925	40	40
DARTFORD AND GRAVESHAM NHS TRUST	1,535	705	705	46	46
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	4,085	1,270	1,270	31	31
FRIMLEY HEALTH NHS FOUNDATION TRUST	3,740	1,655	1,655	44	44
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	2,375	1,010	1,010	43	43
MEDWAY NHS FOUNDATION TRUST	1,945	925	925	48	48
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	3,280	1,240	1,315	38	40
ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	1,265	715	715	57	57
SURREY AND SUSSEX HEALTHCARE NHS TRUST	1,910	895	895	47	47
WEST SUFFOLK NHS FOUNDATION TRUST	1,560	710	710	46	46
WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST	3,225	1,130	1,130	35	35

c. SHMI - Supplementary information: Deaths split by deprivation quintile

The pack includes a breakdown of deaths split by deprivation quintile and the following table highlights the proportion of deaths at MTW in each. This shows that 5.7% of our deaths fell in quintile 1 'most deprived', whereas 30.1% of our deaths fall into quintile 5 'least deprived'. This profile is significantly different than the national average and our local acute peers.

Provider name	Percentage of deaths in deprivation quintile 1 (Most)	Percentage of deaths in deprivation quintile 2	Percentage of deaths in deprivation quintile 3	Percentage of deaths in deprivation quintile 4	Percentage of deaths in deprivation quintile 5 (Least)
ENGLAND	23.7	20.7	19	17.6	15.9
BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	11.4	14.1	20.9	24	25.4
DARTFORD AND GRAVESHAM NHS TRUST	15.9	22.9	25.7	19.3	15.4
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	23.5	21.7	24.6	21	8.3
FRIMLEY HEALTH NHS FOUNDATION TRUST	2.9	16.5	17.7	19.5	40.2
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	5.7	13.2	24.7	25.4	30.1
MEDWAY NHS FOUNDATION TRUST	26.5	27.9	18.7	15.5	9.4

Provider name	Percentage of deaths in deprivation quintile 1 (Most)	Percentage of deaths in deprivation quintile 2	Percentage of deaths in deprivation quintile 3	Percentage of deaths in deprivation quintile 4	Percentage of deaths in deprivation quintile 5 (Least)
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	26.5	23.7	17.1	15.7	16.4
ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	1.8	5.6	14.3	24.2	47.8
SURREY AND SUSSEX HEALTHCARE NHS TRUST	1.5	16	23.1	23.1	31.1
WEST SUFFOLK NHS FOUNDATION TRUST	3.4	18.9	35.1	27.3	13.6
WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST	7.6	16.3	32.4	25.5	17.1

* indicates value suppressed for the purposes of disclosure control

d. SHMI - Supplementary information: % of Deaths in the Community

The table below shows the number of deaths that occurred in the community within 30 days of discharge from the Trust. This shows that MTW is higher than the national average.

Provider name	Observed deaths	Number of deaths which occurred in hospital	Number of deaths which occurred outside hospital	Percentage of deaths which occurred in hospital	Percentage of deaths which occurred outside hospital
ENGLAND	293,659	200,991	92,668	68	32
BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	2,295	1,600	695	70	30
DARTFORD AND GRAVESHAM NHS TRUST	1,535	1,095	435	71	28
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	4,085	2,565	1,520	63	37
FRIMLEY HEALTH NHS FOUNDATION TRUST	3,740	2,545	1,200	68	32
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	2,375	1,470	905	62	38
MEDWAY NHS FOUNDATION TRUST	1,945	1,350	600	69	31
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	3,280	2,465	815	75	25
ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	1,265	800	465	63	37
SURREY AND SUSSEX HEALTHCARE NHS TRUST	1,910	1,335	575	70	30
WEST SUFFOLK NHS FOUNDATION TRUST	1,560	990	570	63	37
WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST	3,225	2,155	1,070	67	33

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.

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

Trust	Jan-20	Feb-20	Mar-20	2019/20	Apr-20	May-20	Jun-20	Jul-20	YTD
No of Deaths	164	138	171	1636	165	149	103	109	632
No of Completed Reviews	143	108	136	1409	106	104	67	56	342
%age completed reviews	**87.2%**	**78.3%**	**79.5%**	**86.1%**	64.2%	69.8%	65.0%	51.4%	54.1%
No of Un-reviewed Deaths	21	30	35	227	59	45	36	53	290

%age completed reviews	Jan-20	Feb-20	Mar-20	2019/20	Apr-19	May-19	Jun-19	Jul-19	YTD
A&E	**50.0%**		**100.0%**	**99.1%**	100.0%	100.0%	83.3%	100.0%	86.7%
Acute Medicine	**89.1%**	**78.9%**	**78.4%**	**86.8%**	61.7%	72.4%	69.1%	45.3%	53.0%
Specialist Medicine	**76.5%**	**70.6%**	**80.8%**	**85.4%**	55.6%	74.1%	56.3%	47.4%	53.5%
Surgery	**100.0%**	**90.9%**	**100.0%**	**82.6%**	100.0%	60.0%	55.6%	60.0%	56.9%
Trauma & Orthopaedics	**90.0%**	**100.0%**	**90.9%**	**56.4%**	50.0%	25.0%	50.0%	100.0%	40.0%
Head & Neck				**100.0%**	100.0%				50.0%
Urol, Gonc, Breast, Vasc	**66.7%**	**20.0%**	**25.0%**	**87.5%**	0.0%	0.0%			0.0%
Cancer & Haematology				**100.0%**			0.0%	0.0%	0.0%
Children's									
Women's & Sexual Health	**100.0%**			**100.0%**			0.0%		0.0%
Trust Total	**87.2%**	**78.3%**	**79.5%**	**86.1%**	64.2%	69.8%	65.0%	51.4%	54.1%

The table above shows the results for Q4 2019-20 and April – July 2020 as at 8 September 2020.

During April 2019 – March 2020, 53 deaths have had an SJR completed which is 3.2% of the total deaths to date.

Mortality Steering Group

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:

- Staff to follow the processes in place to ensure administration of steroid therapy in accordance with prescribing guidelines
- Staff to consider prescribing and administration of essential treatments in alternative formulations for patients who are nil-by-mouth to prevent missed doses
- The risks of high flow oxygen with COPD patients need to be considered in all departments and hospital areas – particularly with transfers between departments
- End of life care pathways should be used and discussions with families about transitioning to end of life care clearly documented
- Where indicated patients should be referred to psychiatric services prior to discharge
- Use of Individualised Care Plan for the Dying Patient may improve documentation of assessment and actions taken in last couple of days for EoLC symptoms.

The following practice was highlighted in Mortality Reviews:

- Surgical Reconfiguration facilitates continuity of care for our patients
- Good use of Hospital Passport
- Good assessments undertaken in Maidstone ED resulting in safe and prompt transfer to Pembury
- Prompt assessment by T&O and Ortho-geriatric teams
- Prompt referral to and acceptance by ITU
- Prompt SALT review aided diagnosis and plan to be enacted
- Prompt active input by the Palliative Care Team
- Constant MDT review and good team working together. Great documentation of decision making by clinical teams.

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 to all Medical Examiner and Medical Examiner Officer roles
- Provided induction and training packages for the Medical Examiner Officers
- Maintained regular contact with the regional Medical Examiner team
- Created a preliminary rota to ensure cross site cover
- Commenced the scrutiny process in the first week of September 2020.

The following next steps have been identified:

- 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
- The Medical Examiner Service will provide a monthly update to the MSG with regards to number of screenings undertaken and number of SJRs commissioned starting in October 2020.

Update on progress against the CNST maternity incentive scheme standards	**Divisional Director of Midwifery, Nursing and Quality**

The enclosed report seeks to

- Provide information on the progress and position against the 2019/2020 maternity CNST scheme, which does not require submission to NHS resolution as per previous years due to a 'COVID pause'.
- Assure the Trust Board that 2020/21 will continue as normal
- Provide assurance that whilst the maternity services have not been asked to provide evidence of compliance, they are still maintaining the majority of the standards required.

Which Committees have reviewed the information prior to Board submission?

- Women's Directorate Board, 16/09/20

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

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

Update Report on the Compliance for Maternity CNST Scheme 19/20

The Maternity Incentive Scheme was launched three years ago and detailed 10 safety actions. The purpose of the scheme is to support the delivery of safer maternity care across the United Kingdom, and applies to all acute trusts that deliver maternity services and are members of the CNST scheme. The ten safety actions are incentivised and announced each year in Autumn. Trusts must demonstrate that they have achieved all elements of the scheme in order to receive the payment. This scheme must be supported by the Trust Board and signed off by such each year.

Due to the COVID19 outbreak in March 2020 it was announced that the incentive scheme was placed on hold with no expectation for organisations to demonstrate their compliance with the safety actions. We were advised that we would not be monitored against our submission of items, and that each trust could take their own stance on how they proceeded. At Maidstone Tunbridge Wells NHS Trust we took the decision that if we could continue we would. The table below shows the 10 safety actions and the current status of MTW maternity services.

Safety Action	Current Status	Plan
1. Perinatal Mortality Review Tool used to review Perinatal deaths	We hold a review panel every month and we have reviewed all perinatal death cases to date	Continue with quarterly board reports and plan to produce a yearly update as part of the governance year end report
2. Submit data to the Maternity Services Data Set (MSDS) to the required standard	Continued regardless of COVID19 position and fully up to date. Currently not getting monthly compliance data from NHS digital.	No further action. Continue as normal
3. Demonstrate the transitional care services to support the recommendations made in Avoiding Term Admissions into Neonatal units programme	Meetings continue with good representation across the division and regionally	Continue as normal
4. Clinical workforce planning	Job planning completed each year to ascertain demand and capacity which in turn creates an understating of what our workforce requirements are. We did a full quota of job planning in the allocated time frame	Continue as normal but scope for additional workforce requirements associated with COVID reset and recovery programme.
5. Midwifery workforce planning	This is performed yearly as part of a trust wide approach.	Continue as normal but scope for additional workforce requirements associated with COVID reset and recovery programme. Additionally engage in the BR+ review arranged by the LMS
6. Demonstrate compliance of all 5 elements of the Saving Babies Lives Care Bundle version 2 (SBLCBv2)	We have a clear action log for all 5 elements and are now fully recruited to the fetal wellbeing posts	To progress with the work that is set in the SBLCBv2 and ensure we meet these elements, exploring any additional safety elements that we require.
7. Gathering service user feedback and using the MVP to	During COVID we have worked closely with the MVP to ensure	Continue working closely with MVP. Increase the diversity amongst the

coproduce maternity services	women understand the restrictions in place, but to also understand the important elements of recovery.	group and have some presence at the patient experience committee.
8. 90% of staff have attended an in house multi professional maternity emergencies training in last year.	Due to COVID our face to face training compliance was impacted. Our current compliance for this element is 57%	Face to face training has been reinstated with socially distanced numbers of 13 for those who are grossly out of date or are new to the trust. The rest has been organised as eLearning with time to be allocated to staff. This is a recovery plan at present with a virtual package in place for those who are only 1 year out of date. It is predicted (but not official as yet) that the CNST targets due to be released will accept eLearning as a standard. The CNST scheme are also due to release a PROMPT eLearning package of which we will purchase and compounds the prediction of eLearning being acceptable. It is hoped that we can be back on track with a 95% compliance rate by early next year. We are currently sitting at 60% compliance. We will further be fully staffed by October 2020 which will afford us the opportunity to assign more study sessions without compromising safety.
9. Trust safety champions meet bi monthly	Due to COVID these meetings were postponed. These are now back in the diary of all 3 champions for bi monthly catch ups.	No further action required
10. Report of 100% of qualifying 19/20 incident under NHS Resolutions Early Notification Scheme.	We have continued to report during COVID as we did Pre COVID	Continue as normal with excellent compliance.

In conclusion, we have maintained the 'norm' with the majority of this data collection work. We recognise that the most affected area in the 10 safety actions is the MDT PROMPT training; this has seen the biggest impact during the pandemic phase. Due to the nature of staffing shortages and directives for socially distanced venues this has sadly been unpreventable. In October 2020 we will be fully recruited to for the first time in 2 years.

We are eagerly awaiting the year 4 specifications (due out on 1st October 2020) for this work and expect to be back on track with any areas that we have witnessed a fall in compliance. The safety actions for 20/21 may be different from those this year so would be unable to predict our future success, but have a good level of confidence. It is also anticipated eLearning will be acceptable for the PROMPT training of which we will purchase the bespoke package.

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The Trust's Phase three (of NHS response to COVID-19) planning; plan for the forthcoming winter; contingencies for a second wave of COVID-19 cases; lessons learned from the first COVID-19 wave; and the latest position re overseas nursing recruitment	**Director of Strategy, Planning and Partnerships / Chief Operating Officer / Director of Workforce / Chief Nurse**

It was agreed at the Trust Board meeting in July 2020 to submit a report to the Trust Board in September 2020 that covered a) the Trust's plan for the forthcoming winter, b) the contingencies for a second wave of COVID-19 cases, c) lessons learned from the first wave of COVID-19 cases, and d) the latest situation regarding overseas nursing recruitment.

A document has been duly prepared to address these issues, and also incorporate the Trust's Phase three (of NHS response to COVID-19) planning (which relates to the letter sent to all Chief Executives of all NHS Trusts and Foundation Trusts by the NHS Chief Executive and NHS Chief Operating Officer on 31st July). However, as the content of the document reflects 'work in progress', this has not been formally submitted to the Trust Board. The 'work in progress', document has however been made available to Trust Board members (via the "documents" section of the Admincontrol meetings portal), and will be subject to a detailed discussion at the Trust Board meeting on 24/09/20. The content of the document will also be considered at the Finance and Performance Committee meeting on 22/09/20.

Which Committees have reviewed the information prior to Board submission?
- Finance and Performance Committee, 22/09/20

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

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

NHS Maidstone and Tunbridge Wells NHS Trust

The allocation of resources and funding as part of the 'reset and recovery' programme	Chief Finance Officer / Chief Operating Officer

Summary / Key points:

- The Trust has identified that investment is necessary to support the Reset and Recovery Programme.
- This paper identifies the areas for investment and highlights the risks to investment.
- This paper was presented to the Finance and Performance Committee in August 2020, which recommended the investment for approval to the Trust Board.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

1. For approval of the overall approach to investments to support Reset and Recovery
2. For approval to recruit to critical roles to support the reset and recovery programme
3. To highlight those programmes that will require full Business Case approval at a later time.

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

1. Introduction

This paper explains funding required for the Reset and Recovery programme and identifies potential sourcing of the income. There are PIDs (Project Initiation Documents) for all schemes and some have business cases to support. The Trust would like to approval to the overall investment programme and therefore authority to recruit to critical posts.

2. Reset and Recovery Programme

The Reset and Recovery Programme has reviewed the PIDs and prioritised the following investments which is agreed and supported by the Executive Team.

Table 1

Workstream	2020/21 (Oct 20 to Mar 21)	FYE	WTE
Staff and Patient Safety	-30	-30	21
Staff Welfare	-390	-779	
Trust Command Centre	-150	-300	
Outpatients	-350	-700	
Cancer	-350	-700	
Acute and Urgent Care	-548	-2,777	8
Elective Care	-1,022	-2,501	18
Social Distancing and Home Working	0	0	0
Total Reset and Recovery	**-2,839**	**-7,788**	**47**

The costs required for continued COVID swabbing and testing have been removed as these are to be funded centrally, although further guidance is awaited at this time. Any shortfall in funding against expected costs would cause a pressure to the Trust.
A full business case is required for the 7 Day Services in Medicine investment (the first year of which is included in the Acute and Urgent Care investments above). This will be a multiyear investment programme but at this stage only the costs for the first year have been included. The Board is asked to agree year one funding in advance of sign off of the full business case.

Each of the rest of the investments will need to complete a business case brief (short form business case), however these investments individually can be approved by the Executive Team.

In addition to the Reset and Recovery programme, there are other investments the Trust will need to commit to this financial year. The table below shows the totality of investments, alongside available funding.

Table 2

	2020/21 (Oct 20 to Mar 21)	FYE
Funding Source		
Contingency	5,000	5,000
Other funding available	1,706	
Total Funding Source	**6,706**	**5,000**
Investments		
Reset and Recovery	-2,839	-7,788
Patient Flow	-212	-423
Winter Pressures	-1,883	-1,883
HR Review	-140	-240
Business Cases already approved	-2,209	-2,437
Operational Structural Changes	-319	-638
Transforming Intranet	-56	-56
Total Investments	**-7,658**	**-13,465**
Net Funding less Investment	**-952**	**-8,465**

4. Assumptions, Risks and Mitigations

Assumptions

- Winter Pressures will be contained within the funding available. This in part will be delivered by realising the operational benefits of schemes such as Teletracking and senior decision makers at the front door.
- Swabbing, FIT Testing and Temperature check are funded as part of COVID funding on an ongoing basis
- It is assumed the utilisation of Independent Sector Providers continues to be funded by NHS I/E.
- The elective additional posts are assumed to cover reduced productivity in theatres or undertake work in the Independent Sector on NHS patients and therefore no additional non pay or ward costs.
- Costs are based on substantive appointments not agency usage
- There is recruitment to other existing vacancies which isn't assumed to be additional investment
- The costs of the Medway Stroke service transfer are fully funded; discussions are in progress with the CCG to confirm this.

Risks

- If the Board approves the investment the expectation is that our contingency will be fully deployed. Under the expected financial regime for the remainder of the year, it would be prudent to assume that the opportunity for mitigation will be less than in previous years.

- If the Trust doesn't meet the performance requirements set out in the phase 3 letter there could be financial penalties to the Trust – this could also be a benefit. Further guidance is awaited.
- Once the full and final guidance for M7 – M12 has been received and digested, this could cause the Trust additional financial pressures.

Mitigations

It is expected that the shortfall in funding in 2020/21will be funded through slippage in recruitment to posts. The full year effect of the investments could be mitigated as follows;

- The Financial Framework for 2021/22 is still to be confirmed, it could be assumed the ongoing costs of COVID would be funded going forward or the performance requirements adjusted to reflect the reduction in efficiencies. The assumption below represents 12 months of c.10% of top up funding received in 20/21.
- The 7 Day Services in Medicine business case is planned to reduce admissions and reduce LOS by having senior decision makers at the front door, and increased consultant led ward rounds, particularly at the weekend.
- Teletracking, a bed management system and approach, should reduce medical outliers and therefore LOS for these patients.

Potential Mitigations		
		£ 000
COVID Support continues	Hypothetical c£300k pm	3,600
7 day services	Potential Benefits over 4 years	4,755
Teletracking	Savings from year 3	1,439
Elective Incentive Scheme	To be confirmed	TBC

5. Recommendation

The Board is asked to approve the investment programme outlined above.

The Board is asked to approve the funding for year one of the 7 Day Services in Medicine prior to receipt of the full Business Case, which will cover multiple years.

Responsible Officer's Annual Report 2019/20 — Medical Director

As a designated body, the Trust has responsibilities to provide a quality assured appraisal process to all doctors with a 'prescribed connection'. As Responsible Officer, the Medical Director must give assurance to the Trust Board that processes, compliance and monitoring of the medical appraisal and revalidation processes, as well as the ability of the Trust to respond appropriately to concerns raised about medical performance, meet national standards defined in legislation, by NHS England and by the GMC.

The appraisal year for doctors runs from 1st April to 31st March. At Maidstone and Tunbridge Wells NHS Trust medical appraisals are conducted between September and January.

The Board is asked to review the report and approve the Statement of Compliance (Appendix D) confirming that the Trust, as a designated body, is in compliance with the regulations governing appraisal and revalidation.

Once approved, the Statement will then be signed by the Chief Executive, before being submitted to the higher-level Responsible Officer (by 30th September 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]

1. To review the report and;
2. To approve the Statement of Compliance (Appendix D) confirming that the Trust, as a designated body, is in compliance with the regulations governing appraisal and revalidation

[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

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MTW appraisers 2020/21 (August 2020)

A&E Medicine
Dr N Bagley
Dr T Bell
Dr A Feazey
Dr J Ironside
Dr C Lowe
Dr J MacDonald
Dr E Townsend

Anaesthetics
Dr J Appleby
Dr M Browning
Dr H Burdett
Dr A Challiner
Dr G Graham
Dr R Griffiths
Dr G Lawton
Dr R Leech
Dr A Rajasekaran
Dr M Sinden
Dr A Turner
Dr R Williams

General Surgery, Gynae Oncology, Urology & ENT
Mr D Balasubramaniam
Mr A Bhat (SAS)
Mr M Cynk
Mr O Devaja
Miss R Lloyd
Mr S Montalto
Mr G Omar (SAS)
Mr A Papadopoulos
Mr J Shotton
Mr R Tamhane (SAS)

Medicine
Dr D Barnes
Dr G Bird
Dr K Budack (SAS)
Dr D Harrington
Dr S Husain
Dr J Kumar
Dr C Lawson
Dr T Loke
Dr R Nemane (SAS)
Dr P Reynolds
Dr S Sivappriyan
Dr P Tsang

GU Medicine
Dr L Navaratne

Oncology
Dr C Abson
Dr R Burcombe
Dr M Cominos
Dr R Jyothirmayi
Dr J Summers
Dr J Waters

Ophthalmic surgery
Mr F Ah-Fat
Mr E Ansari
Mr A Bates
Mr S Hasan

Orthopaedics
Ms R Ayodele
Mr J Nicholl
Mr K Ravikumar
Mr G Slater

Paediatrics
Dr B Bhaduri
Dr H Kisat
Dr N Pandya

Pathology
Dr M Boyle
Dr A Fleming
Dr S Mumford
Dr G Russell
Dr J Schofield

Radiology
Dr D Baker
Dr S Ghosh
Dr T Johnson-Smith
Dr N Ryan
Dr C Wetton

Women's
Miss R Bajracharya
Mr D Datta
Ms S Flint
Ms M Matthews
Miss S Nazir
Mrs W Ogunnoiki

Trust Headquarters: Maidstone Hospital, Maidstone, Kent ME16 9QQ
Telephone: 01622 729000 Fax 01622 226416

MTW – 2019/2020

- April 2020
  - 484 connected doctors
  - 475 completed an appraisal
- 98.14% appraisal rate

  99.27% Consultants

  96.50% Staff grade / associate specialist / trust grade (SAS)

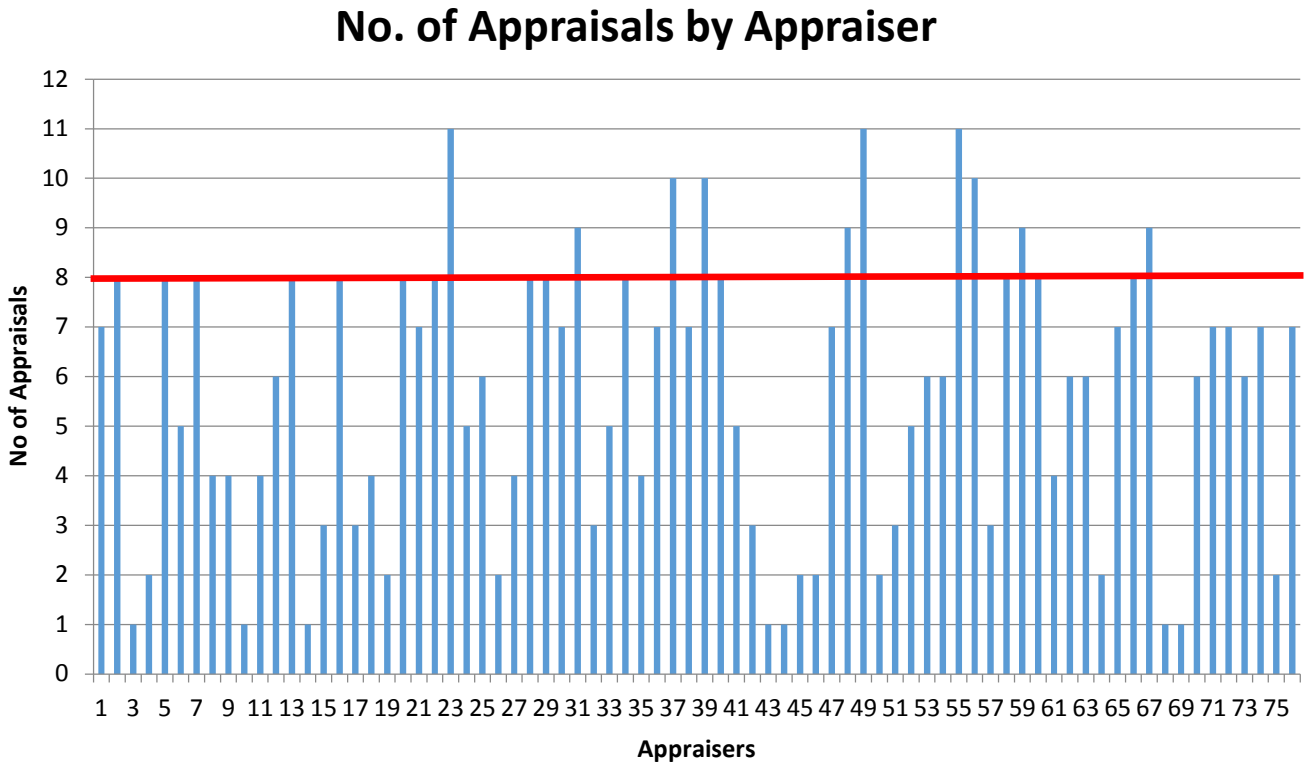
  97.06% Locums (short term contracts)
- August 2020
  - 479 (98.9%) appraisals
  - 5 Did not have an appraisal

MTW – 2019/2020

- March 2019 - April 2020
  - 156 recommendations to the GMC
  - 138 revalidation
  - 18 deferrals – all due to lack of a 360
  - 0 non-engagement
- 76 appraisers
  - 71 Consultants
  - 5 SAS doctors
- 15 New appraisers currently being trained targeting specialities how have or will have low appriaser numbers

Section 2	Appraisal						
2.1	Only doctors with whom the designated body has a prescribed connection at 31 March 2020 should be included. Where the answer is 'nil' please enter '0'. AS of August 2020	Number of Prescribed Connections	Completed Appraisal (1)	(Optional) Completed Late (1a)	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (3)	Total
2.1.1	Consultants (permanent employed consultant medical staff including honorary contract holders, NHS, hospices and government/other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work).	273	267	37	5	1	273
2.1.2	Staff grade, Associate Specialist, Specialty Doctors (permanent employed staff - SAS)	143	118	24	21	4	143
2.1.3	Doctors on Performer Lists (for NHS England and Armed Forces only)	0	0	0	0	0	0
2.1.4	Doctors with practising privileges (For Independent Healthcare Providers)*	0	0	0	0	0	0
2.1.5	Temporary or short term contract holders (temporary directly employed staff)	68	48	13	20	0	68
2.1.6	Other doctors with a prescribed connection to this designated body (doctors not falling into above categories)	0	0	0	0	0	0
2.1.7	TOTAL	484	433	74	46	5	484

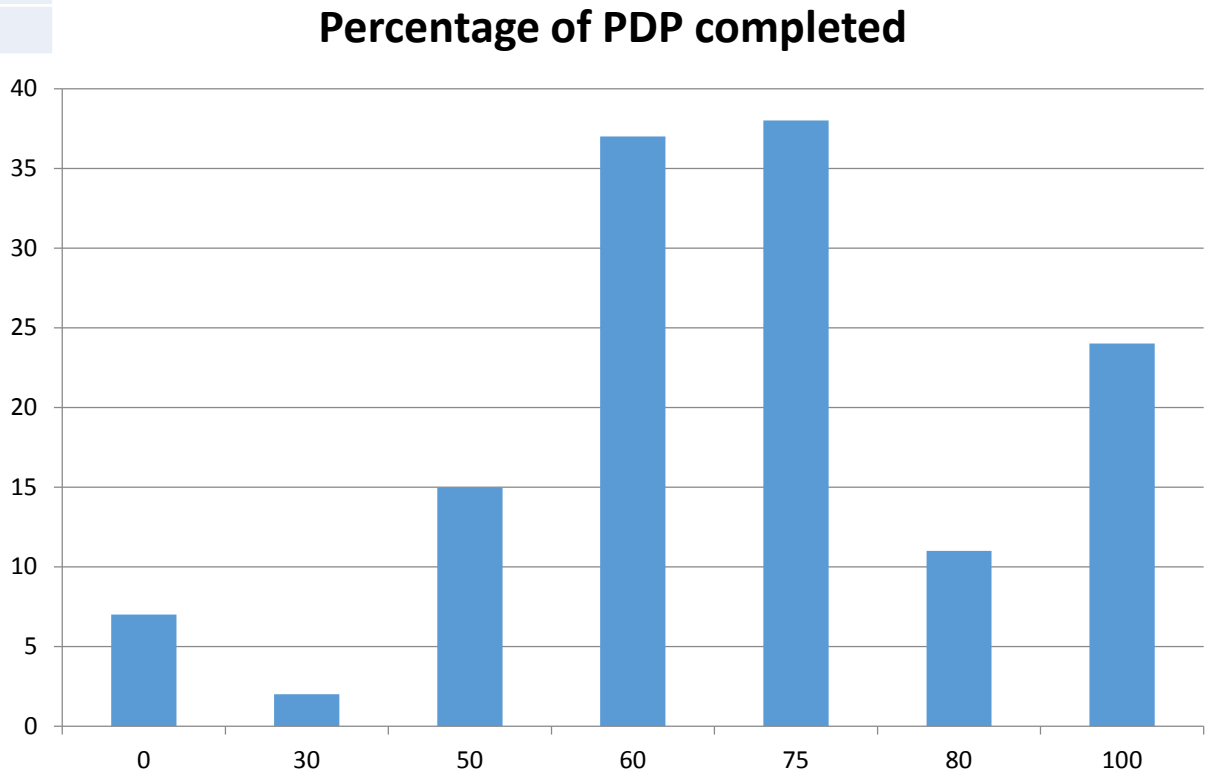
* MTW does not keep data on practising privileges for independent providers



Average number of appraisals per appraiser = 5.8 (1 – 11) [5 0-13]

3 [6] Appraisers > 10 appraisals

PDP achieved	Number
0	7
30	2
50	15
60	37
75	38
80	11
100	24



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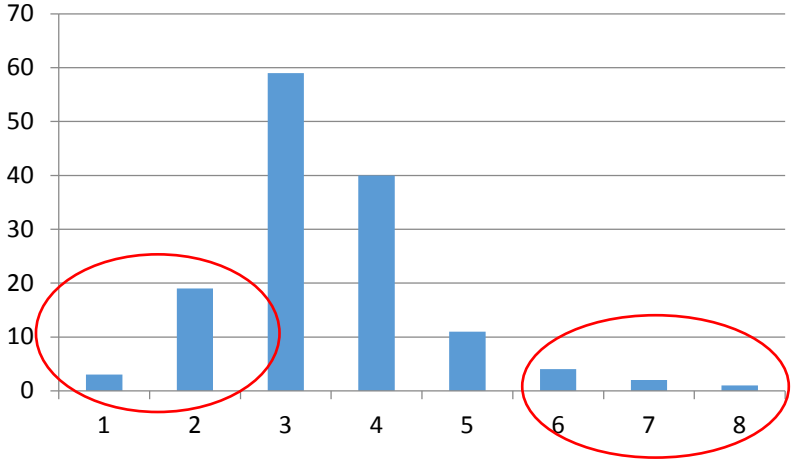
2	19		30	2
3	59		50	17
4	40		60	39
5	11		75	31
6	4		80	11
7	2		100	24
8	1			

Number of PDP points



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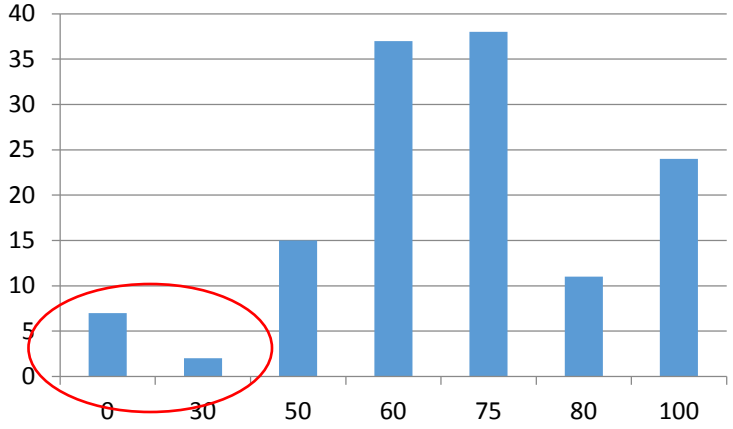

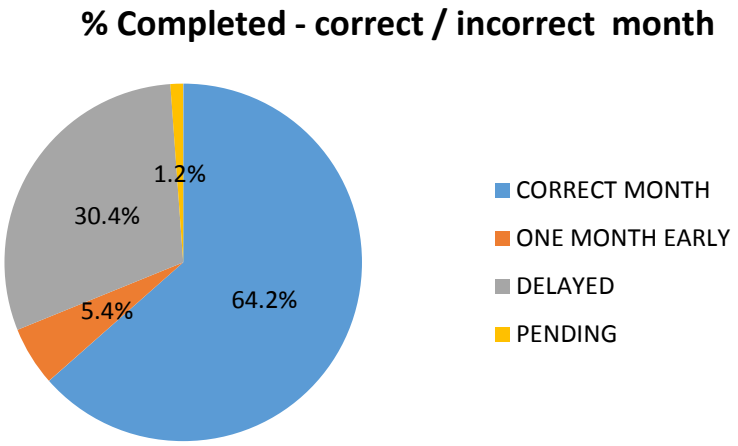
% Completed - correct / incorrect month
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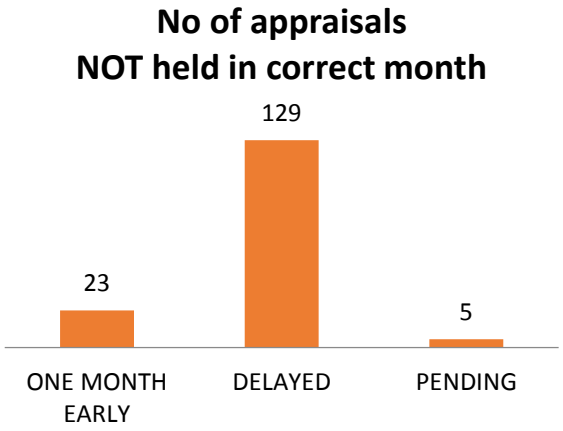
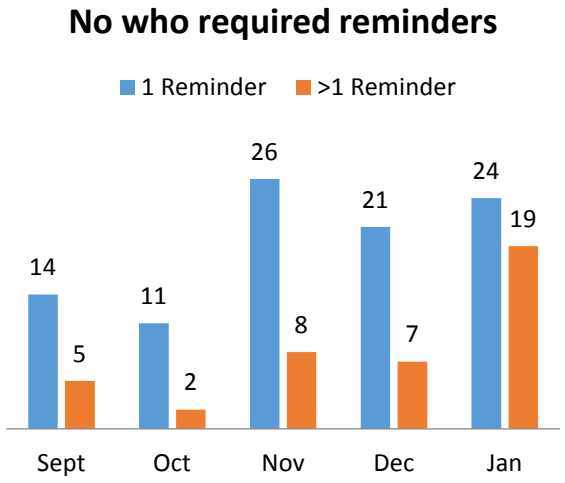
64.2%
5.4%
CORRECT MONTH
ONE MONTH EARLY
DELAYED
PENDING


No of appraisals
NOT held in correct month
23
129
5
ONE MONTH EARLY
DELAYED
PENDING


No who required reminders
1 Reminder
>1 Reminder
14
5
11
2
26
8
21
7
24
19
Sept
Oct
Nov
Dec
Jan

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – Maidstone and Tunbridge Wells NHS Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: Not submitted for 2019/20 – due to COVID-19 postponement; no requirement to submit Action from last year: None Comments: AOA table of compliance available Action for next year: Ongoing compliance

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: None Comments: Dr Peter Maskell, Medical Director fulfils these requirements Action for next year: None

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: None Comments: MTW NHS Trust has 76 appraisers (71 Consultants and 5 SAS doctors). The Trust has funded a new appraiser course. This targeted specialities will low appraiser numbers and will train a further 15 appraisers. In 2021 MTW will have 82 Consultant and 9 SAS appraisers. The RO is supported by an appraisal lead and an appraisal manager. Action for next year: A further targeted appraiser course is planned in 2021

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: None Comments: This is maintained on the GMC Connect website and regularly checked by the Revalidation Manager Action for next year: Ongoing

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: None

Comments: MTW reviews and updates the Medical Appraisal and Revalidation policy every 3 years. Last updated 2019.

Proposed changes are discussed with the appraisers and the RO. We have introduced a maximum number of appraisals per appraiser, plan to ensure a 360 occurs in the 2 years prior to a revalidation recommendation and have introduced a scheme to ensure appraisers are notified of any information that a doctor has been asked to discuss. These changes will be incorporated into the 2021 policy.

Action for next year: Ensure that any proposed changes are included in the annual report

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: None

Comments: A random sample of 20 appraisals was audited looking for supporting evidence. The audit found that there was evidence to support appraiser statements. There were cases where 360 reviews did not appear to have been discussed in detail and differences between a doctor and national comparators had not been highlighted. The importance of this was discussed at appraiser updates

Action for next year: To repeat and audit in 2021

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: None

Comments: MTW encourages all doctors to make the most of all development opportunities available to them. All doctors are invited to attend annual appraisal training. This training explains the MTW appraisal system and how to use development opportunities within the Trust

Action for next year: Ongoing

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: Previous audit suggested that in some cases supporting information was not available to support statements made in the appraisal documentation. This was discussed at appraiser update sessions.

Comments: The national MAG form is used at MTW and all medical practitioners complete an annual appraisal. . Review by the appraisal lead of 140 appraisals suggested that there were very few cases where supporting information was not provided. This will be fed back to appraiser and appraisee. A formal audit of 20 appraisals by a group of 4 experienced appraisers did not identify any appraisals with insufficient supporting information

Action for next year: To continue to highlight the importance of supporting information in appraise and appraiser update sessions and to continue with an annual audit.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: N/A

Comments:

Action for next year:

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: None

Comments: MTW reviews and updates the Medical Appraisal and Revalidation policy every 3 years. Last updated 2019

Action for next year: None

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: None

Comments: MTW has 76 trained medical appraisers and is currently training a further 15 approved appraisers

Action for next year: Review of new appraisers and further training for another 15 approved appraisers, targeting specialities with low appraiser numbers

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development

events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: None Comments: Annual update sessions are held by the Appraisal Lead and there are quality assurance systems that permit feedback of performance to appraisers. Appraisees are asked to give feedback on their appraisals. Completion of feedback forms this year was less than previously possibly due to COVID-19. The appraisal lead reviews all appraisals and any deficiencies are fed back to individual appraisers Action for next year: Continued appraisal review, we will aim to increase appraisee feedback.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: None Comments: An annual internal audit takes place at MTW of appraisal inputs and outputs. These are reviewed by the appraisal lead and RO Action for next year: Ongoing

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: None Comments: There are existing processes and MTW will continue to refer individuals where there are fitness to practice concerns in line with GMC requirements. This year all recommendations were made ahead of the recommendation deadline Action for next year: Ongoing

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: None Comments: The Revalidation Manager ensures timely recommendations. The revalidation lead contacts all doctors for whom a deferral is recommended explaining the reasons for the deferral and working with the doctor to ensure a

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

positive future recommendation. No non-engagement recommendations were made this year.

The GMC has advised that due to the COVID-19 pandemic all doctors due to revalidate 17th March 2020 -16th March 2021 will have their revalidation date moved back by one year. The appraisal lead wrote to all affected doctors to explain this. Doctors have been given the opportunity to revalidate on their original date and a small number have requested this.

Action for next year: Review doctors postponed during COVID-19 pandemic and support revalidation for those who are eligible.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: None

Comments: Monitoring doctors' performance and development is a key contributor to clinical governance. Doctors are encouraged to critique their performance, reflect on positive and adverse events in order to learn without fear of persecution or blame, purse CPD activities and record/analyse outcomes. Doctors may be asked to discuss a specific issue at their appraisal.

Action for next year: Ongoing

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: None

Comments: Doctors will discuss conduct and performance at their appraisal. We are developing a system to ensure that an appraiser is aware before the appraisal meeting of any complaints or SIs involving a doctor they are due to appraise.

Action for next year: Ongoing

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: None

Comments: MTW have existing processes for responding to concerns about doctor's fitness to practise

Action for next year: Ongoing

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

Action from last year: None Comments: MTW have existing processes in place for responding to concerns about doctors Action for next year: Ongoing

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

Action from last year: None Comments: If there are concerns about a doctor working in this Trust and the doctor works for another provider then the MTW RO will contact any other ROs as required. Action for next year: Ongoing

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: None Comments: MTW have existing processes in place to ensure safeguards exist and are free from bias and discrimination Action for next year: Ongoing

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: None

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Comments: Processes are in place at MTW to undertake all mandatory pre-employment background checks to an individual's start date to ensure licenced medical practitioners are qualified and experienced for the role

Action for next year: Ongoing

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **Actions still outstanding from last year's review:**

- Previous audit suggested that in some cases supporting information was not available to support statements made in the appraisal documentation this was discussed at appraiser update sessions. In 2020 review by the appraisal lead of 140 appraisals suggested that there were very few cases where supporting information was not provided. This will be fed back to appraisers and appraisees. A formal audit of 20 appraisals by a group of 4 experienced appraisers did not identify any appraisals with insufficient supporting information

- **Current Issues:**

- COVID-19 postponed revalidation. This will lead to a significant increase in the number of GMC recommendations in 2021. The MTW appraisal system does have the capacity and systems to support this.

- **New Actions:**

- Review doctors postponed during COVID-19 pandemic and organise revalidation for those who are ready
- Appraiser numbers will be reviewed in 2021 with a plan to train new appraisers in those specialities where there are or soon will be relatively low appraiser numbers.

- Introduce a process to ensure that appraisers are aware ahead of the appraisal meeting of any complaints or SIs involving the appraisee.

- Plan to move to a system where a 360 is performed in the year prior to the pre-revalidation appraisal

Overall conclusion:

The MTW appraisal system is well supported by appraisers and appraisees.

The MTW appraisal system is effective. MTW will continue to develop systems to monitor and improve appraisal quality

There are no plans to change current appraisal and revalidation recommendation system

Section 7 – Statement of Compliance:

The Board of Maidstone and Tunbridge Wells NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Maidstone and Tunbridge Wells NHS Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

NHS Maidstone and Tunbridge Wells NHS Trust

Health & Safety Annual Report, 2019/20 and agreement of the 2020/21 programme (including Trust Board annual refresher training on health & safety, fire safety, and moving & handling)	**Risk and Compliance Manager**

This report has been prepared by the Trust Competent Persons for the Board.

The Board should lead on health and safety and set the agenda. This performance report allows the Board to:

- Discuss and agree the Trust's health and safety objectives
- Agree the work programme for 2020/21
- Formerly delegate the management to the Health and Safety Committee.

This annual report provides:

- A review of the Trust's Health and Safety performance for 2019/20
- Assessment against objectives and KPIs set in the previous year
- Discussion of the key health and safety issues identified within the year
- Discussion document for the Board to determine the objectives and KPIs for 2020/21
- Identifies the strategy and action plan for the next year and going forward

The data shows that around 25% of reported incidents of harm relate to staff, contractors and visitors and 75% relate to patients. There are many programmes and initiatives focused on patient safety so this report concentrates on issues relating to staff safety only.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

1. To discuss the report and note the role of the Board.
2. Information and assurance
3. To accept the work programme for 2020/21

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

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Health and Safety – Annual Board Report and Programme for 2020/21

Requested/ Required by: Trust Board and the Trust Management Executive

- Health and Safety at Work etc Act 1974.
- Management of Health and Safety at Work Regulations 1999.
- Workplace Health and Safety Standards 2013

Main author: Risk and Compliance Manager (Rob Parsons)
Contact Details: ext. 24581 rob.parsons@nhs.net

Other contributors: Head of Fire and Safety,
Occupation Health Clinical Nurse Manager,
Security and Car Parks Manager,
Radiation Protection Adviser,
Falls Prevention Practitioner,
Vascular Access Specialist Practitioners
Moving and Handling Advisor

Document lead: **Chief Operating Officer**
(Board lead for Health and safety)

Directorate: Clinical Governance

Health and Safety – Annual Board Report and Programme for 2020/21

Requirement for document:	This annual report and programme is: • A review of the Trust's health and safety statistics and performance for 2019/20. • Assessment against objectives and KPI's set in the previous year. • Discussion of the key health and safety issues identified within the year. • Discussion document for the Board to determine the objectives and KPI's for 2020/21. • Identifies the strategy and action plan for the next year and going forward.
Cross references:	This report is in response to key health and safety legislation enacted under the Health and Safety at Work etc Act 1974. This report is supported by Trust key policies and procedures: • Health and Safety Policy and Procedure • Risk Management Policy and Procedure

Version Control:		
Issue:	**Description of changes:**	**Date:**
12	First annual Board report	May 2012
14	Second annual Board Report	May 2013
15	Third annual Board Report	May 2014
16	Fourth annual Board Report	May 2015
17	Fifth annual Board Report	July 2016
18	Sixth annual Board Report	August 2017
19	Seventh annual Board Report	August 2018
20	Eighth annual Board Report	August 2019
21	Ninth annual Board Report	August 2020

Contents

1. Executive Summary

Introduction

The Health and Safety Executive (HSE) advised that the Board should lead on health and safety and set the agenda. This performance report allows the Board to:

- Discuss and agree the Trust's health and safety objectives
- Agree the work programme for 2020/21
- Formerly delegate the management to the Health and Safety Committee.

This annual report provides:

- A review of the Trust's health and safety statistics and performance for 2019/20.
- Assessment against objectives and KPIs set in the previous year.
- Discussion of the key health and safety issues identified within the year.
- Discussion document for the Board to determine the objectives and KPIs for 2020//21.
- Identifies the strategy and action plan for the next year and going forward.

Staff, contractor and visitor incident statistics make up 18.7% of the total incidents reported, which is dominated by patients incidents (81.3%). There are many programmes and initiatives for patient safety so this report concentrates on staff, contractor and visitor safety.

Highlights

- Specific objectives have been completed from 2019/20, though there remain a number of areas where ongoing objectives have been carried over.
- Overall reporting rates have increased by 14.5% compared with 2018/19.
- Injury rates have increased by 9% and the number of incidents reported under RIDDOR decreased from 26 in 2018/19 to 24 in 2019/20.
- A change to the way Datix records injuries to encompass incidents of 'harm' made direct comparison with previous years data more difficult. As a result most incident categories saw a significant increase in harm incidents.
- Violence, aggression and harassment incidents were the most common type of health and safety-related incidents. There was an overall 15% decrease in these incidents, though there was a 32% increase in comparable harm incidents to injuries that occurred in 2018/19.
- Sharps harm incidents increased by 21% compared with injuries in 2018/19. There were fewer RIDDOR reportable dangerous occurrences from exposure to known blood borne viruses (BBV) than in previous years.
- There remains under reporting of sharps incidents when compared with Occupational Health referrals.
- There was a 24% increase in falls harm incidents when compared with injuries in 2018/19, but a 5% decrease in the number of incidents.
- There has been an increase of 43% in moving and handling harm incidents when compared with previous injury rates. Better reporting of these types of incidents is a factor and a Moving and Handling Advisor was appointed in 2019/20.

Health and Safety Executive

HSE will not undertake proactive inspections or visits to health care organisations at the same frequency as higher risk industries. However, they will undertake proactive inspections in line with their own strategy and reactive visits based on intelligence.

2. Introduction

The Health and Safety Executive (HSE) advised the Board in 2012 that they should lead on health and safety and set the agenda. This performance report is to allow the Board to discuss health and safety and lead the strategy moving forward.

Health and Safety legislation requires the Trust Board to control the health and safety risks to their employees and others not in their employment. “Others” refers to contractors, volunteers, visitors and includes patients, and it is patients who generally suffer most harm in a clinical environment. There are numerous standards, requirements and bodies whose key role is to protect the safety of patients. This report and strategy will focus on the staff safety, which, in turn, is a key element of patient safety.

Staff, contractor and visitor incident statistics make up 18.7% of the total incidents reported. This group, however, make up 25% of the total incidents of harm. These have been divided into groups based on severity:

- Deaths to employees, contractors and visitors (deaths at work).
- Incidents and Injuries reportable to the HSE under the “Reporting of Injuries, Diseases and dangerous Occurrences’ Regulations 2013” (RIDDOR).
- All staff and visitor injuries.

The injuries have been divided into 7 types based on the categories used by the HSE in their national statistics. 96% of the total incidents of harm fit into these categories. This allows for bench marking against all industry and the health sector:

- Falls (staff and visitor slips, trips and falls)
- Medical Sharps (needle stick injuries)
- Violence and abuse (includes physical assault and trauma).
- Struck by or collision with an object
- Moving and handling
- Contact with machinery and hot surface (includes hot liquids)
- Contact with a hazardous substance (includes biological agents)

Reporting rates are important as a reduction in injuries could be a result of improving standards or reduced reporting.

The Trust has an Occupational Health Service that undertakes health surveillance on staff to identify or prevent occupational diseases if they arise from employees work. They maintain records of referral of staff for workplace illness.

3. Review of Objectives and Programme set for 2019/20

In September 2019 the Trust Board agreed a programme for 2019/20:

Action	Leads	Progress and Comments
Health and Safety Management		
Improve the H&S audit systems in place to include active monitoring of compliance and review reminders to managers	Head of Fire and Safety	Synbiotix is still currently in use. However, the Risk Module on Datix can record the required information and allows for better active monitoring. Roll out of the move to Datix delayed due to COVID-19.
Reduce the number of incidents and RIDDOR involving doors through improved awareness, reporting and	Head of Fire, and Safety / Estates	There has been a decrease in RIDDOR incidents from five in 2018/19 to three in 2019/20 (two >7 day injuries, one

Action	Leads	Progress and Comments
monitoring.	Compliance Officer	specified injury)
Raise awareness to increase accuracy of incident reporting and quality of investigations for staff/Trust/Public incidents	Head of Fire and Safety / Risk and Compliance Manager	Ongoing monitoring of incidents and investigations prior to final approval takes place. Incident investigation training has been provided by the Patient Safety Team.
Promotion of revised risk assessment policy and procedure including changes to risk grading matrix and risk assessment documentation	Risk and Compliance Manager	The changes were made and advertised and Risk Leads, Risk Assessors and relevant managers have been made aware of the changes.
Roll out of Datix IQ Cloud incident reporting	Interim Datix Project Manager	Datix IQ Cloud incident reporting was not rolled out, with the Trust remaining with Datix Web. However, the Trust does now have the Datix Web Risk module.
Falls		
Continue with awareness and training to further reduce staff falls. Falls Prevention Awareness Week 23-29 September to promote falls prevention for patients and staff.	Falls Prevention Practitioner / Risk and Compliance Manager / Head of Fire and Safety	Falls prevention training sessions and Health and Safety awareness training and updates sessions provided to staff to raise awareness. Falls Prevention Awareness week with information stands at Maidstone Hospital and Tunbridge Wells Hospital to promote falls prevention awareness to staff and members of the public and patients.
Slip, trip and falls incidents involving members of public. Investigations into incidents to be carried out by Head of Fire, Safety and Compliance wherever possible.	Head of Fire and Safety	Head of Fire, Safety and Environment has taken lead in investigating these types of incidents wherever possible. There was no RIDDOR incident involving members of the public and nine for staff members in 2019/20. Review of incidents report and identification of any early emerging trends to then take action to reduce the risk of recurrence.
Environmental Hazards to be reviewed annually by departments and wards.	Department/ ward Manager	Hazard Profile checklist should be completed annually in all departments and other relevant risk assessments reviewed periodically.
Radiation Protection		
Control of Electromagnetic Fields at Work Regulations 2016	Radiation Protection Advisor/ EME and Technical Services Manager	The last phase of the project has continued to carry out more detailed assessments on the remaining small number of generic equipment types which have not been assessed.
Continued compliance with revised legislation: The Ionising Radiations	Radiation Protection	An action plan has been developed and is being monitored and is progressing.

Action	Leads	Progress and Comments
Regulations 2017 and The Ionising Radiation (Medical Exposure) Regulations 2018	Advisor	Compliance with the previous regulations leads to compliance with much of the new regulation.
Violence and abuse		
Produce business case for funding for additional security officers	Security and Car Parks Manager	Ongoing with the objective of increasing security numbers from 3 to 5.
CCTV has been placed on the risk register for MGH and TWH	Security and Car Parks Manager	Business case is in the development stage to be submitted to Trust Board for approval.
To continue with the education of the security team in relation to dementia, learning disabilities, MHA and MCA	Security and Car Parks Manager and Corps of Security	All CORPS security staff will be placed on the mandatory training matrix following approval by CORPS Security as they are the employer.
Moving and Handling		
External provider to review status of moving and handling assessments and training provision before Moving and Handling objectives can be set	External moving and handling provider	A Moving and Handling Advisor has been appointed, the new advisor will be completing these instead of an external provider. These were started by the external provider and the worked together with the Moving and Handling Advisor to complete them. They are now being prepared for ratification. Training provision has been reviewed and a new plan is being developed.
Sharps		
The Safety, Health and Risk Advisory Group (SHRAG) will investigate strategies to change staff attitude and the embedded medical sharps culture	Head of Fire and Safety	The Safety, Health and Risk Advisory Group (SHRAG) has taken on this work.
Continue to review new safety devices in the market place across the Trust.	Vascular Access Specialist Practitioners (VASPs)	Responded to Medical Device Field Safety Notice in July 2019 regarding Gripper Needle occlusions. Action taken – effected Batch and Lot no's identified and removed from stock.
Continue to respond to learning obtained from the analysis of reported injury data and to provide appropriate training updates as required	Vascular Access Specialist Practitioners (VASPs)	Investigations into sharps/splash incidents are not always carried out with uniform rigor and can focus on actions taken after the incident rather than root cause of the incident. VASPs monitor incident reports and investigate where possible, time constraints permitting.
Occupational Health		
Raise awareness and encourage staff and their managers to report work related stress and other ill health events through Datix.	Occupational Health Manager / Head of Fire and Safety / Risk and	OH is in the process of recruiting 2 mental health practitioners. It is expected they will run stress awareness workshops; undertake some reactive de-briefs for traumatic events and see staff within OH department for

Action	Leads	Progress and Comments
	Compliance Manager	stress support and other mental health issues
Review and raise awareness of risk assessments that do or could identify the need for health surveillance	Occupational Health Manager	Discussions with department managers have continued alongside workplace visits to review and risk assess current working practices and hazard avoidance / removal processes. This has helped identify the need for continued surveillance and on which staff require it.
Reduce the gap between sharps / splash injuries reported on DATIX and the OH system.	Occupational Health Manager	Members of staff encouraged to report during statutory and mandatory training and OH attendance.

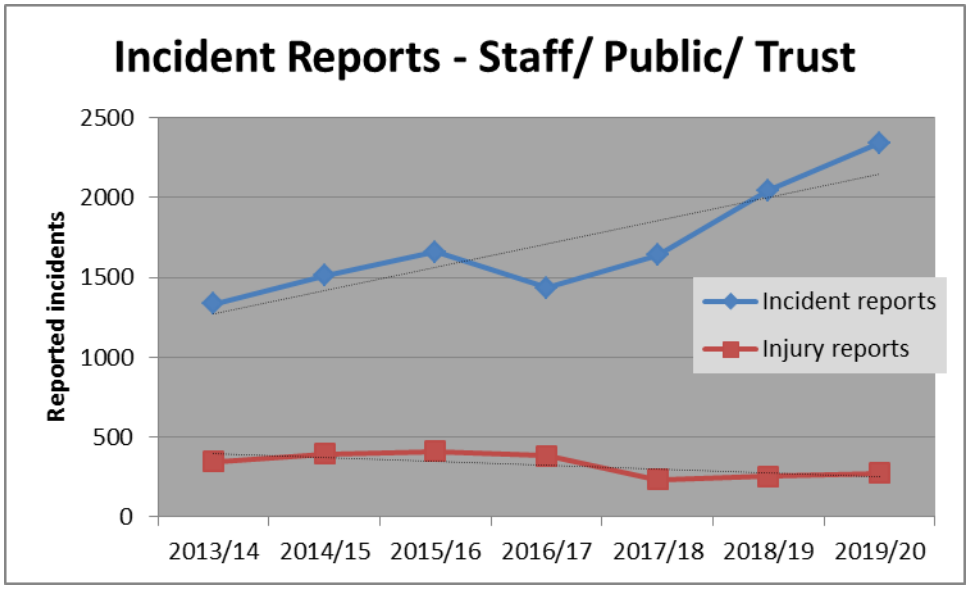
4. Statistics for 2019/20

The Datix incident database was interrogated for all non-patient incidents for the period of 01/04/19-31/03/20.

4.1. Reporting

There were 2343 staff/ public/ Trust incidents reported in 2019/20. This is a 14.5% increase from 2047 the previous year.

The ratio of reports to injuries has increased to approximately 8.5 reports for every injury from 8 reports per injury in 2018/19.



In order to compile Health and Safety statistics for the Health and Safety Committee, an analysis of incident descriptions is undertaken each month. The overall number of injury reports for 2019/20 is based on this analysis. The total number of staff/ public/ Trust injuries reported increased by 9% from 253 to 276.

4.2. Injuries/ Harm Incidents

The data for 2019/20 has been compared with the data from the previous 4 years.

The Trust submitted 24 RIDDOR reports in the year at an average of 2 per month. This is a slight decrease from 26 the previous year. 62.5% were submitted within HSE timescales, which is a decrease from 69% in 2018/19 and remains a concern. The proportion of over 7 day injuries remains high which has had an effect on the percentage of reports submitted within HSE timescales.

RIDDOR Category	Year reported				
	2015/16	2016/17	2017/18	2018/19	2019/20
7 Day injury	16	20	16	15	17
Specified injury	10	14	3	5	5
Dangerous occurrences	1	3	4	6	2
Accidental death	0	0	1	0	0
	27	**37**	**24**	**26**	**24**

The increase in overall reporting rates (14.5%) is greater than the increase in injury rates at 9%. When directly health and safety-related incidents are isolated there has been a decrease of 5.7% in the number of incidents reported. These figures would suggest a more significant increase in the reporting of non-health and safety-related incidents.

71% of RIDDOR reports were over 7 day injuries. Of these 17 incidents five were primarily caused by moving and handling (two during patient handling, three non-patient handling), three were as a result of violence and aggression, three were caused by slips, trips and falls (two slips, one fall from chair), three as a result of being struck by something, two traps in doors, with the other incident caused by a member of staff hitting their head against something.

There has been no change in the number of specified injuries, with five. All were fractures, with three as a result of slips, trips and falls, one as a result of being struck by a door and one suffered during an assault. There were no RIDDOR incidents involving members of the public, compared with one in 2018/19.

There has been a decrease in the number of dangerous occurrences from six in 2018/19 to two. Both of these dangerous occurrences were sharps incidents reported as exposure to known blood borne virus (BBV).

4.3. Categories of incidents resulting in injury / Harm

Due to a change in the way outcomes are recorded on Datix as levels of harm, injury data (i.e. injury? Y/N) is no longer captured, with some very minor injuries recorded as ‘No Harm’, in line with ‘insignificant’ on the risk grading matrix, and other non-injury events recorded as ‘Harm’. For example, a very minor injury requiring no first aid attention may be reported as ‘No Harm’, whereas significant damage to a piece of equipment will be reported as ‘Harm’. This has led to an increase in ‘Harm’ incidents in most categories when compared with previous years’ injury rates.

The eight largest categories make up approximately 96% of all directly health and safety-related harm incidents. All but one of these categories has seen an increase.

	2018/19 (injuries)	2019/20 (Harm)	% of total	Change
Falls	45	56	18%	+24%
Sharps (medical)	58	65	21%	+12%
Violence, abuse and harassment	57	75	24%	+32%
Collision, trap or struck by an object	33	34	11%	+3%
Moving and handling	30	43	13%	+43%
Contact with machinery or hot surface	5	3	1%	-40%
Contact with hazardous substance	5	10	3%	+100%
Cuts non-medical sharps	14	20	6%	+43%
Others	4	13	4%	+225%
	251	**319**		

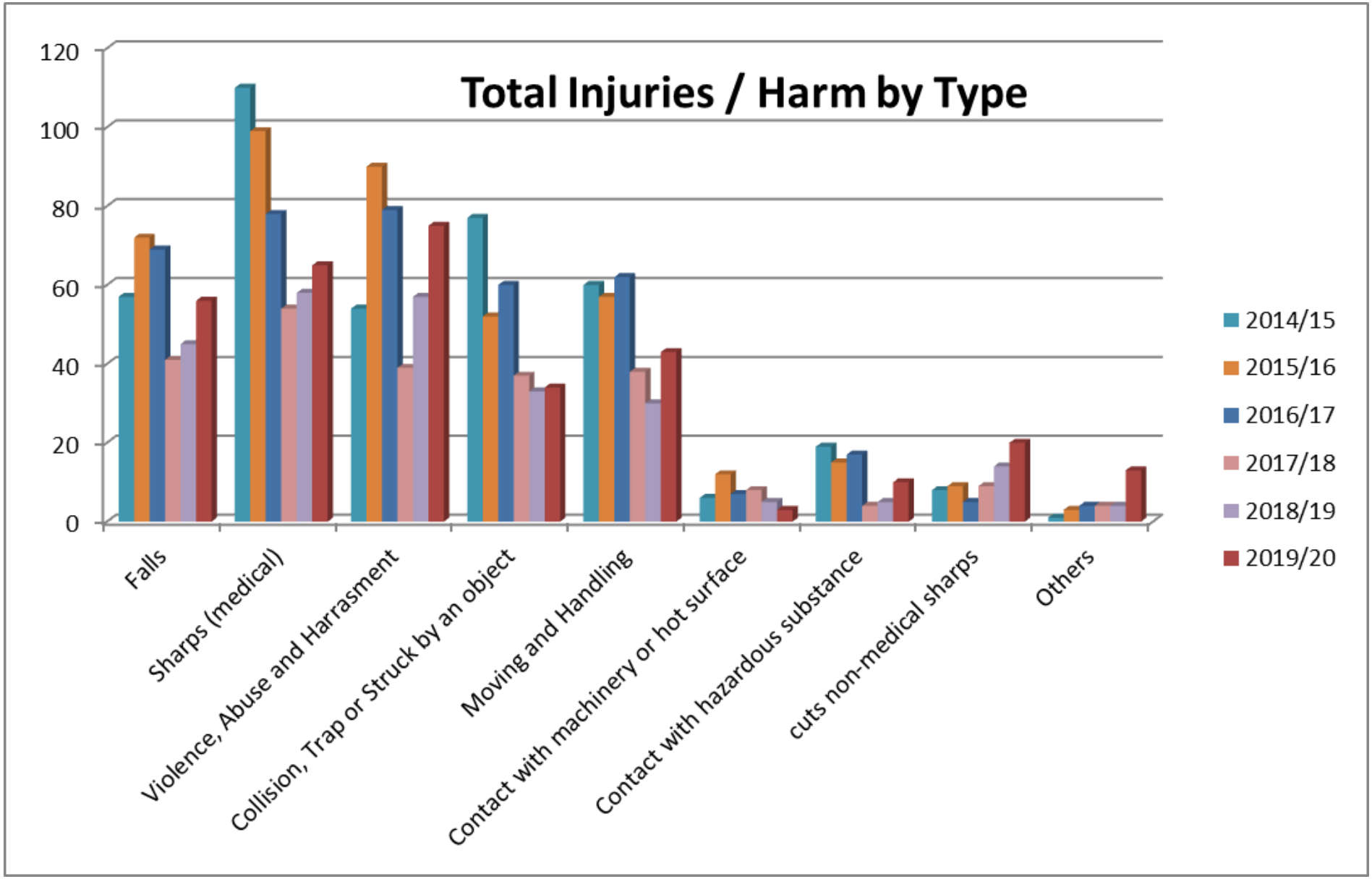
More detailed analysis is given in **Section 6** below.

Of the top five categories, the largest increase by type is harm as a result of moving and handling (+43%). While the overall number of incidents is down by 15% when compared with last year, incidents of harm caused by violence, abuse and harassment have increased by 32%. Please note this figure does not include incidents of harm caused by verbal abuse, focusing on physical assaults to allow for closer comparison with previous years. There were still significant increases in falls (+24%) and sharps (+12%) injuries. Incidents of collision, trap etc. increased by the lowest rate of the top five categories at +6%.

The number of incidents categorised as ‘Other’ trebled. Many of these ‘Other’ incidents of harm would not have resulted in injury and therefore not been included in previous years’ reports.

There remains a discrepancy between sharps injuries reported and occupational health attendances (see 6.4.3 below).

The chart below compares 2019/20 incidents of Harm by type with injuries in the previous five years:


Total Injuries / Harm by Type
120
100
80
60
40
20
0
Falls
Sharps (medical)
Violence, Abuse and Harrasment
Collision, Trap or Struck by an object
Moving and Handling
Contact with machinery or hot surface
Contact with hazardous substance
cuts non-medical sharps
Others
2014/15
2015/16
2016/17
2017/18
2018/19
2019/20

4.4. Injuries by Division and Directorate

The table below shows incidents of harm by directorate/ specialty:

Division	Directorate	Falls	Sharps (medical)	Violence, abuse and harassment*	Collision, trap or struck by an object	Moving and handling	Contact with machinery or hot surface	Contact with hazardous substances	Cuts non-medical sharps	Others	Total Incidents of Harm
Cancer Services	Haematology	1	2	1							4
	Oncology	3	3	1		2			4		13
	Outpatients	1	2	1	2	1			1	1	9
		5	**7**	**3**	**2**	**3**			**5**	**1**	**26**
Corporate Services	Corporate								3		3
	Clinical Governance	1						1			2
	Decontamination							1			1
	Estates	5		1	4	1	1		1		13
	Facilities	8	1	5	5	7	1	2	1	4	34
	Finance	2			1	1					4
	Information Technology	2			1	2			1		6
	Nursing	1			1	1					3
	Workforce				2						2
		19	**1**	**6**	**14**	**12**	**2**	**4**	**6**	**4**	**68**

Division	Directorate	Falls	Sharps (medical)	Violence, abuse and harassment*	Collision, trap or struck by an object	Moving and handling	Contact with machinery or hot surface	Contact with hazardous substances	Cuts non-medical sharps	Others	Total Incidents of Harm
Diagnostic and Clinical Support Services	Imaging	2	3	1	1	4		1	1		13
	Pathology	2	6	3	3	1			1		16
	Pharmacy	1									1
	Therapies	3	1	1		4					9
		8	**10**	**5**	**4**	**9**		**1**	**2**		**39**
Medicines and Emergency Care	Acute Medicines and Geriatrics	1	4	36	2	4	1	2		1	51
	Emergency Medicine	6	3	10		1		1	1	2	24
	Medical Specialties	2	8	13	2	2			1		28
		9	**15**	**59**	**4**	**7**	**1**	**3**	**2**	**3**	**103**
Surgery	General Surgery	2	6	3	1			1			13
	Head and Neck		2		1	2					5
	Orthopaedics	1	5	6	1	2					15
	Surgical Specialties		1								1

Division	Directorate	Falls	Sharps (medical)	Violence, abuse and harassment*	Collision, trap or struck by an object	Moving and handling	Contact with machinery or hot surface	Contact with hazardous substances	Cuts non-medical sharps	Others	Total Incidents of Harm
	Theatres and Critical Care	6	10	3	1	6		1	1	5	33
	Urology etc.	1	2	1							4
		10	**26**	**13**	**4**	**10**		**2**	**1**	**5**	**71**
Women's Children's and Sexual Health	Children's Services	3	2	3	4	1			2		15
	Sexual Health								1		1
	Women's Services	2	4		2	1			1		10
		5	**6**	**3**	**6**	**2**			**4**		**26**
	Totals	**56**	**65**	**89***	**34**	**43**	**3**	**10**	**20**	**13**	333

*This figure includes incidents of verbal abuse which resulted in harm.

The size of the respective divisions and directorates and the activities undertaken has a clear influence on the number and nature of injuries that occur.

- While the overall figure has risen, the Medicines and Emergency Care Division accounted for two thirds of incidents of harm from violence, abuse and harassment, slightly down from 69.4% of total injuries in 2018/19. Acute Medicines and Geriatrics had by far the most these types of harm incidents with 40.4% of the total. This compares with 36.8% of injuries in 2018/19. Emergency Medicine actually saw an overall reduction from 14 injuries in 2018/19 to 10 harm incidents in 2019/20.

- The Surgery Division had the most sharps harm incidents, with 40% of the total (this was 37.9% of injuries in 2018/19). Theatres and Critical Care is the Directorate with the most Sharps incidents.
- Slips, trips and falls harm incidents were reported by most directorates. Corporate Services reported around a third (33.9%) of the total, with Facilities (8) the directorate with the highest number.
- Similarly most directorates have reported moving and handling harm incidents and overall numbers have increased when compared with injuries in 2018/19, from 30 to 43 in 2019/20. Facilities (7) and Theatres and Critical Care (6) had the most.
- Although incidents of harm and injuries cannot be directly compared, the Facilities Directorate went from 10 injuries in 2018/19 to 34 incidents of harm in 2019/20, with significant increases in most categories.

These figures are discussed in more detail in **Section 6** below.

5. Benchmarking

The HSE uses accident rates to compare organisations. One measure is the number of RIDDOR reportable incidents per 100,000 employees. The HSE publish data for the health sector and for all industries. Data is based on total employee numbers rather than whole time equivalents.

	RIDDOR rate per 100,000 employees
All industries (2018/19)	254
Human health and social work (2018/19)	310
MTW 2013/14	232
MTW 2014/15	329
MTW 2015/16	324
MTW 2016/17	479
MTW 2017/18	358
MTW 2018/19	370
MTW 2019/20	**329**

There has been a decrease in the Trust RIDDOR rate per 100,000. The CCG has set risk levels; rates of <600 are rated as green, 600 to 660 as amber and >660 as red. **MTW is rated as green.**

Further comparison data was obtained from other local trusts. The Healthcare Risk Management Group (HRMG) has members from many trusts in the South East.

Type of Trust	**Total RIDDORs**	**Employees**	**RIDDOR Rate (per 100,000 staff)**	
MTW	24	7297	**329**	2019/20
Health sector (HSE national data)			**310**	2018/19
Acute & Community NHS Trust	18	3860	**466**	2019/20
Acute & Community NHS Trust	10	4150	**241**	2019/20
Mental Health NHS Trust and Community Partnership Trust	21	3403	**617**	2019/20
Community Services Foundation Trust	17	5480	**310**	2019/20
Private Hospital	4	476	**840**	2019/20
Private Hospital	2	523	**382**	2019/20
HMRG Total	**96**	**25189**	**381**	2019/20

MTW's RIDDOR rate is slightly higher than the health sector average and lower than that of the HRMG. The variety of trusts providing data and the fact that no data was available from other acute NHS trusts makes direct comparison difficult, with the closest comparators the acute and community trusts. Benchmarking was only possible against organisations willing to share their data.

6. Key Health and Safety Areas

6.1 Falls

Falls account for 18% of staff/public/Trust incidents of harm, compared with 17.9% of injuries in 2018/19. The number of harm incidents from falls was 56. The overall number of slips, trips and falls incidents reported (including near misses and no harm incidents) decreased by 5% to 95.

Facilities is the directorate with the most slip, trip and fall injuries, with 8.

6 of the RIDDOR incidents were related to slips, trips and falls. Three of these were specified injuries and three >7 day injuries. Wet floors were a factor in three of the RIDDOR incidents. The management of wet floors, including during cleaning and following spillages and leaks is a key area and are reflected in the objectives for 2020/21 (see Section 9).

There were 26 incidents involving members of the public compared with 38 in the previous year. There weren't any RIDDOR incidents compared to one in 2018/19.

Falls prevention is a key patient safety agenda item for the Trust. There is therefore a need to continue to focus on management of environmental hazards in the work place.

6.2 Violence and Abuse

Harm incidents from violence, abuse and harassment account for 26.7% of the total, and is the highest single category. It remains the highest directly health and safety-related incident category by number of incidents. The number of incidents of violence, abuse and harassment reported (including near misses and no harm incidents) decreased by 15% to 269.

Two thirds of harm incidents take place in the Medicines and Emergency Care Division. Security presence in the Emergency Departments has contributed towards a decrease in the number of incidents in the Emergency Medicine Directorate.

The higher number of harm incidents in Acute Medicines and Geriatrics reflects the number of incidents where patient factors are a contributory factor.

The CCTV system at Maidstone has been expanded and covers a vast majority of the interior of the hospital and most of the entry/exit points as well as ANPR on all 3 routes in/out of the site. Proposal is being put together for expansion of the CCTV system at Maidstone to cover vulnerable areas and car parks and including a dedicated CCTV room. A proposal will be put forward to upgrade the CCTV at Tunbridge Wells.

A proposal will be put together to increase the security staff from three to five at each site to allow for better evidence/corroboration, officer safety, response times and a permanent CCTV operator.

Body Worn Video (BWV) for security staff is being trialled at both sites and it is highly likely it will become permanent. In addition, body armour is being purchased for all regular security staff at both sites. The Security and Car Parks Manager is also looking to trial a more discrete version of BWV for staff in ED.

The Security and Car Parks Manager is looking to be trained as a conflict resolution trainer to initially assist in its delivery, with the aim of taking over delivery to keep it in house.

6.3 Moving and Handling

Moving and handling-related incidents account for around 13% of staff incidents of harm. There was an increase of 43% when compared with injuries from last year. Six RIDDOR incidents were related to moving and handling activities, and this trend has continued into 2020/21, particularly >7 day injuries.

In 2019/20 a Moving and Handling Advisor was appointed and they have been reviewing Trust Policies and Procedures and existing risk assessments and safe systems of work with an external training provider. Bespoke training for specific staff groups has also been developed and the Moving and Handling Advisor has also been encouraging incident reporting as it was felt that under reporting had been taking place in the absence of in house specialist support.

6.4 Sharps/ splash

6.4.1. Medical sharps

Harm incidents from medical sharps increased by 12% when compared to injuries from sharps in the previous year, from 58 to 65. The overall number of reported incidents (including near misses and those recorded as no obvious harm) decreased by 6% to 105.

In 2018/19 there were six RIDDOR reportable sharps/ splash dangerous occurrences. In 2019/20 there were two, both needle stick injuries. To date there has been no HSE follow up on these incidents.

A medical device Field Safety Notice was issued in July 2019 regarding Gripper Needle occlusions. The effected batch and lot numbers were identified and removed from stock. There have been no other sharps related equipment issues. The VASPs will continue to monitor and respond to issues raised.

The SHRAG has discussed sharps/splash incidents not being investigated with uniform rigor. The VASPs have monitored Datix sharps reports and investigated these incidents where time constraints allow.

6.4.2 Eye Splash Injury

While only two harm incidents were reported, there were 20 eye splash incidents in the Trust including near misses and those recorded as ‘No obvious harm’, a decrease from the 18 eye splash incidents reported in 2018/19. There weren’t any ‘splash’ incidents reportable under RIDDOR due to exposure to known BBV, compared with three in 2018/19.

6.4.3 Sharps Injury Comparisons

Occupational Health reported that 148 staff had been referred following sharps injury. This was compared against Datix incidents of ‘dirty sharps’ (i.e. not clean sharps, so potential for contamination) incidents (see table below):

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Datix 'Dirty sharps' incidents	6	5	6	5	13	7	9	11	4	2	6	4	**78**
OH attendances	16	11	8	15	17	13	11	20	9	9	12	7	**148**

There were 78 'dirty sharps' incidents involving staff reported on Datix by incident date. While miss-categorisation may account for some of this difference, the disparity from previous years remains and may even have increased in 2019/20. Further vigilance and education is required on the need to report sharps incidents.

6.5 Collisions, Traps or Struck by and Object

These incidents occur when staff move around the workplace. It can be indicative of cramped conditions, bad housekeeping and rushing around and are often associated with moving and handling activities. In 2018/19 there were 33 injuries. This year there were 34 harm incidents which, although a 3% increase when compared to 2018/19 injuries, is less of an increase than most other incident categories.

There has been a decrease in RIDDOR incidents from five in 2018/19 to three in 2019/20 (two >7 day injuries, one specified injury). Communications have been published to highlight the hazard and need for continued vigilance and prompt reporting of defects.

6.6 Machinery, Hot Surfaces and Fluids

Burn/scald injuries have decreased, with three harm incidents compared with five injuries in 2018/19.

7. Health and Safety Executive Inspections and Investigations in 2019/20

7.1 Trust Inspection

The CQC have taken over much of the day to day enforcement responsibility from the HSE for health and social care activities. RIDDOR reports are passed on to the CQC from the HSE.

There has been a gradual decline in the number of prosecutions of NHS Trusts and these have been limited to clear and significant health and safety breaches as well as breaches which occurred before the implementation of the memorandum of understanding with the CQC.

They will however undertake a limited number of inspections of NHS Trusts across the region with the focus on moving and handling practices and management of violence and aggression in line with their priorities and sector plans (see 7.2 below).

They may also undertake reactive visits based on intelligence. These include:

- RIDDOR incidents
- Reports from other agencies such as CQC, MHRA, Environment Agency etc.
- Whistle blowing

In October 2019 similar guidelines to those which led to a significant increase in fines for health and safety-related offences from 2016 were applied to CQC cases. As a result recent successful CQC prosecutions have seen higher levels of fines for organisations.

7.2 HSE Objectives for 2020/21

Across all sectors the HSE's objectives for 2020/21 are to:

- Lead and engage with others to improve workplace health and safety
- Provide an effective regulatory framework
- Secure effective management and control of risk
- Reduce the likelihood of low frequency, high impact catastrophic events

In the public sector the HSE will lead and engage with others to improve workplace health and safety by:

- Applying the Stress Management Standards through carrying out pilot exercises in healthcare, education, prisons and other parts of the public sector;
- Re-energising the control measures for tackling musculoskeletal disorders in healthcare and identifying any emerging issues and solutions;
- Challenging, at a strategic level, ambulance services' performance in reducing MSDs;
- Providing direction and guidance to key stakeholders in health and social care on the management of violence and aggression in the workplace;
- Maintaining existing relationships with influential stakeholders and groups and making new ones where this can improve our understanding of and influence on the sector, particularly in relation to changing structures of service provision.

Therefore the HSE's priorities in healthcare remain stress, moving and handling and violence and aggression.

8 Summary and Conclusions

- Specific objectives have been completed from 2019/20, though there remain a number of areas where ongoing objectives have been carried over.
- Overall reporting rates have increased by 14.5% compared with 2018/19.
- Injury rates have increased by 9% and the number of incidents reported under RIDDOR decreased from 26 in 2018/19 to 24 in 2019/20.
- A change to the way Datix records injuries to encompass incidents of 'harm' made direct comparison with previous years data more difficult. As a result most incident categories saw a significant increase in harm incidents.
- Violence, aggression and harassment incidents were the most common type of health and safety-related incidents. There was an overall 15% decrease in these incidents, though there was a 32% increase in comparable harm incidents to injuries that occurred in 2018/19.
- Sharps harm incidents increased by 21% compared with injuries in 2018/19. There were fewer RIDDOR reportable dangerous occurrences from exposure to known blood borne viruses (BBV) than in previous years.
- There remains under reporting of sharps incidents when compared with Occupational Health referrals.

- There was a 24% increase in falls harm incidents when compared with injuries in 2018/19, but a 5% decrease in the number of incidents.
- There has been an increase of 43% in moving and handling harm incidents when compared with previous injury rates. Better reporting of these types of incidents is a factor and a Moving and Handling Advisor was appointed in 2019/20.

9 Objectives for 2019/20

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPI's
Health and Safety Management (Head of Fire, Safety and Compliance)					
Improve the H&S audit systems in place to include active monitoring of compliance and review reminders to managers	Synbiotix system is no longer fit for purpose and therefore the H&S audit system will be migrated to Datix.	Head of Fire & Safety	Risk and Compliance Manager	Progress will be monitored by lead and reported to the H&S committee.	Minimum of 75% compliance with aspiration towards 85% - 90%. This takes into consideration that this will be major revision of system.
Roll out of Datix reporting H&S Audit	Roll out of H&S audit recording on Datix over the next 6 months	Risk and Compliance Manager	Head of Fire & Safety and Risk Leads.	Active monitoring and regular reporting on Risk Assessments	Increase in visibility of H&S audit progression across the Trust.
Reduce the number of incidents and RIDDOR involving slips, trips and falls through improved awareness, reporting and monitoring.	Awareness campaign to reinforce wet floor signage following routine cleaning and after liquid spills.	Head of Fire & Safety	Quality & Technical Manager	Active monitoring and monthly review of incidents	Reduction by at least 25% of injury and RIDDOR rates for incidents involving slips, trips and falls involving wet or damaged flooring.
	Scheduled audit programme of hospital corridors to be in place by 01/01/2021.	Compliance Officer (Estates)	Statutory Compliance Manager	Audit findings	Audits completed as per plan.
Raise awareness to increase accuracy of incident reporting and quality of investigations for staff/Trust/Public incidents	Include specific section on incident reporting as part of statutory and mandatory training.	Risk and Compliance Manager / Head of Fire & Safety	Patient Safety Team	Active monitoring when reviewed and before final approval	Reduction in % of incidents sent back to handler to be reviewed Qualitative judgement on accuracy and quality of

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPI's
					incident reports and investigations
Reduce number of RIDDOR reports submitted outside of HSE timescales	For the last 2 years reports to the HSE within timescales has been between 55%-70% this is unacceptable.	Head of Fire & Safety/Risk and Compliance Manager	Area Managers and Supervisors.	Review of RIDDOR incidents on database.	Increase reporting within timescales to 85%
Falls (Falls Prevention Practitioner)					
Focus work to improve multifactorial risk assessment for patients at risk of falls	April 2020- March 2021	Lead Nurse for Falls Prevention;	Practice Development Nurses; Clinical Skills Facilitator and Ward Managers	Slips, Trips and Falls Group	Continue with awareness and training to further reduce staff falls.
Continue with awareness and training to further reduce staff falls. Promote Falls Prevention- participate in Falls Awareness Week (21st to 28th September 2020)	April 2020- March 2021 21st to 28th September 2020	Risk and Compliance Manager/ Head of Fire, Safety and Environment/ Lead Nurse for Falls Prevention Lead Nurse for Falls Prevention	Divisional Leads Link Nurses for Falls Prevention	Health and Safety Committee Slips, Trips and Falls Group	Objective measure of investigation quality
Environmental Hazards to be reviewed annually by departments and wards	April 2020- March 2021	Departmental/Ward Manager	Directorate leads	Slips, Trips and Falls Group	Hazard profile checklist completion and relevant risk assessment in place.
Violence and abuse (Trust Security Manager)					

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPI's
Produce business case for funding for additional security officers	Lack of security personnel leaves the Trust vulnerable, monitoring upturn of issues of violence and aggression.	Trust Security Manager	Associate Director Facilities	Progress will be monitored by lead and reported to the H&S committee.	Ongoing with the objective of increasing security numbers from 3 to 5.
CCTV has been placed on the risk register for MGH and TWH	Business case is in the development stage to be submitted to Trust Board for approval.. April 2020. Business case submitted	Trust Security Manager	Director of E and F	Progress will be monitored by lead and reported to the H&S committee.	CCTV Upgraded and installed in key identified areas of weakness.
To continue with the education of the security team in relation to dementia, learning disabilities, MHA and MCA	Security staff to be placed on Trust mandatory training matrix	Trust Security Manager and Corps of Security	CORPS Security	Progress will be monitored by lead and reported to the H&S committee.	All security staff annually up to date with mandatory Trust training.
Moving and Handling					
Develop a new training plan for moving and handling that will incorporate a more specific pathway for different areas, including bespoke training and support the monitoring of competencies	Develop by End of Sept 2020 Launch fully by Jan 2021	Moving and Handling Advisor	Lead Nurse for Falls Prevention; Learning and Development Team	Evaluations Feedback Attendance Competencies	Compliance improved for Moving and Handling training; Improved work practices, better use of equipment and problem solving based on qualitative judgement by Trust specialists.
Review moving and handling equipment and resources within the Trust	Ongoing	Moving and Handling Advisor	Medical Device Trainer/Co-ordinator; EME Services Manager	Datix reports Feedback from staff Medical Devices Group	Quarterly audit completion rates; Reduction in related moving and handling incident reports on Datix.

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPI's
				Health & Safety Committee	
Review the standard operating procedures and risk assessments for moving and handling	By the end of Dec 2020	Moving and Handling Advisor	Lead Nurse for Falls Prevention; Trust Managers	Datix reports Feedback from staff	Improved work practices based on qualitative judgement by Trust specialists.
Sharps/Splash (Safety, Health and Risk Advisory Group)					
The Safety, Health and Risk Advisory Group (SHRAG) will investigate strategies to change staff attitude and the embedded medical sharps culture	Throughout the year	Head of Fire and Safety	SHRAG members	SHRAG will report to the H&S Committee	Decrease incidents of Harm from sharps injuries. Improvement in quality of investigations based on qualitative assessment.
Continue to review new safety devices in the market place across the Trust.	Ongoing in 2020/21	Vascular Access Specialist Practitioner	Procurement	The VASP will continue to report issues or concerns to the SHRAG and Medical Devices Committee	Compliance with the H&S (Sharp Instruments in Healthcare) Regulations 2013.
Continue to respond to learning obtained from the analysis of reported injury data and to provide appropriate training updates as required	Complete in 2020/21	Vascular Access Specialist Practitioner	Health Safety and Risk Leads	The VASP will continue to report issues or concerns to the SHRAG	Reduce injuries as a result of lack of training
Radiation Protection					
Improve resilience in radiation protection for non-ionising radiations – ultrasound and lasers.	August 2021	Head of Radiation Physics	Risk and Compliance Manager	Progress will be monitored by lead and reported to the H&S committee	1) Ultrasound lead is in position and trained 2) Laser protection audit team has at least 3 fully trained

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPI's
					members
Occupational Health (Occupational Health Manager)					
Raise awareness and encourage staff and their managers to report work related stress and other ill health events through Datix.	Continue throughout 2020/21	Occupational Health Manager / Head of Fire, Safety and Environment / Risk and Compliance Manager	Occupational Health Department, including Mental Health Practitioners	Reported to H&S Committee via Occupational health report.	Comparison of numbers referred to numbers reported.
Review and raise awareness of risk assessments that do or could identify the need for health surveillance	Continue throughout 2020/21, review previous assessments	Occupational Health Manager	Risk Leads and Risk and Compliance Manager	Reported to H&S Committee via Occupational health report.	New job roles / practices identified for health surveillance or PPE / risk avoidance where possible.
Reduce the gap between sharps / splash injuries reported on DATIX and the OH system.	Continue throughout 2020/21	Occupational Health Manager	Risk Leads; Head of Fire, Safety and Environment / Risk and Compliance Manager	Reported to H&S Committee via OH reporting and DATIX reports.	Significant increase in the numbers reporting on Datix that also attend OH.
Review Latex Policy and Procedure	New version of Latex Policy and Procedure to be ratified and published by end of 20/21	Occupational Health Manager	Occupational Health Department; Other relevant departments	Reported to H&S Committee via Policy List produced by Risk and Compliance Manager	New version of Latex Policy and Procedure to be ratified and published by end of 20/21

Appendix A

2020/21 Training update - What does the Board need to know?

1. Health and safety

1.1. Health and safety law places duties on organisations and employers, and directors can be personally liable when these duties are breached – members of the board have both collective and individual responsibility for health and safety.

1.2. Addressing health and safety offers significant opportunities, including:

1.2.1. Reduced costs and reduced risks – employee absence and turnover rates are lower, accidents are fewer, the threat of legal action is lessened;

1.2.2. Increased productivity – employees are healthier, happier and better motivated.

1.3. Safety-I and Safety-II

1.3.1. Most think of safety as the absence of accidents or incidents (or an acceptable level of risk) (Hollnagel et al, 2015). From this perspective, which has been termed **Safety-I,** "as few things as possible go wrong". When things do go wrong failures or malfunctions of specific components, such as equipment, procedures, workers and the organisation itself are identified. A chain of immediate, underlying and root causes are identified and eliminated or controlled. The approach can be seen as simplistic, linear – one thing leads to another in the chain(s) of causation – and bimodal – if something has gone wrong, then it needs to be, and can be, fixed (Hollnagel et al, 2015).

1.3.2. In this report, the statistics are largely based on things that have gone wrong, been reported and what is going to be done about them. Objectives look to reduce the number of incidents, improve compliance and raise awareness where it is perceived to be lacking because of what negative outcomes have occurred or what positive outcomes haven't. It takes a largely Safety-I approach.

1.3.3. The Safety-I approach does not consider why human performance practically always goes right.

1.3.4. **Safety-II** (or Safety Differently), on the other hand, is defined as "as many things as possible go right (under varying conditions)". A simplistic, bimodal approach would view human performance as something that can go wrong and can be fixed. According to Safety-II as work practices have become more complex and unpredictable, some degree of variability, flexibility, or adaptiveness are required for the system to work (Hollnagel et al, 2015).

Performance adjustments and variability are therefore both normal and necessary, and a reason for acceptable and unacceptable outcomes.

1.3.5. Indeed, in unpredictable and unprecedented times, the need for workers to become adaptive and flexible in a rapidly changing environment becomes clearer. Learning from what has gone right in these conditions will help form safer, more effective practice.

1.3.6. There are, however, disadvantages of taking a wholly Safety-II stance. Where organisations have done so, some have seen incident and fatality rates increase, sometimes by significant amounts (Cooper, 2020). A change in philosophy is required for some (Green, 2020), while certain, more process driven work systems, where there is less variability, would need to take a Safety-I view in the majority of instances.

1.3.7. In practice a balanced approach is required and learning from what has gone right (under varying conditions) should be applied to risk, health and safety management in the same way as learning from what, on certain occasions, hasn't. In addition, what, in the majority of cases, has gone exactly as expected (Green, 2020). Application of good practice and innovation (Safety-II) to other departments, directorates and divisions must continue to take place in the same way that learning from incidents (Safety-I) should be shared across the Trust.

1.4. Healthcare prosecutions 2019/20

1.4.1. The number of prosecutions of NHS Trusts has decreased since the CQC has become the primary enforcement agency for health and safety offences in health and social care. Therefore the table below includes some private health and social care organisations.

Date	Organisation	Incident date(s)	Incident(s)	Penalty	Prosecuted by	Learning
April 2019	The Priory Group (Private mental healthcare company)	November 2012	14 year old found unresponsive with a ligature in locked room	£300k + £66k costs	HSE	Failure to carry out suitable and sufficient ligature risk assessment and training in life support.
June 2019	Sussex Partnership Trust	February 2016	Took place in healthcare unit at HMP Lewes. Patient committed suicide, tying bed sheets to sink taps as	£200k	HSE	Failed to provide same level of care as in community. Did not address a clear and well-documented risk.

Date	Organisation	Incident date(s)	Incident(s)	Penalty	Prosecuted by	Learning
			ligature			
October 2019	Bupa Care Homes	July 2015	Resident fell from toilet, where they were left having been given night sedation. Complained of pain and asked for xray but not taken to hospital until 5 days later	£100k + £23.5k costs	CQC	Had not been reassessed after several falls. As a result staff did not follow training. Delay in getting assistance.
November 2019	Nazareth Care Charitable Trust	May 2017	Resident fell down flight of six stairs, suffered a fractured skull and died	£40k	HSE	Stairs were only roped off. A lack of a physical barrier to control falls risk.
December 2019	Slieve Dhu Care Home	June 2016	Resident fell sustaining a serious head injury and died four weeks later	£12k		Care plan stated resident must have someone close when toileting. This had not happened on this occasion
December 2019	Derbyshire County Council – Grange Care Home	March 2016	Resident with dementia and history of falls fell and suffered multiple rib fractures and lung damage. Staff did not seek immediate medical advice.	£500k + £5k costs	CQC	Council's falls policy out of date, no falls assessment and controls not put in place. Staff shortages.

While the majority of the cases have not taken place in NHS acute trusts, the themes are patient/resident falls and the management of ligature risk, with risk assessment not undertaken and controls not followed. Whether the same kinds

of incidents could take place at MTW need to be considered and, if they could, the further mitigation that is required. If the Trust is assured that suitable and sufficient controls are in place then these need to be monitored and maintained.

1.4.2. In October 2019 new general sentencing guidelines where introduced which apply to CQC cases. They are similar to the guidelines have applied to the HSE since 2016 where guilty parties will get 1/3rd off their fine for an early guilty plea. The guidelines are also likely to see a significant increase in the size of fines, as has been found for health and safety offences prosecuted by the HSE since 2016.

2. Moving and Handling

The Policy and Procedure for the Moving and Handling of Patients and Loads has been reviewed by TCR, the external training and consultancy provider, and the new Moving and Handling advisor.

2.1. Training

Training in moving and handling is part of the statutory and mandatory programme and compliance can be monitored, but training alone is unlikely to reduce the risk. Practical training which is task-based and is in, or accurately simulates, the work environment has been found to be more effective in changing behaviour than technique or education-based training (Burke et al, 2006; HSE, 2007; McDermott et al, 2012). The HSE's new health priority plan for musculoskeletal disorders (MSDs) aims for a shift in emphasis away from manual handling training and up the hierarchy towards risk elimination or reduction through work design and organisation (Pinder, 2018).

A new training plan is being developed to incorporate a more robust work force. It will include training specific for different areas and staff teams throughout the Trust. There will be a mixture of eLearning to install the theory behind the practice and then practical sessions to allow staff to learn the safest way to move loads and patients. Staff will then be asked to complete competencies within in their areas of work. This allows the Trust to have a monitoring process of staffs skills and capabilities.

2.2. Risk assessment

Employers should apply the principles of avoid, assess, reduce, review with regards to moving and handling. They should avoid hazardous moving and handling as far as is reasonably practicable. Where it cannot be avoided then the task should be assessed and controls introduced to reduce the risk. Then these risks will be reviewed regularly to support the practice that is carried out.

The TILEE (TASK, INDIVIDUAL, LOAD, ENVIRONMENT, EQUIPMENT) acronym is well-known and is given in theory on most training courses and in most training packages. It

provides structure to both dynamic and formal risk assessments. The Trust's moving and handling risk assessments should consider these elements.

Competent advice and guidance as well as an ongoing strategy to ensure that ergonomic principles are applied and the organisation is responsive to developments in the field are needed. The fundamental requirement under health and safety law is to control reasonably foreseeable risks so far as is reasonably practicable. Therefore, the role of Moving and Handling Advisor was introduced in January. Within this role they will be supporting staff teams around the Trust to understand and react on the risks that are involved when completing moving and handling tasks, so therefore the risks can be mitigated.

With the Moving and Handling Advisor in place there has been an increase in incident and injury rates but that may be due to the encouragement of reporting more to support the observations and assessments being undertaken to improve practice and reduce risks. Rapid access to advice and guidance post incident is important to prevent recurrence. However, reducing the number and severity of incidents through effective proactive risk assessment before the incident can occur is what the law requires. Risk assessments will be reviewed and the Moving and handling advisor will support areas to make sure all staff are aware of their relevant risk assessments to support them in the daily tasks they are completing.

The Trust needs to remain vigilant to ensure its moving and handling risk control strategy, which is faced on a daily basis by a variety of staff groups, is fit for purpose and protects staff and patients. .

2.3. Incident management

In terms of reactive risk management, investigations into moving and handling-related incidents can tend to focus on the training element, without first considering what it was about the task itself, work environment and other psycho-social factors that could have been contributory factors. The Moving and Handling Advisor supports the investigation into incidences and highlights what might stop the incident from happening again.

2.4. Equipment

Equipment that supports moving and handling is a fundamental element in any risk management strategy.it can reduce the potential musculoskeletal injuries to staff while supporting patients to being more independent. Moving and handling equipment has two main functions: patient enablement, sustaining independence as far as possible and reducing the risk to staff and informal carers. Audits are being completed on the moving and handling equipment throughout the Trust. Assessments will be looked at of the need and requirements of different equipment in each area of the Trust.

2.5. Summary

In summary, moving and handling presents a clear risk to staff and patients. Training is an important element but should be part of a multi-dimensional approach which considers strategies higher up the hierarchy of risk control and should not be overly relied upon to reduce the risk.

3. Fire Safety

3.1. In April 2019 the latest version of the Fire Policy and Procedure was ratified. It was subsequently published. The Chief Executive, as the Responsible Person, is:

3.1.1. Responsible for ensuring the implementation of the Regulatory Reform (Fire Safety) Order 2005 (RRFSO) and the Health Technical Memorandum (HTM) 05.01 in all Trust premises, ensuring that all statutory requirements applicable to fire safety are observed and that appropriate fire safety policies and programmes of work are implemented to maintain and improve fire safety precautions in Trust premises.

3.1.2. Responsible for nominating appropriate leads to whom specific implementation actions can be delegated.

3.2. Appropriate leads include the Director of Estates and Facilities, the Authorising Engineer (Fire) and the Fire Officer.

3.2.1. The Director of Estates and Facilities has the nominated responsibility for fire safety related matters. This includes championing fire safety matters at board level, proposing programmes of work and investment relating to fire safety for consideration as part of the Trust's annual business plan, the provision and maintenance of estate properties, plant and equipment, ensuring compliance with statutory and mandatory requirements and recommendations to ensure fire safety in respect of relevant persons and property protection.

3.2.2. HTM 05-01: Firecode recognises the need for such additional skilled resource and describes the role of a Fire Engineer under the title Authorising Engineer (Fire).

3.2.3. The Head of Fire and Safety takes the role of the Trust Fire Officer and undertakes the day-to-day fire safety activities. Their duties include:

- Ensuring that all Fire Risk Assessments are conducted in line with the Regulatory Reform Fire Safety Order 2005 and the relevant HTM 05-03;
- Ensuring maintenance of fire safety systems to relevant British Standards;

- Ensuring that an effective training programme is implemented;
- Attending major fire exercises, where applicable;
- Receiving reports for all fire incidents;
- Informing the Health and Safety Committee and arranging for them to be acted upon as appropriate;
- Establishing effective liaison with Fire and Rescue Authority necessary;
- Assisting in the writing of all fire safety policies and procedures;
- Investigating all fires that occur in properties owned by the Trust.

3.3. Also in 2019/20:

3.3.1. The upgrade of the fire alarm system at Maidstone Hospital was completed in 2019/20. Final cause and effect testing was delayed due to the COVID-19 pandemic. This has recommenced and been integrated with fire alarm testing.

3.3.2. A new Authorising Engineer (Fire) was appointed. An initial inspection of Maidstone has been undertaken with a further inspection planned for later in the year.

3.3.3. All of Maidstone's Fire Risk Assessments have been update and reissued. Tunbridge Wells' will follow in 2020/21.

3.4. There remain some recurrent and persistent issues, which are:

3.4.1. Fire doors being propped open with cardboard along the main corridors at Maidstone. Regular inspection/audits of communal areas takes place. In addition, a specific audit of the fire escape routes by the Fire Officer was carried out.

3.4.2. The service corridor on Level -2 at Tunbridge Wells Hospital can become partially blocked with beds and other equipment.

3.4.3. Fire alarm activations – often false alarms caused by deodorant, toasters, microwaves, etc. Common causes have been evaluated and the Fire Officer is considering actions to address these.

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Summary report from Workforce Committee, 17/07/20 (incl. quarterly report from the Guardian of Safe Working Hours)	**Committee Chair (Non-Exec. Director)**

The Workforce Committee met on 17th July 2020.

The key matters considered at the meeting were as follows:

- The **actions from previous meetings** were reviewed and the need to apply momentum to the actions, particularly those that had been open for some time, was emphasised.
- Under the **review of the workforce Key Performance Indicators** (incl. the workforce implications of COVID-19), it was agreed that the Trust Secretary should arrange for the report on staff who were subject to COVID-19 shielding that would be submitted to the Executive Team Meeting on 28/07/20 to be circulated to Committee members. It was also agreed that the Director of Workforce should check and confirm the appraisal compliance rate among staff who had been less affected by the COVID-19 period (and who therefore should have had more time available to undertake their appraisal.
- The **workforce strategic 'roadmap'** (incorporating the response to the external review of Human Resources and the work planned with Western Sussex Hospitals NHS Foundation Trust) was reviewed, and it was agreed that the Trust Secretary should revise the Committee's forward programme to reflect the content of the 'roadmap'. It was also agreed that the Director of Workforce should update the 'roadmap' to reflect the comments made at the meeting and submit a revised version to the meeting on 18/09/20.
- A report was received on **The MTW new normal – Staff Welfare** (incl. engagement and equality issues).
- The Head of Staff Engagement and Equality and Chair of the Cultural and Ethnic Minorities Network attended to give an **update on the Workforce Race Equality Standard (WRES) (incl. and an update on plans regarding reverse mentoring)**, and it was agreed that both should advise the Trust Secretary of the requirements for the desired "Diversity by Design"/reverse mentoring session with the Trust Board, to enable the session to be arranged with the Chair of the Trust Board. It was also agreed that they would submit an update on the progress with the reverse mentoring programme to the Committee's meeting on 18/09/20. It was further agreed the Chief Finance Officer, Director of Workforce and Chief Executive should liaise, to agree the arrangements for underwriting the costs of the reverse mentoring programme, if the Trust's bid for external funding was declined.
- An **update on the support for vulnerable staff** (incl. update on compliance with Black, Asian, and Minority Ethnic staff risk assessments) was given and it was agreed that the Director of Workforce should liaise with the Director of Medical Education to consider, and implement, a more proactive approach to ensuring compliance with risk assessments for doctors in training
- The Associate Director for Organisational Development gave an **update on the Culture and leadership programme**, and it was agreed to confirm what percentage of leaders in Agenda for Change bands 8a to 8c were intended to participate in the "Exceptional Leaders" programme. It was also agreed to arrange for the photograph on the "Update on Senior Leaders Programme" page of the report to be replaced with a more suitable alternative.
- The **findings from staff exit interviews** were reviewed and it was agreed that the Head of Staff Engagement & Equality should explore the options, including an automated email prompt, for increasing the return rate of staff exit questionnaires. It was also agreed that the Chief Nurse should arrange for the Recruitment and Retention Group to consider the report (and then report the outcome of the Group's consideration to the Workforce Committee).
- The **Guardian of Safe Working Hours** attended to give their latest **quarterly update** report (which has been enclosed in Appendix 1).
- An **update on the relevant aspects of the Board Assurance Framework** was noted, as were the **recent findings from relevant Internal Audit reviews**.
- The **summary report from the** Committee's only sub-committee, the **Health & Safety Committee**, was noted, but it was agreed that the Trust Secretary should ask the Chair of that Committee to confirm how that forum incorporated learning, and report the response.

In addition to the actions noted above, the Committee agreed that:

- The Director of Workforce should liaise with the Medical Director and notify the Workforce Committee of the actions taken in response to the Guardian of Safe Working Hours exception reports received from surgical FY1s as a result of expectations to write reports for governance meetings during clinical time.
- The Trust Secretary should schedule an informal telephone call/virtual meeting in August 2020 to enable Committee members to consider (and agree) the actions to be taken to increase the Trust's response rate for the national NHS staff survey 2020.
- The Trust Secretary should arrange for the WRES action plan to be approved by the Trust Board, in October 2020 (having first been considered by the Workforce Committee on 18/09/20)

The issues from the meeting that need to be drawn to the Board 's attention as follows: The latest quarterly report from the Guardian of Safe Working Hours is enclosed in Appendix 1.

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

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

1. Information and assurance
2. To note the latest quarterly report from the Guardian of Safe Working Hours (Appendix 1)

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

WORKFORCE COMMITTEE – 17TH JULY 2020

NHS Maidstone and Tunbridge Wells NHS Trust

QUARTERLY UPDATE FROM THE GUARDIAN OF SAFE WORKING HOURS (APRIL TO JUNE)	**GUARDIAN OF SAFE WORKING HOURS**

The latest quarterly report from the Guardian of Safe Working Hours in enclosed. The report covers the period April 2020 to June 2020.

- A total of 13 exception reports were received in this period
- Surgery raised 4, all from FY1 doctors.
- Medicine raised 9, mainly from FY1 doctors.
- The very small number of exception reports generated in this quarter, is likely related to the reduced intensity of workloads of the various specialities in general. This has been recognised across the region at other institutions.
- There were no fines incurred during this period, or work schedule reviews needed

Reason for circulation to Workforce Committee

Review and discussion

Reporting Period: April – June 2020

This report covers the period April – June 2020 in which time 13 exception reports were raised.

Directorate	Exception reports raised
Medicine	9
Surgery	4

Breaking these down by grade, all exception reports were raised by foundation trainees.
All exception reports were due to excessive hours worked, with none concerning inadequate support or supervision.

Issues were due to minor staff shortages, excessive workload and tasks arising close to shift finish, needing completion.

Main Issue raised

The main issue from this report is that 4 exception reports were generated by medical FY1 doctors, regarding the level of staffing on the post-take team at weekends. This was for both sites.

They feel that the amount of work generated, after attending the post-take ward round, often resulting in individuals leaving work several hours late.

This issue has been a recurring theme over the past few years, for which I have discussed with the medical management team.

I have contacted Lawrence Maiden Chief of Service for medicine, Gaurav Agarwal/Alex Keogh Acute medicine consultants and Matt Read Deputy manager for acute medicine with regard this issue to review service provision over this weekend period.

Exception Reports

High level data:

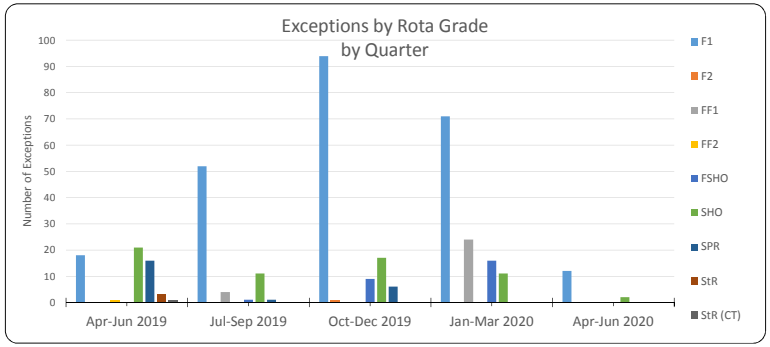
Number of doctors in training on 2016 TCS (total):	360

a) Exception reports (with regard to working hours)

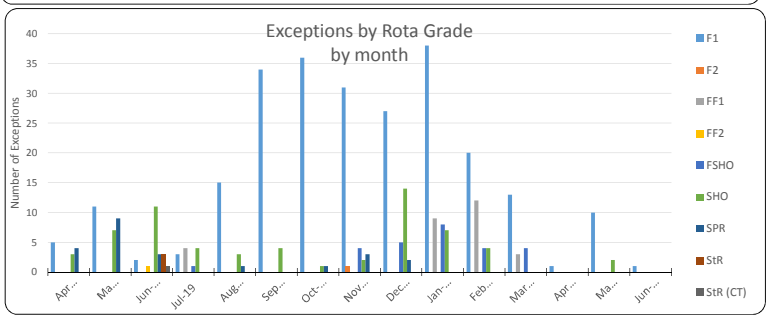
Exception reports by department: April – June 2020				
Specialty	Carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Medicine	0	9	6	3
Surgery	0	4	1	3
Total	**0**	**13**	**7**	**6**

Exception reports by grade: April – June 2020				
Grade	Carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	11	5	6
F2	0	2	2	0
Total	**0**	**13**	**7**	**6**

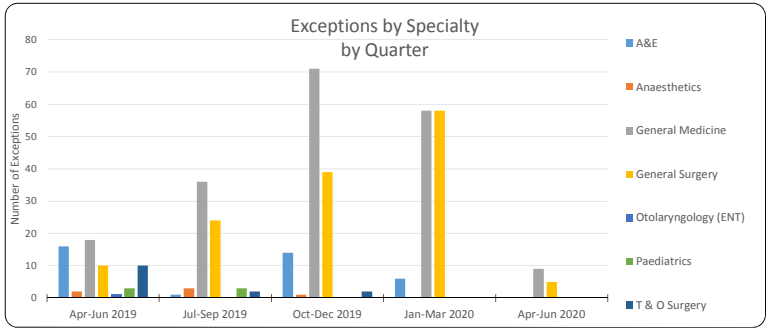
Exception reports (response time)				
Grade	48 hours	Within 7 days	longer than 7 days	Still open
F1	0	0	5	6
F2	0	0	2	0
Total	**0**	**0**	**7**	**6**



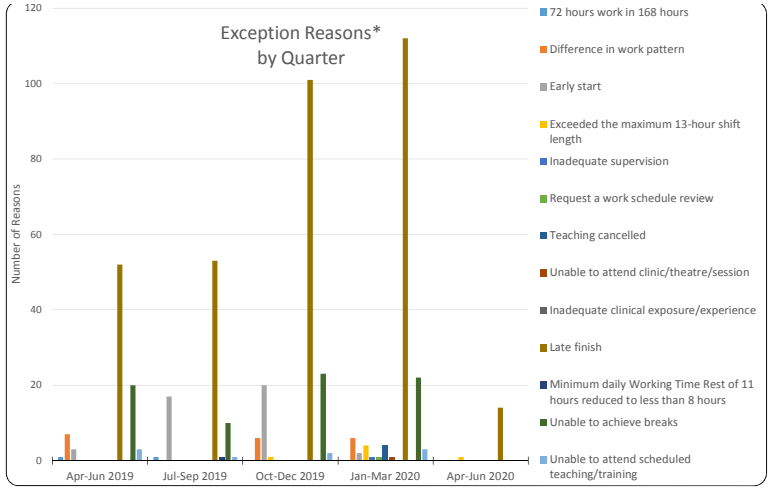
Rota Type	Apr-Jun 2019	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Total	%
F1	18	52	94	71	12	**247**	**63.0%**
F2			1			**1**	**0.3%**
FF1		4		24		**28**	**7.1%**
FF2	1					**1**	**0.3%**
FSHO		1	9	16		**26**	**6.6%**
SHO	21	11	17	11	2	**62**	**15.8%**
SPR	16	1	6			**23**	**5.9%**
StR	3					**3**	**0.8%**
StR (CT)	1					**1**	**0.3%**
Total	**60**	**69**	**127**	**122**	**14**	**392**	**100.0%**



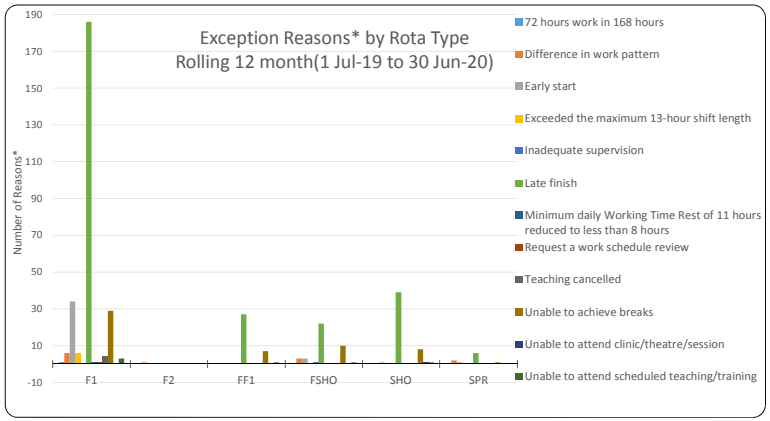
	Months																
Rota Type	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20**	**Apr-20**	**May-20**	**Jun-20**	**Total**	**%**
F1	5	11	2	3	15	34	36	31	27	38	20	13	1	10	1	**247**	**63.0%**
F2								1								**1**	**0.3%**
FF1				4						9	12	3				**28**	**7.1%**
FF2			1													**1**	**0.3%**
FSHO				1				4	5	8	4	4				**26**	**6.6%**
SHO	3	7	11	4	3	4	1	2	14	7	4			2		**62**	**15.8%**
SPR	4	9	3		1		1	3	2							**23**	**5.9%**
StR			3													**3**	**0.8%**
StR (CT)			1													**1**	**0.3%**
Total	**12**	**27**	**21**	**12**	**19**	**38**	**38**	**41**	**48**	**62**	**40**	**20**	**1**	**12**	**1**	**392**	**100.0%**



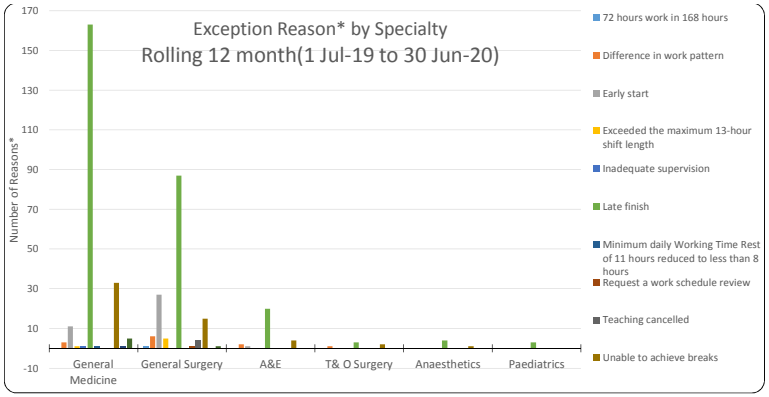
Specialty	Apr-Jun 2019	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Total	%
A&E	16	1	14	6		**37**	**9.4%**
Anaesthetics	2	3	1			**6**	**1.5%**
General Medicine	18	36	71	58	9	**192**	**49.0%**
General Surgery	10	24	39	58	5	**136**	**34.7%**
Otolaryngology (ENT)	1					**1**	**0.3%**
Paediatrics	3	3				**6**	**1.5%**
T & O Surgery	10	2	2			**14**	**3.6%**
Total	**60**	**69**	**127**	**122**	**14**	**392**	**100.0%**



Exception Reasons*	Apr-Jun 2019	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Total	%
72 hours work in 168 hours	1	1		0		**2**	**0.4%**
Difference in work pattern	7		6	6		**19**	**3.9%**
Early start	3	17	20	2		**42**	**8.5%**
Exceeded the maximum 13-hour shift length			1	4	1	**6**	**1.2%**
Inadequate supervision				1		**1**	**0.2%**
Request a work schedule review				1		**1**	**0.2%**
Teaching cancelled				4		**4**	**0.8%**
Unable to attend clinic/theatre/session				1		**1**	**0.2%**
Inadequate clinical exposure/experience				0		**0**	**0.0%**
Late finish	52	53	101	112	14	**332**	**67.3%**
Minimum daily Working Time Rest of 11 hours reduced to less than 8 hours		1		0		**1**	**0.2%**
Unable to achieve breaks	20	10	23	22		**75**	**15.2%**
Unable to attend scheduled teaching/training	3	1	2	3		**9**	**1.8%**
Total	**86**	**83**	**153**	**156**	**15**	**493**	**100%**



	Rota Grade						
Exception Reason*	**F1**	**F2**	**FF1**	**FSHO**	**SHO**	**SPR**	**Total**
72 hours work in 168 hours	1						**1**
Difference in work pattern	6	1		3		2	**12**
Early start	34			3	1	1	**39**
Exceeded the maximum 13-hour shift length	6						**6**
Inadequate supervision				1			**1**
Late finish	186		27	22	39	6	**280**
Minimum daily Working Time Rest of 11 hours reduced to less than 8 hours	1						**1**
Request a work schedule review	1						**1**
Teaching cancelled	4						**4**
Unable to achieve breaks	29		7	10	8	1	**55**
Unable to attend clinic/theatre/session					1		**1**
Unable to attend scheduled teaching/training	3		1	1	1		**6**
Grand Total	**271**	**1**	**35**	**40**	**50**	**10**	**407**



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

	Specialty						
Exception Reason*	**General Medicine**	**General Surgery**	**A&E**	**T& O Surgery**	**Anaesthetics**	**Paediatrics**	**Total**
72 hours work in 168 hours		1					**1**
Difference in work pattern	3	6	2	1			**12**
Early start	11	27	1				**39**
Exceeded the maximum 13-hour shift length	1	5					**6**
Inadequate supervision	1						**1**
Late finish	163	87	20	3	4	3	**280**
Minimum daily Working Time Rest of 11 hours reduced to less than 8 hours	1						**1**
Request a work schedule review		1					**1**
Teaching cancelled		4					**4**
Unable to achieve breaks	33	15	4	2	1		**55**
Unable to attend clinic/theatre/session	1						**1**
Unable to attend scheduled teaching/training	5	1					**6**
Grand Total	**219**	**147**	**27**	**6**	**5**	**3**	**407**

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the Charitable Funds Committee, 21/07/20	Committee Chair (Non-Executive Director)

The Charitable Funds Committee (CFC) met on 21st July 2020.

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

- The Committee reviewed the **draft Charitable Fund Annual Report and Accounts for 2019/20** wherein it was agreed that all Committee members should Review the draft Charitable Fund Annual Report and Accounts for 2019/20 and report any proposed amendments to the Head of Financial Services by the 12th October 2020. It was also agreed that the Trust Secretary should investigate and submit a proposal to the November 2020 meeting in regards to how the Committee could take a more robust approach to the risk management of the Trust's Charitable Funds (in light of the "Risk Management" section in the Annual Report 2019/20).
- The **financial overview at Month 3** was considered and it was noted that:
  - The fund balance stood at £969.8k, an increase of £206.8k since 1st April 2020
  - 41 specific donations had been received exceeding £1k totalling £193.3k. The largest single donation was £77.5k from NHS Charities Together for COVID-19
  - No requests for expenditure had been refused during the period
  - In total the Trust had received £164.7k from donations for COVID-19
  - It was agreed that the Fundraising Manager should review the NHS Charities Together Benchmarking report; investigate the underlying causes of the differences in donations received and recommend any measures that could be taken for the Trust to improve its fund raising efforts
  - It was agreed that the Head of Financial Services should check and confirm the threshold below which the value of 'gifts in kind' did not need to be estimated and included in the charitable fund accounts.
- The Committee reviewed **a proposal for the management and administration fee for 2020/21** and the Committee **approved the proposal** as submitted
- A **Fundraising update (incl. an update on the establishment of the Charity Management Committee and the details of donations given during the COVID-19 period)** was provided wherein it was agreed that Chair of the Charity Management Committee should liaise with the Fundraising Manager and the Director of Strategy, Planning and Partnerships to consider how the League of Friends of Tunbridge Wells Hospital and the League of Friends of the Maidstone Hospital could be involved in the work of the Charity Management Committee and report the outcome of the discussion to the November 2020 meeting.
- The Committee received an update on **proposed partnership with Maggie's Centres**
- Under **"To note the Committee's forward programme"** it was agreed that the Assistant Trust Secretary should Amend the Committee's forward programme to reflect the decision that the future "fundraising update" items should include an update from the "Charity Management Committee"

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

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

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

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

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

Summary report from Audit and Governance Committee, 30/07/20 (Incl. the Annual Audit Letter for 2019/20)	Committee Chair (Non-Executive Director)

The Audit and Governance Committee met on 30th July 2020.

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

- Under the **Review of actions from previous meetings** the outstanding action of "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." was discussed in detail and the following subsequent actions were agreed:
  - That the Trust Secretary should liaise with the Chair of the Trust Board to implement effectiveness reviews of the Trust Board and each of the Trust Board Sub-Committees, and consider how the Trust Board review could incorporate governance within the wider health and social care system
  - That the Director of Audit, Tiaa Ltd (Head of Internal Audit) and Audit Manager, Tiaa Ltd should undertake an Internal Audit review of the Trust's compliance with the Reservation of Powers and Scheme of Delegation, once the next update is ratified by the Trust Board
  - That the Director of Audit, Tiaa Ltd (Head of Internal Audit) should liaise with the Chief Finance Officer to develop and agree the scope of an advisory review to assess the effectiveness of the data received by the Trust's management for decision making
  - That the Trust Secretary should liaise with the Chief Finance Officer to identify an appropriate mechanism to enable the Committee and Trust Board to be notified of changes within the wider health and social care system that limit or constrain the Trust's decision-making or strategic direction
- The committee was provided with an **"Update on the Board Assurance Framework for 2020/21"**
- An **Update on progress with the Internal Audit plan for 2020/21 (incl. progress with actions from previous Internal Audit reviews; and dedicated discussion of Outstanding Audit Recommendations)** was reported, wherein the Outstanding Audit Recommendations included those that had been closed were noted and assurance provided by the Chief Finance Officer that those Outstanding Audit Recommendations that remained open would be addressed before the November 2020 meeting. The list of recent Internal Audit reviews, is shown below (in section 2)
- The latest **Counter Fraud update** was received which included details of the new referrals to the Counter Fraud Service since the last Committee meeting.
- There were no areas of concern reported under the **"Audit Progress Report and Sector Update" from External Audit**
- The **External Audit letter for 2019/20** was received and noted (Appendix 1)
- The Chief Finance Officer provided a **summary of the latest financial issues** which included details of the COVID-19 financial regime, the expected changes to the regime from the end of July 2020 and the work that would be implemented to ensure robust Cost improvement Plans (CIPs) for 2021/22
- The **latest losses & compensations data** was noted
- The **latest single tender / quote waivers data** was reviewed and the Committee informed of the intention to deploy a member of the Procurement team within the Estates and Facilities Directorate to reduce the use of single tender / quote waivers. It was agreed that the Trust Secretary should invite **t**he Director of Estates and Facilities to provide assurance at the Committee's meeting in November 2020 in regards to the "Estates Procurement" limited assurance report from Internal Audit and the content of "The latest single tender / quote waivers data" report received at the July 2020 Committee meeting.
- The latest **details of gifts, hospitality and sponsorship** were declared including an update on the "Managing Conflicts of Interests Policy and Procedure (incorporating the treatment of Gifts, Hospitality and Sponsorship)" wherein it was agreed that the Chief Finance Officer

should confirm the timeline for the implementation of the My ESR" self-service portal.
- The **forward programme** was noted
- Under the **Evaluation of the meeting** the limitations and benefits of virtual meetings were discussed

2. The Committee received details of the following completed Internal Audit reviews:
- "Overseas Visitors" (which received a "Reasonable Assurance" conclusion)
- "Learning from Never Events, Incidents and Complaints" (which received a "Reasonable Assurance" conclusion)
- "Consent / WHO Checklist" (which was not allocated an assurance opinion due to the limited amount of testing undertaken due to COVID-19, it has however been agreed that testing will be conducted later in the year and an updated report will be issues with an assurance opinion)

3. The Committee was also notified of the following "Urgent" priority outstanding actions from Internal Audit reviews: N/A

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

5. The issues that need to be drawn to the attention of the Board are as follows:
- The Annual Audit Letter for 2019/20 is enclosed under appendix 1 for assurance

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

Grant Thornton

The Annual Audit Letter for Maidstone and Tunbridge Wells NHS Trust

Year ended 31 March 2020

July 2020

Contents

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Executive Summary

Purpose

Our Annual Audit Letter (Letter) summarises the key findings arising from the work that we have carried out at Maidstone and Tunbridge Wells NHS Trust (the Trust) for the year ended 31 March 2020.

This Letter is intended to provide a commentary on the results of our work to the Trust and external stakeholders, and to highlight issues that we wish to draw to the attention of the public. In preparing this Letter, we have followed the National Audit Office (NAO)'s Code of Audit Practice and Auditor Guidance Note (AGN) 07 – 'Auditor Reporting'. We reported the detailed findings from our audit work to the Trust's Audit & Governance Committee as those charged with governance in our Audit Findings Report on 18 June 2020.

Respective responsibilities

We have carried out our audit in accordance with the NAO's Code of Audit Practice, which reflects the requirements of the Local Audit and Accountability Act 2014 (the Act). Our key responsibilities are to:

- give an opinion on the Trust's financial statements (section two)
- assess the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (the value for money conclusion) (section three).

In our audit of the Trust's financial statements, we comply with International Standards on Auditing (UK) (ISAs) and other guidance issued by the NAO.

Our work

Materiality	We determined materiality for the audit of the Trust's financial statements to be £7,600,000, which is 1.5**%** of the Trust's gross revenue expenditure and finance expenditure.
Financial Statements opinion	We gave an unqualified opinion on the Trust's financial statements on 23 June 2020.
NHS Group consolidation template (WGA)	We also reported on the consistency of the financial statements consolidation template provided to the National Audit Office with the audited financial statements. We concluded that these were consistent
Use of statutory powers	We referred a matter to the Secretary of State, as required by section 30 of the Act, on 22 June 2020 in relation to Maidstone and Tunbridge Wells NHS Trust's continued breach of its break-even duty for the three-year period ending 31 March 2020.

Executive Summary

Value for Money arrangements	We were satisfied that the Trust put in place proper arrangements to ensure economy, efficiency and effectiveness in its use of resources.
Quality Accounts	Due to the Covid-19 pandemic, the Department of Health and Social Care suspended the requirement for the Trust's Quality Accounts to be certified.
Certificate	We certified we have completed the audit of the financial statements of Maidstone and Tunbridge Wells NHS Trust in accordance with the requirements of the Code of Audit Practice on 23 June 2020.

Working with the Trust

During the year we have delivered a number of successful outcomes with you:

- Accounts deadline – you took advantage of the NHS submission extension and provided draft accounts on the 11th of May due to the effect of the COVID-19 Pandemic . With restrictions for non essential travel we worked with you to establish and adopt to new remote access working arrangements to deliver the financial statements audit two days before the deadline.
- Understanding your financial challenges – through the value for money conclusion we provided you with assurance on your operational and financial effectiveness.
- Sharing our insight – we provided regular updates to the Audit and Governance Committee covering best practice. We also shared our thought leadership reports.
- Providing training – we provided your teams with training on financial statements and annual reporting.
- We would like to record our appreciation for the assistance and co-operation provided to us during our audit by the Trust's staff during these extraordinary times

Audit of the Financial Statements

Our audit approach

Materiality

In our audit of the Trust's financial statements, we use the concept of materiality to determine the nature, timing and extent of our work, and in evaluating the results of our work. We define materiality as the size of the misstatement in the financial statements that would lead a reasonably knowledgeable person to change or influence their economic decisions.

We determined materiality for the audit of the Trust's financial statements to be £7,600,000, which is 1.5% of the Trust's gross revenue and financing expenditure. We used this benchmark as, in our view, users of Trust's financial statements are most interested in where the Trust has spent its revenue in the year.

We set a lower threshold of £300,000, above which we reported errors to the Audit and Governance Committee in our Audit Findings Report.

The scope of our audit

Our audit involves obtaining sufficient evidence about the amounts and disclosures in the financial statements to give reasonable assurance they are free from material misstatement, whether caused by fraud or error. This includes assessing whether:

- the accounting policies are appropriate, have been consistently applied and adequately disclosed;
- the significant accounting estimates made by management are reasonable; and
- the overall presentation of the financial statements gives a true and fair view.

We also read the remainder of the Annual Report to check it is consistent with our understanding of the Trust and with the financial statements included in the Annual Report on which we gave our opinion.

We carry out our audit in accordance with ISAs (UK) and the NAO Code of Audit Practice. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Our audit approach was based on a thorough understanding of the Trust's business and is risk based.

We identified key risks and set out overleaf the work we performed in response to these risks and the results of this work.

Audit of the Financial Statements

Significant Audit Risks

These are the significant risks which had the greatest impact on our overall strategy and where we focused more of our work.

Risks identified in our audit plan	How we responded to the risk	Findings and conclusions
Covid - 19	**As part of our audit work we :** • liaised with management to understand the implications of the response to the Covid-19 pandemic had on the organisation's ability to prepare the financial statements and update financial forecasts; • liaised with other audit suppliers, regulators and government departments to co-ordinate practical cross sector responses to issues; • evaluated the adequacy of the disclosures in the financial statements that arose in light of the Covid-19 pandemic; • evaluated whether sufficient audit evidence could be obtained in the absence of physical verification of assets through remote technology; • evaluated whether sufficient audit evidence can be obtained to corroborate significant management estimates such as asset valuations and recovery of receivable balances; • evaluated management's assumptions that underpin the revised financial forecasts and the impact on management's going concern assessment; • discussed with management any potential implications for our audit report if we have been unable to obtain sufficient audit evidence.	The Trust made appropriate disclosures in respect of Covid-19 in its Annual Report and statement of accounts.
Improper revenue recognition	**As part of our audit work we have:** • evaluated the Trust's accounting policy for recognition income from patient care activities and other operating revenue for appropriateness and compliance with the DHSC Group Accounting Manual 2019/20; • updated our understanding of the Trust's system for accounting for income from patient care activities and other operating revenue, and evaluated the design of the associated controls; • reviewed the contracts with the Trust's main commissioners; • tested healthcare income from the Trust's main commissioners for the year to contract documentation and invoices billed; • reviewed the year end Agreement of Balances tool and followed up any significant discrepancies in intra-NHS income or receivables with Trust management;. • completed substantive testing of a sample of non-patient care income to ensure these items agree back to supporting documentation	Our audit work did not identify any significant issues in respect of improper revenue recognition.

Audit of the Financial Statements

Significant Audit Risks - continued

These are the risks which had the greatest impact on our overall strategy and where we focused more of our work.

Risks identified in our audit plan	How we responded to the risk	Findings and conclusions
Management override of controls	**As part of our audit work we have:** • evaluated the design effectiveness of management controls over journals; • analysed the journals listing and determined the criteria for selecting high risk unusual journals; • tested unusual journals made during the year and the accounts production stage for appropriateness and corroboration; • gained an understanding of the accounting estimates and critical judgements applied by management and considered their reasonableness.	Our audit work did not identify any significant issues in respect of management override of controls.
Valuation of land and buildings	**As part of our audit work we completed;** • reviewed management's processes and assumptions for the calculation of the estimate, the instructions issued to valuation experts and the scope of their work; • considered the competence, expertise and objectivity of any management experts used; • held discussions with the valuer about the basis on which the valuation is carried out and challenged the key assumptions; • reviewed and challenged the information used by the valuer to ensure it is robust and consistent with our understanding; • considered the reasonableness of the estimate and the adequacy of disclosure in the financial statements; • completed testing of revaluations made during the year to ensure they are input correctly into the Trust's asset register.	Our audit work did not identify any significant issues in respect of valuation of Property, Plant and Equipment. The financial statements included the disclosure of the material uncertainty stated by the valuer in his valuation of the Trust's land and buildings. Given the magnitude of the asset valuation to the balance sheet and the caveat made by the valuer in his valuation report, we highlighted the material uncertainty in our audit report drawing attention to the disclosure made in the statement of accounts.

Audit of the Financial Statements

Other Audit Risks - continued

Risks identified in our audit plan	How we responded to the risk	Findings and conclusions
Modular Car Parking – Operating Lease Treatment	**As part of our audit work we:** • assessed the reasonableness of assumptions made by management; • confirmed that the relevant accounting policies were appropriately applied; • recalculated the key inputs and outputs of the lease model such as the lease's net present value, fair value, and internal rate of return and assessed whether the accounting entries made by management were reasonable.	Our audit work did not identify any significant issues in respect to the accounting treatment of the modular car parking disclosures in the accounts.
Capital Programme for 2020	**As part of our audit work we :** • reviewed individually significant or unusual transactions; • tested on a sample basis, additions and assets under construction to invoices, certificates or equivalent to confirm that the cost was accurately recorded and appropriately treated as capital.	Our audit work did not identify any significant issues in respect to the Trust's capital programme and additions in year.

Audit of the Financial Statements

Audit opinion

We gave an unqualified opinion on the Trust's financial statements on 23 June 2020.

Preparation of the financial statements

The Trust presented draft financial statements for audit in accordance with the national deadline and pandemic lockdown restrictions that existed at the time. The financial statements were supported by a good set of working papers. The finance team responded promptly and efficiently to our queries during the course of the audit.

Issues arising from the audit of the financial statements

We reported the key issues from our audit to the Trust's Audit and Governance Committee on 18 June 2020.

Annual Report, including the Annual Governance Statement

We are also required to review the Trust's Annual Report, including the Annual Governance Statement. These were provided on a timely basis with the draft financial statements with supporting evidence.

Whole of Government Accounts (WGA)

We issued a group return to the National Audit Office in respect of Whole of Government Accounts, which did not identify any issues for the group auditor to consider.

Other statutory powers

We are also required to refer certain matters to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014. On 22 June 2020 we reported to the Secretary of State under Section 30a of the Local Audit and Accountability Act 2014 in relation to Maidstone and Tunbridge Wells NHS Trust's continued breach of its break-even duty for the three year period ending 31 March 2020..

Certificate of closure of the audit

We certified we have completed the audit of the financial statements of the Trust in accordance with the requirements of the Code of Audit Practice on 23 June 2020.

Value for Money conclusion

Background

We carried out our review in accordance with the NAO Code of Audit Practice, following the guidance issued by the NAO in April 2020 which specified the criterion for auditors to evaluate:

In all significant respects, the audited body takes properly informed decisions and deploys resources to achieve planned and sustainable outcomes for taxpayers and local people.

Key findings

Our first step in carrying out our work was to perform a risk assessment and identify the risks where we concentrated our work.

The risks we identified and the work we performed are set out overleaf.

Overall Value for Money conclusion

We are satisfied that in all significant respects the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2020.

Value for Money conclusion

Value for Money Risks

Risks identified in our audit plan	How we responded to the risk	Findings and conclusions
Financial sustainability The 2019-20 budget planned for a deficit position of £7m before the receipt of £13.8m of Provider Substantiality Fund income (PSF) and Marginal Rate Emergency Tariff (MRET).	As part of our work we : • updated our understanding of the Trust's financial position, • considered any improvements to its financial arrangements; • Developed an understanding of the financial plans for the year ahead.	Trusts are expected to plan to break even over a rolling three year cycle, achieving this within the political and operational environment in which they have to operate. The operating environment is complex; demand for the Trust's elective and emergency services is increasing; a national position of workforce shortages for key disciplines which are met by expensive agency staff; a high quality threshold demanded by the public and enforced by regulators and constrained financial resources within the health economy. The NHS Long Term plan sets out an ambition to return the provider sector to financial balance by 2020/21. In addition, this year, the Coronavirus pandemic has highlighted and brought focus on the importance of the crucial role NHS Trusts have in delivering patient care in the economy. The Trust delivered a retained surplus of £7 million (including £7.6m of PSF and £6.2m of MRET) for the year ended 31 March 2020. This is £0.1m favourable to the planned £6.9m control total agreed with NHS Improvement (including PSF and MRET funding) at the start of the year. Achievement of the control total assumed delivery of planned £22.3m Cost Improvement Programme (CIPs) savings. The Trust delivered £22.4m (£13.8m in 2018/19) of CIPs during the year. This is a noted improvement compared to the £10.3m underperformance in CIP delivery in 2018/19. Reporting of progress against the financial plan to the Finance and Performance Committee was detailed and comprehensive throughout the year. The FPC were updated monthly on the progress of the Trust's existing financial budget, CIPs, slippages and mitigations being developed to address the risk against non-delivery of the plan. As a result of the Covid-19 pandemic, the NHS suspended the 2020/21 financial planning arrangements and guaranteed commissioner income in the form of block payments from April to October 2020. The Trust will need to continue to monitor and model future scenarios as NHS Improvement/England clarify the revised arrangements for 2020/21. Based on the work we completed, we concluded that the Trust's arrangements are adequate for achieving financial sustainability. Our Value for Money conclusion was therefore unqualified.

A. Reports issued and fees

We confirm below our final reports issued and fees charged for the audit and provision of non-audit services

Reports issued

Report	Date issued
Audit Plan	19 March 2020
Audit Findings Report	18 June 2020
Annual Audit Letter	30 June 2020

Fees

	Planned £	Actual fees £
Statutory audit	70,000	tbc
Charitable fund	1,900	tbc
Total fees	**71,900**	**tbc**

Fees for non-audit services

Service	Planned Fees £	Actual Fees £
Audit related services - Quality Accounts	7,500	tbc
Total	**7,500**	**tbc**

The Quality Accounts procedures were cancelled in 2019/20 due the COVID-19 prior to final work commencing. We will agree with The Trust the fee for the aborted work already undertaken in respect of this before its cancellation, and any residual costs arising from COVID-19 arrangements in delivering the audit, in determining the final fee.

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from Quality Committee, 13/08/20 Committee Chair (Non-Exec. Director)

The Quality Committee met (virtually, via webconference) on 13th August 2020 (a Quality Committee 'deep dive' meeting).

1. **The key matters considered at the meeting were as follows:**
   - The Chief of Service for Medicine and Emergency Care (who also chairs the Mortality Surveillance Group (MSG)) attended to give a presentation (along with the Deputy Director of Quality Governance) on the **mortality review process**. The process, and the progress that continued to be made via the MSG, was commended, but it was agreed to consider how changes in practice could be audited/monitored, following the completion of the final step of the Mortality Review procedure i.e. "feedback and Learning to be disseminated to Divisions". It was also agreed to arrange for a clinical audit to be undertaken of a sample of "deaths with no comorbidities recorded", to check whether the patients genuinely had no comorbidities.
   - The Divisional Director of Operations (DDO) for Surgery then attended to present on **COVID-19 and harm reviews of patients who have waited a long time**. The challenges faced by the Trust were acknowledged, as was the importance of the issue, so it was agreed that an "Update on harm reviews for patients who have waited a long time" item should be scheduled at each 'main' Quality Committee meeting, from September 2020 onwards (with the and invite the DDO for Surgery invited to attend to speak to the associated written report).
   - A discussion was then held on the **items that should be scheduled for scrutiny at future Quality Committee 'deep dive' meetings**, and it was agreed that the meeting in October 2020 should have items on "Review of maternity services – update", "A review of water safety/quality", and "A review of the quality-related plans for outpatient services (including the plans regarding virtual outpatient clinics)" scheduled. It was also agreed that the meeting in December 2020 should have items on "The effectiveness of divisional clinical governance arrangements" and "A review of the quality-related plans for outpatient services – update" scheduled.

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 Quality Committee, 16/09/20 | **Committee Chair (Non-Executive Director)**

The Quality Committee met on 16th September (a 'main' meeting), via virtual means.

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

- A report was received on the actions being taken by the Trust in response to the concerns raised at the meeting in March 2020 regarding the **patient transport service** provided under contract to the CCG. As it was also agreed (in March) to update the Trust Board on the actions being taken, the report received by the Committee has been enclosed in Appendix 1.
- The issues raised from the **reports from the clinical Divisions** included the challenges with returning to pre-COVID-19 activity levels; staffing issues; the efforts to address the ongoing issues with the Child and Adolescent Mental Health Services; and the positive steps the Cancer Services Division had taken to improve communication and engagement with staff.
- An update was given on **the work to achieve an 'Outstanding' CQC rating**.
- An **update on the 'MTW new normal'/'reset and recovery' programme** was given and the challenges with delivering the Referral to Treatment waiting time target in the context of the national focus being on reducing the 52-week waiting time backlog were discussed.
- The Medical Director reported on the **output from the COVID-19 Ethics Committee**.
- The Divisional Director of Operations for Surgery attended to give an **update on harm reviews for patients who have waited a long time**, and it was agreed that the Medical Director would arrange for the report that had previously been submitted to the Committee that described the methodology of the harm reviews to be circulated to the Committee's Non-Executive Director members.
- The Deputy Director of Quality Governance reported on **progress with implementing the Quality Strategy**, and two proposed amendments to the Strategy were agreed - firstly that the goals of "enhancing functional independence" (no.8) and "patient flow" (no.12) be combined, due to the overlapping objectives within each of the goals; and secondly that the reinstatement of the #EndPJParalysis initiative be moved from "enhancing functional independence" (no.8) to "engagement" (no.9). It was further agreed that the proposals should be submitted to the Board, for approval. The Trust Board is therefore asked to approve these two changes to the Strategy that it approved in January 2020.
- The Chief of Service, Medicine & Emergency Care gave the latest **update on mortality** and it was agreed that they should investigate why mortality for "Acute no-specialist Ave" reduced to 0 in April 2020 but the Trust's mortality increased for that month.
- The latest **Serious Incidents (SIs)** were reported and the **final version of the Quality Accounts 2019/20** was received, for completeness (the Committee considered the draft version in July 2020).
- The reports of **recent findings from relevant Internal Audit reviews**; **relevant aspects of the Board Assurance Framework** and last **Quality C'ttee 'deep dive' meeting** were noted.
- Reports were received from the **Committee's sub-committees** (the Complaints, Legal, Incidents, PALS, Audit and Mortality (CLIPAM) group; the Infection Prevention and Control Committee; the Joint Safeguarding Committee; and the Drugs, and Therapeutics and Medicines Management Committee).

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

- The Deputy Director of Quality Governance should provide the Chief of Service for Med. & Emerg. Care with further details of the statement in the "Review of progress with implementing the Quality Strategy" report that "Eating Disorders policy currently being developed"

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

- The Trust Board is asked to approve two proposed changes to the Quality Strategy

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

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

1. Information and assurance
2. To approve two proposed changes to the Quality Strategy that were agreed by the Committee (as described above)

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

Appendix 1: Report on the actions being taken by the Trust in response to the concerns raised by the Diagnostics & Clinical Support Division (at the Committee's meeting in March 2020) regarding the patient transport service that was provided under contract to West Kent Clinical Commissioning Group (as was).

'MAIN' QUALITY COMMITTEE – SEPTEMBER 2020

NHS Maidstone and Tunbridge Wells NHS Trust

THE ACTIONS BEING TAKEN BY THE TRUST IN RESPONSE TO THE CONCERNS RAISED BY THE DIAGNOSTICS & CLINICAL SUPPORT DIVISION REGARDING THE PATIENT TRANSPORT SERVICE THAT WAS PROVIDED UNDER CONTRACT TO WEST KENT CLINICAL COMMISSIONING GROUP	**DEPUTY CHIEF NURSE**

It was agreed at the 'main' Quality Committee on the 11th March 2020 that the Deputy Chief Nurse should "Arrange for a report to be submitted to the 'main' Quality Committee in May 2020 on the actions being taken by the Trust in response to the concerns raised by the Diagnostics & Clinical Support Division regarding the patient transport service that was provided under contract to West Kent Clinical Commissioning Group". The report was subsequently deferred to enable the prioritisation of the Trust's response to COVID-19; however the requested report has now been submitted.

The issue of a poor patient transport service is unfortunately familiar to the trust and there is no easy solution as the G4S transport contract sits with the CCG, we escalate to the CCG and liaise with them to address issues as they arise but it is a complex issue due to KPI's within the service specification.

We are looking at how we can improve the patients journey and experience whilst they wait for transport, such as ensuring that transport is booked promptly and patients are made 'Ready to go' on the transport IT system in good time. The discharge lounges are considering extending their hours as we go into winter. Coincidently the problem has been less of an issue since the COVID pandemic as we have seen less face to face contacts but are mindful that as footfall increases the problems may rearise.'

We will proactively liaising with the CCG and G4S to ensure that the service meets the needs of our patients as we return our services to normal.

Reason for submission to the Quality Committee (decision, discussion, information, assurance etc.)
Discussion and assurance

Summary report from the Finance and Performance Committee, 25/08/20 (including approval of revised Terms of Reference)	**Committee Chair (Non-Exec. Director)**

The Committee met on 25th August, via a webconference.

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

- The **annual review of the Committee's Terms of Reference** resulted in an updated version being agreed. These are enclosed in Appendix 1, for approval, with the proposed changes shown as 'tracked'. None of the proposed changes are material.
- The **allocation of resources and funding as part of the 'reset and recovery' programme** was considered and approval to commence the recruitment process was granted. The Committee noted the complex situation in satisfying the recent COVID-19 'Phase Three' letter that had been issued by NHS England (NHSE)/NHS Improvement (NHSI), and reconciling local efforts to increase levels of activity. Approval was granted on the basis that further work was being undertaken regarding activity projections and on the completion of Business Cases to support investment. It was noted that there would be a further discussion at the Trust Board meeting on 24/09/20, where the long-term situation could be reviewed in more detail. It was also agreed that the Chief Finance Officer and Trust Secretary should ensure the activity and financial analysis in the Trust Board report included the values of the potential upsides that were anticipated to mitigate the potential £8.463m full year effect gap between the total value of the proposed investments and the current total funding source.
- A detailed discussion was again held on the "**MTW new normal"** (i.e. the 'reset and recovery' programme), which considered the requirements of the COVID-19 'Phase Three' and elective incentives letters issued by NHSE/I and the Trust's response. A **detailed update on the outpatients 'reset and recovery' programme workstream** was also given by the workstream leads.
- A brief update was given on the **winter plan** and it was noted that a draft plan was intended to be submitted to the Committee and Trust Board in September 2020.
- An update was given on the **national NHS financial regime** and a proposal to extend the **budget process** that had been applied to months 1 to 4 to months 5 and 6 was approved.
- An update was given on the **Trust's energy strategy**.
- The **financial performance for month 4** was noted and it was agreed to arrange for the Committee's meeting on 22/09/20 to include a focus on capital funding and expenditure.
- The **month 4 non-finance related performance** was noted, which included which included that the Trust's recent performance on the Emergency Department 4-hour waiting time target had only been beaten by Milton Keynes University Hospital NHS Foundation Trust.
- The Committee approved a proposal to enter into a new five year **contract with the Trust's current provider of Managed Laboratory Services** (the Trust Board delegated its authority to the Committee to approve the Case in July, as the Trust Board did not meet in August). It was however agreed to arrange for the Pathology Directorate to check and confirm the validity of the 9% of projected growth in activity that was used to calculate the "Variable Costs" in the Financial Case.
- The Committee **approved two Business Cases** (for Personal Protective Equipment and Fit Testing; and Enhanced Supportive Care).
- The programme of **reviews of previously approved Business Cases** covered two Cases: Outsourced outpatient pharmacy; and East Kent oncology. For the former, it was noted that the Case had not progressed and the original partner had withdrawn from the venture so the Case was, in effect, null and void., It was therefore confirmed that the Business Case for a new proposed Joint Venture be considered as it when it was developed and submitted i.e. via the Trust's standard Business Case review and approvals process.

2. In addition the agreements referred to above, the Committee agreed that:

- An item should be scheduled at the Committee's meeting on 22/09/20 regarding the Trust's use of management information

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

- Revised Terms of Reference are enclosed in Appendix 1, for approval.

Which Committees have reviewed the information prior to Board submission? N/A
Reason for receipt at the Board (decision, discussion, information, assurance etc.) 1. Information and assurance 2. To approve revised Terms of Reference for the Finance and Performance Committee (see Appendix 1)

Appendix 1: Revised Terms of Reference (for approval)

FINANCE AND PERFORMANCE COMMITTEE

Terms of Reference

NHS Maidstone and Tunbridge Wells NHS Trust

1. Purpose

The Trust Board has established the Committee to provide the Trust Board with:

- Assurance on the effectiveness of financial management, treasury management, investment and capital expenditure and financial governance
- An objective assessment of the financial position and standing of the Trust
- An objective assessment of performance-related issues affecting the key operational targets and the Trust's financial position
- Advice and recommendations on all key issues of financial management, financial performance and operational performance
- Assurance on Information Technology performance (and IT-related business continuity)

2. Membership

Membership of the Committee is as follows:

- The Committee Chair - a Non-Executive Director or Associate Non-Executive Director appointed by the Trust Board
- The Committee Vice-Chair - a Non-Executive Director or Associate Non-Executive Director appointed by the Trust Board
- An Associate Non-Executive Director
- The Chief Finance Officer/Deputy Chief Executive*
- The Chief Operating Officer*
- The Chief Executive*

Members are expected to attend all relevant meetings.

3. Quorum

The Committee shall be quorate when one Non-Executive Director or Associate Non-Executive Director and two Members of the Executive Team (see * above) are present. If a member of the Executive Team cannot attend a meeting, they should aim to send a representative in their place.

For the purposes of being quorate, any Non-Executive Director or Associate Non-Executive Director (including the Chair of the Trust Board) may be present; and any two Members of the Executive Team may be present (including any of those not listed in the Membership). Deputies representing Members of the Executive Team will count towards the quorum.

4. Attendance

All other Non-Executive Directors (including the Chair of the Trust Board), Associate Non-Executive Directors and Members of the Executive Team are entitled to attend any meeting of the Committee.

The Committee Chair may also invite others to attend, as required, to cover certain agenda items, and/or ensure the Committee meets its pPurpose and complies with its dDuties.

5. Frequency of meetings

The Committee shall generally meet each month, but the Committee Chair may schedule additional meetings, as required (or cancel any scheduled meetings)

6. Duties

The Committee has the following duties:

Financial Management

- To Rreview financial plans and strategies and ensure they are consistent with the Trust's overall vision and strategic goals
- To Eensure a comprehensive budgetary control framework is in place and operating effectively
- To Mmonitor financial performance against plan, and ensure corrective action is taken where appropriate
- To Ddevelop and monitor key financial performance indicators, and advise the Trust Board on action required to improve performance / address risks.
- To Rreview and monitor the Trust's Cost Improvement Programme (CIP)
- To Mmonitor the delivery of the recommendations of the 'Lord Carter report' ("Operational productivity and performance in English NHS acute hospitals: Unwarranted variations"), and subsequent related publications or national guidance.
- To Eensure the Trust is actively engaged in and addresses all productivity opportunities presented as part of national initiatives

Treasury Management

- To Rreview any significant (in the judgement of the Chief Finance Officer) proposed changes to the Trust's treasury management policies, processes and controls
- To Aapprove external funding and borrowing arrangements, including approval of working capital facilities and capital investment loan applications (within the Committee's delegated authority), or to review such applications, and make a recommendation to the Trust Board if the value exceeds the Committee's delegated authority)
- To Rreview the Trust's cash flow and balance sheet, to ensure effective cash management plans are in place

Capital Expenditure and Investment

- To Rreview the Trust's capital plan ensuring its alignment to strategic priorities
- To Rreview and assess the financial implications of the PFI contract for Tunbridge Wells Hospital, including any options for re-financing
- To approve Business Cases for capital and service development, within the financial limit set out in the Reservation of Powers and Scheme of Delegation
- To Rreview Business Cases for capital and service development above the financial limitthreshold set -out in the Reservation of Powers and Scheme of Delegation, and make a recommendation to the Trust Board regarding the approval of such Cases
- To Rreceive assurance on the effectiveness of the Trust's investment appraisal and approval process (via consideration of post-project reviews)

Financial Governance, Reporting, Systems and Function

- To Rreview and assess the arrangements for financial governance
- To Rreview and assess the effectiveness of financial information systems and monitor development plans, including the development of Service Line Reporting (SLR)
- To Rreview and assess the capacity and effectiveness of the finance function and ensure development plans are in place to meet the current and future requirements of the Trust
- To aAssess the organisational awareness and adherence to financial management disciplines and controls and promote congruence between quality patient care and the achievement of financial objectives
- To Rreview and approve the Trust's approach to its National Cost Collection return/s

Procurement

- To Mmonitor performance against the Trust's Procurement Strategy and Procurement Transformation Plan

Performance

- To mMonitor and review non-quality performance-related issues, particularly in relation to the key patient access targets
- To mMonitor and review the indicators within the Trust Performance Summary ScorecardIntegrated Performance Report (IPR) (and associated information) prior to review by the Trust Board
- To Eescalate performance-related issues to the Trust Board in the event of any concerns

Informatics (including Information Technology

- To ~~R~~review Information Technology strategies and plans and ensure they are consistent with the Trust's overall vision and strategic goals
- To ~~R~~review plans and proposals for major development and investment in Information Technology, and advise the Trust Board accordingly, paying particular attention to the financial implications and risks of the proposals

Assurance and Risk

- To ~~A~~assure itself on (i) the identification of principal risks associated with the financial performance and financial management of the Trust, and Information Technology, (ii) the effective management of those risks and (iii) the escalation to the Trust Board of matters of significance

7. Parent Committees and reporting procedure

The Committee is a sub-committee of the Trust Board.

A summary report of each Committee meeting will be submitted to the Trust Board. The Chair of the Committee will present the Committee report to the next available Trust Board meeting

8. Sub-Committees and reporting procedure

The Committee has no standing sub-committees, but may establish fixed-term working groups, as required, to support the Committee in meeting the p~~P~~urpose and/or d~~D~~uties listed in these Terms of Reference.

9. Emergency powers and urgent decisions

The powers and authority which the Trust Board has delegated to the Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least two Members of the Executive Team (see * in the above "Membership" section). The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Committee.

10. Administration

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

The Trust Secretary will ensure that each committee is given appropriate administrative support and will liaise with the Committee Chair on:

- The Committee's Forward Programme, setting out the dates of key meetings & agenda items
- The meeting agenda
- The meeting minutes and the action log

11. Review of Terms of Reference and monitoring compliance

The Terms of Reference of the Committee will be reviewed and agreed by the Committee at least annually, and then formally approved by the Trust Board.

History

- Terms of Reference agreed by Finance Committee, May 2013
- Terms of Reference reviewed and agreed by Finance Committee, May 2014 (with a minor additional to duties agreed at the June 2014 Finance Committee)
- Terms of Reference approved by Trust Board, July 2014
- Terms of Reference (revised) agreed by Finance Committee, June 2015
- Terms of Reference (revised) approved by Trust Board, July 2015
- Terms of Reference (minor revision) agreed by Finance Committee, September 2015
- Terms of Reference (minor revision) approved by Trust Board, September 2015
- Terms of Reference (reviewed and revised) agreed by Finance Committee, June 2016
- Terms of Reference (revised) approved by Trust Board, June 2016
- Terms of Reference (reviewed and revised) agreed by Finance Committee, June 2017

- Terms of Reference (revised) approved by Trust Board, June 2017
- Terms of Reference approved by Trust Board, October 2017 (to add Associate Non-Executive Directors to the membership)
- Terms of Reference agreed by the Finance and Performance Committee, April 2018 (to remove the Deputy Chief Executive from the membership, following the discontinuation of that post)
- Terms of Reference (revised) approved by Trust Board, May 2018 (to remove the Deputy Chief Executive from the membership, following the discontinuation of that post)
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, July 2018
- Terms of Reference (revised) approved by the Trust Board, July 2018
- Terms of Reference agreed by the Finance and Performance Committee, August 2018 (to add a further Associate Non-Executive Director to the membership)
- Terms of Reference (revised) approved by the Trust Board, September 2018
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, August 2019
- Terms of Reference (revised) approved by the Trust Board, September 2019
- Terms of Reference (reviewed and revised) agreed by the Finance and Performance Committee, August 2020
- Terms of Reference (revised) approved by the Trust Board, September 2020

Trust Board meeting – 24th September 2020

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the Patient Experience Committee, 03/09/20	**Committee Chair (Non-Executive Director)**

The Patient Experience Committee (PEC) met on 3rd September 2020.

The key matters considered at the meeting were as follows:

- The Committee reviewed the **Trust's Clinical Strategy** and was informed regarding the plans for external stakeholder involvement and the Committee's role in the further development of the Trust's Clinical Strategy. It was agreed that the Director of Strategy, Planning & Partnerships should submit an update on the development of the Trust's Stroke Rehabilitation Service to the December 2020 meeting
- The Committee undertook **An in-depth review of complaints related to communications** which included the a review of the Divisional action plans to reduce the number of complaints related to the key themes of "Difficulty getting through / making contact"; "Lack of information provided / inconsistent information / incorrect information provided"; and "Lack of compassion / Not listening / Tone / Manner". The Committee supported the actions outlined within the report to reduce the number of complaints related to communications and improve the patient experience across the Trust. It was agreed that the Complaints & PALS Manager / Divisional Director of Nursing & Quality, Cancer Services should Liaise with the Chair of the League of Friends of the Maidstone Hospital to confirm if permission had been granted to further discuss the specific complaint related to the Administrative Services within the Cancer Services Division, and if so, to investigate the actions that could be taken to improve the Administrative Services provided within the Cancer Services.
- The Committee noted a **review of complaints received during Quarter 2**
- The Deputy Chief Nurse provided an **update on The Patient and Carer Strategy ("Making it Personal")(Incl. plans for the development of Patient Feedback)** which included details of the mechanism that had been implemented to ensure the monitoring and effective implementation of the Patient and Carer Strategy ("Making it Personal"). It was agreed that the Deputy Chief Nurse should ensure that future reports for "Patient Feedback" items included real-time data from the various patient feedback mechanisms across the Trust.
- The Chief Nurse gave a report on the **Findings from the National Inpatient Survey 2019 and Trust response** which included that there was no significant variation from the National Inpatient Survey 2018 results and that it had been highlighted the information patients received during the discharge process was a key area for improvement which was aligned with the work being developed as part of the Patient Experience Strategy.
- Under **To consider the Forward Programme** it was agreed that the Assistant Trust Secretary should schedule the December 2020 meeting to be held virtually, via webconferencing facilities and schedule an informal Committee meeting for October 2020, to focus on the development of the Committee's Terms of Reference and forward programme (incl. giving consideration to a revision of the external membership of the Committee to better represent the local demographic).

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