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

Thu 26 November 2020, 09:45 - 13:00

Virtual meeting, via webconference

Maidstone and Tunbridge Wells NHS Trust

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-3FLrIuzYSc29211EQ).

11-1.
To receive apologies for absence

David Highton

11-2.
To declare interests relevant to agenda items

David Highton

11-3.
To approve the minutes of the 'Part 1' Trust Board meeting of 22nd October 2020

David Highton

Board minutes 22.10.20 (Part 1).pdf (10 pages)

11-4.
To note progress with previous actions

David Highton

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

11-5.
Report from the Chair of the Trust Board

David Highton

Chair's report.pdf (1 pages)

11-6.

Report from the Chief Executive

Miles Scott

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

11-7.
Integrated Performance Report (IPR) for October 2020 (incl. an update on progress with the Perinatal Mortality Review Tool; and planned and actual ward staffing for Oct. 2020)

Miles Scott and colleagues

IPR for Oct 2020 (incl. PMRT and planned and actual ward staffing).pdf (41 pages)

Planning and strategy

11-8.
Update on Phase three (of NHS response to COVID-19) performance and 16-week plan (incorporating the winter plan)

Sean Briggs and colleagues

Update on Phase three (of NHS response to COVID-19) performance and 16-week plan (incorporating the winter plan).pdf (16 pages)

11-9.
Capital funding and expenditure for 2020/21

Steve Orpin

Capital funding and expenditure for 2020-21.pdf (3 pages)

11-10.
To approve a Business Case for a replacement Linear Accelerator (LinAc) at Kent and Canterbury Hospital

Steve Orpin / Amanjit Jhund

Bus Case for replacement of LA3C at Canterbury.pdf (20 pages)

11-11.
Communications resourcing plan

Amanjit Jhund

Communications resourcing plan.pdf (8 pages)

Board Assurance Framework

11-12.
Review of the Board Assurance Framework 2020/21

David Morgan

Board Assurance Framework 2020-21.pdf (13 pages)

Assurance and policy

11-13.
Update from the Senior Information Risk Owner (SIRO) (incl. the current position on the Data Security and Protection Toolkit for 2020/21)

Claire O'Brien

Update from the SIRO.pdf (4 pages)

Reports from Trust Board sub-committees

11-14.
People and Organisational Committee, 15/10/20 (as the Workforce Committee) (incl. quarterly report from the Guardian of Safe Working Hours) and 20/11/20

Emma Pettitt-Mitchell

The report from the meeting on 20/11/20 will be verbal.

Summary of Workforce Cttee, 15.10.20.pdf (3 pages)

11-15.
Quality Committee, 16/10/20 and 11/11/20

Sarah Dunnett

Summary of Quality C'ttee, 16.10.20.pdf (1 pages)
Summary of Quality C'ttee, 11.11.20.pdf (1 pages)

11-16.
To approve a proposal for the Quality Committee to replace the People and Organisational Development Committee as the ‘parent’ committee of the Health and Safety Committee

Kevin Rowan

Proposal to change parent committee of H&S cttee.pdf (1 pages)

11-17.
Audit and Governance Committee, 04/11/20 (incl. approval of revised Terms of Reference)

David Morgan

Summary of Audit and Governance Committee, 04.11.20 (Incl. Terms of Reference and request to defer SFIs etc.).pdf (9 pages)

11-18.
Finance and Performance Committee, 24/11/20

Neil Griffiths

N.B. The report will be issued after the meeting on 24/11/20.

11-19.
Charitable Funds Committee, 24/11/20

David Morgan

This will be a verbal report.

11-20.
To approve revised Terms of Reference for the Remuneration and Appointments Committee (annual review)

David Highton

Revised Terms of Reference for RemCom.pdf (3 pages)

11-21.
To consider any other business

David Highton

11-22.
To approve the motion (to enable the Board to convene its ‘Part 2’ meeting) that...

David Highton

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

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 22ND OCTOBER 2020, 9.45 A.M, VIA WEBCONFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board	(DH)
	Sean Briggs	Chief Operating Officer	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Neil Griffiths	Non-Executive Director	(NG)
	Peter Maskell	Medical Director	(PM)
	David Morgan	Non-Executive Director	(DM)
	Claire O'Brien	Chief Nurse	(COB)
	Steve Orpin	Deputy Chief Executive/Chief Finance Officer	(SO)
	Emma Pettitt-Mitchell	Non-Executive Director	(EPM)
	Miles Scott	Chief Executive	(MS)
In attendance:	Karen Cox	Associate Non-Executive Director	(KC)
	Richard Finn	Associate Non-Executive Director	(RF)
	Amanjit Jhund	Director of Strategy, Planning & Partnerships	(AJ)
	Cheryl Lee	Director of Workforce	(CL)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Jo Webber	Associate Non-Executive Director	(JW)
	Kevin Rowan	Trust Secretary	(KR)
	Rantimi Ayodele	Chair of the Cultural and Ethnic Minorities Network (CEMN) (for items 10-12 to 10-14)	(RA)
	Jo Garrity	Head of Staff Engagement and Equality (for items 10-12 to 10-14)	(JG)
	Christian Lippiatt	Freedom to Speak Up Guardian (FTSUG) (for items 10-14 and 10-15)	(CLi)
	Jane Saunders	Programme Director for EPR (Sunrise) and Digital Transformation (for item 10-11)	(JS)
	Wilf Williams	Accountable Officer, NHS Kent and Medway Clinical Commissioning Group (for item 10-10)	(WW)
Observing:	The meeting was livestreamed on the Trust's YouTube channel.		

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

10-1 To receive apologies for absence

No apologies were received.

10-2 To declare interests relevant to agenda items

No interests were declared.

10-3 To approve the minutes of the 'Part 1' Trust Board meeting of 24th September 2020

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

10-4 To note progress with previous actions

The submitted report was noted. Questions or comments were invited. None were received.

10-5 Report from the Chair of the Trust Board

DH referred to the relevant attachment and emphasised how appreciative he and the Non-Executive Directors were of the efforts being made by staff, particularly in relation to the aim to deliver pre-COVID-19 levels of clinical activity. DH added that such efforts should not be, and had

not been, taken for granted. DH also noted the appointment of a Consultant Geriatrician, while MS added that some Critical Care consultant appointments had been made on 21/10/20.

10-6 Report from the Chief Executive

MS referred to the relevant attachment and highlighted the key points therein, which included the recent activity regarding the Exceptional People Outstanding Care programme, and in particular the Exceptional Leaders Outstanding Care programme, which was being undertaken in partnership with Lane4 Management Group Ltd. MS also drew attention to the various donations the Trust had received over the recent past, and thanked the various donors.

10-7 Integrated Performance Report (IPR) for September 2020 (incl. planned and actual ward staffing for Sept. 2020)

MS referred to the relevant attachment and stated that the IPR needed to be considered in the context of the Phase three (of NHS response to COVID-19) plans, which were having a positive impact. MS also highlighted the continued good performance on complaints responses but noted that some staffing pressures had started to emerge.

COB then referred to the “Safe” domain and stated that the “Actual” “Overall Safe staffing fill rate” of 91.7% was an anomaly with the eRoster system that had not yet been addressed. COB added that although there were some issues regarding staffing, these were not at a level that gave COB any cause for concern. COB also elaborated on the latest falls position and gave assurance that that continued to be a priority.

SM then referred to the infection control aspects of the “Safe” domain and highlighted that there had been no hospital-acquired COVID-19 cases in September 2020, although some COVID-19 admissions had started to be seen in recent weeks.

PM then referred to the “Effective” domain and highlighted the improved performance on the “Stroke Best Practice Tariff” indicator and Sentinel Stroke National Audit Programme (SSNAP) rating. PM also reported on the performance regarding transient ischaemic attacks (TIAs) and noted that mortality had started to increase slightly, but had now stabilised. MS referred to the stroke performance and drew attention to the fact that the Secretary of State for Health and Social Care’s decision on the Independent Reconfiguration Panel’s recommendation (regarding the establishment of the Hyper Acute Stroke Unit) was still awaited, which meant that the capital funding for the refurbishment of the Trust’s stroke unit was still not forthcoming. MS added that the stroke team should therefore be commended for their continued commitment, not least because of the increase in stroke patient activity. MS also reported that the issue had been formally raised with the Integrated Care System (ICS) & he understood it had also been raised with NHS England.

DH stated that he was aware of some bed pressures on the stroke unit that would affect the plans regarding stroke rehabilitation and asked for a comment. PM replied that stroke rehabilitation services had been provided at the KIMS site in Maidstone during the COVID-19 period and consideration was being given to the best future location for that service. PM added that he believed the best solution was to enhance the early assisted discharge arrangements but discussions would continue.

SDu referred back to PM’s remarks regarding TIAs and asked whether there was any evidence that the Trust was missing strokes in patients because of the situation with TIA clinics. PM confirmed that some strokes would likely have been missed in TIA patients presenting in the community. SDu asked whether there was anything that could be done to reinforce the message to the community to be vigilant about their own symptoms. PM concurred that when patients did not present with TIAs the incidence of strokes increased, and gave his perspective on the public health messages, but stated that he believed it was imperative for the Trust to demonstrate that the hospitals were safe to visit, and that the risk of nosocomial infection was low. PM continued that the Trust needed to be clear to patients and the public that it was ‘open for business’ and the communication between clinical teams and the relatives of patients who were currently being treated in hospital continued to be important.

COB then referred to the “Caring” domain and highlighted that the Trust’s performance on the complaints response rate, at 80%, continued to be above the 75% target, while the key themes from complaints were being considered, although one evident theme was the difficulties that the partners of those undergoing pre-pregnancy scans faced because they had not been allowed to accompany their partners during such scans. COB added that the rationale had however been clearly communicated to those affected. COB also noted that the Trust was not yet required to re-introduce the Friends and Family Test (FFT), following the national pause that had occurred during the COVID-19 period, but the Trust wanted to reintroduce the process and had therefore done so.

MS then referred to the “Responsive” domain and highlighted that the content would be addressed under item 10-8, so just invited questions or comments. DH noted that Emergency Department attendances seemed to have reduced in recent weeks so asked whether that was likely to be due to public concerns regarding the second wave of COVID-19 cases or the beneficial effects of the new enhanced NHS 111 clinical assessment service. MS replied that there was no evidence to suggest that the latter had had a beneficial effect, but the situation would need to be monitored as there was some evidence of increased pressure in the local system and the Trust had accepted an ambulance divert from Medway NHS Foundation Trust earlier that week. SB added that there was evidence from other parts of the country, where the second wave of COVID-19 cases had been more pronounced, that ED attendances had started to reduce, as the public’s attitude changed.

JW noted the ‘Medically Fit For Discharge’ numbers were increasing and asked SB whether he was confident that the systems in place during the first COVID-19 wave would be sufficient for the second wave. SB noted the increase and gave assurance that work was continuing with the Trust’s partner organisations to try and address the issues.

SO then referred to the financial aspects of the “Well Led” domain and reported that September was the last month of the financial regime that had been introduced during COVID-19 and the ‘top up’ that the Trust had claimed was its largest to date, although £700k of the claim related to a staff payment award. SO also reported that COVID-19 costs had risen slightly, but these reflected a ‘clear off’ of older items, including the costs associated with exploring the potential Nightingale Hospital in Detling. SO then reported on the latest capital position and noted that that had been discussed in detail by the Finance and Performance Committee on 20/10/20.

CL then referred to the workforce aspects of the “Well Led” domain and noted that there had been a lively and vibrant Workforce Committee meeting in October which would be covered under item 10-17. CL added that a number of the well-led indicators were not reported in the IPR because 25 data points were required to apply the Statistical Process Control (SPC) method, and that would take time to achieve. CL then continued and reported that the response rate for the NHS Staff Survey was currently at 35%, which was as expected at that point, but appealed for support from Trust Board members to encourage staff to complete their surveys at any meetings they attended before the survey closed on 27/11/20. CL also referred to sickness absence data and noted that although the current rate was low, that was expected to rise in the coming weeks, given the COVID-19 pandemic. CL also highlighted that the “Appraisal Completeness” had improved recently, but the target rate was unlikely to be met before the window closed. CL did however commend the considerable work that had been undertaken and stated that was more concerned with the quality of appraisals.

EPM referred to the text in the “Summary” on page 24 of 32 that “The Turnover rate for the last 12 months is 12%. This indicator is experiencing common cause variation (after the limits had been re-set to a new norm) and is consistently failing the target” and asked for an explanation. CL explained that the target was 10% and the Trust was currently at 12%, which she believed was an acceptable level of variance, but stated that she would ensure the narrative in the IPR for the next month more accurately reflected CL’s view of current performance.

Action: Ensure that the text relating to the staff turnover rate in the “Summary” section of the “WELL LED- Operational Objective: Workforce” page of the Integrated Performance Report more accurately reflected the Director of Workforce’s view of current performance (Director of Workforce, October 2020 onwards)

DM asked about the “Use of Agency” indicator which varied markedly from the “Plan”. CL confirmed that that was one of her areas of focus.

DM then asked whether Trust Board members had found the SPC charts helpful or had been confused by the SPC terminology. MS replied that he personally found that both applied but he was cognisant that the system was still new, and many of the indicators had been affected by the COVID-19 pandemic. MS added that it was however important that the members of the Executive Team spent more time considering the nature and monitoring of the indicators when setting the objectives for 2021/22, via the strategy deployment work. DM agreed the system was new, but noted that the issues reported by members of the Executive Team at the Trust Board meeting still followed the way issues had been reported before SPC was introduced, which indicated a lack of comfort with the new system. MS acknowledged the point but explained that his intention was to ensure that the key aspects of each domain were discussed. MC agreed that the confidence in the system was developing, even though some of the data set was not yet fully mature. JW stated that she found the graphs useful, but found the small icons less helpful.

JW then asked about flu vaccinations. CL reported that the Head of Occupational Health was leading on the programme and it was intended to vaccinate all relevant staff by the end of November. CL added that there was a slight concern about the supply of the vaccines but the situation was being monitored, and good progress was being made through peer vaccinators. CL then noted that the Trust now had a responsibility to vaccinate certain patients and asked COB to elaborate. COB explained that the Trust was working through the requirements and aimed to ensure that any processes introduced could be used for a COVID-19 vaccine, when that became available.

RF referred back to DM’s earlier query and stated that he found the new SPC presentation very useful, but there needed to be a clear focus on which indicators were being monitored. The point was acknowledged. EPM also noted that lots of data points were listed as “No SPC” so suggested that either a deadline be set for these or the indicators be removed from the IPR until the data was available. MS noted that he and SO would consider EPM’s point.

MS then asked all Non-Executive Directors to confirm whether they had received a link to the NHS national Staff Survey for 2020. All of the Non-Executive Directors reported they had not received such a link, so CL agreed to arrange for these to be issued.

Action: Arrange for all Non-Executive Directors to be issued with an email/link to enable them to complete the 2020 NHS Staff Survey (Director of Workforce, October 2020 onwards)

Planning and strategy

10-8 Update on Phase three (of NHS response to COVID-19) performance, the OPEL and COVID-19 escalation framework, and 16-week plan (incorporating the winter plan)

SB referred to the relevant attachment and highlighted the key points therein, which included that there had been a small number of COVID-19 admissions, which had been challenging. SB also gave an update on endoscopy activity and highlighted the operational problems with the MRI scanner, which had experienced breakdowns, but noted that work was underway to address the issues by sourcing additional MRI capacity. SB did however confirm that MRI capacity was the largest risk to activity at present.

DH referred to endoscopy activity and asked how much higher the Trust’s percentage would be if the impact of the change in practice to Quantitative Faecal Immunochemical Test (qFIT) had been reflected in the data. SB stated that the percentage would be circa 96%. DH noted that his concern was mainly focused on the financial impact, as the elective incentives framework was now in place. MS confirmed that there was no prospect of the Trust being financially penalised for the performance but discussions were continuing as to whether the Trust could go further, faster.

[N.B. There was a brief recess at the meeting at this point, to try to resolve some technical problems some Trust Board members were experiencing with the virtual meeting platform]

SB then referred to the “Winter Planning” section of the report and highlighted the key points, which included the “Covid Escalation Triggers” section. SB pointed out that further work was however required to align with the latest national guidance, which had changed in the last few days, but the triggers were based on the existing Operational Pressures Escalation Level (OPEL) framework. SB also elaborated on some of the key aspects of the 16-week plan, which included the implementation of the TeleTracking system, and emphasised the importance of the Trust’s staff to the plans, as staff were tired, as many had not had a proper break since the first wave of COVID-19 cases. SB then highlighted the changes that had been made, or were planned, regarding the use of clinical space, which included the Critical Care expansion that would be considered via a Business Case in the ‘Part 2’ Trust Board meeting scheduled for later that day. SB added that the required level of funding had however been provided by SO.

SB then reported that the plan involved holding system incident events every month, to focus on patient flow and increasing discharges, and prepare for having to create capacity for COVID-19 cases, should that be needed. SB then referred to the EU transition section and confirmed he was confident in the plans developed by the Director of Emergency Planning & Communications.

NG commended the work but noted that the implementation of the plan seemed to require a ‘command and control’ approach, so asked how that married with the Trust’s devolved, clinically-led arrangements. SB confirmed that all of the Chiefs of Service had been supportive of the approach, while the Chiefs of Service for Medicine & Emergency Care and Surgery had been particularly involved. SB continued that the plan would be challenging, and he was clear that the Chiefs of Service wanted an element of ‘command and control’, so a balance was required. MS added that the plan had been developed through the existing clinical management structure and not via a parallel ‘command and control’ structure.

RF referred to the “OPEL and Covid Escalation Triggers” pages and asked whether the last trigger should just be “No. of staff” or the number and motivation/engagement of staff. RF also referred to the “Winter/ 16 week plan” page, which listed “Staff morale and wellbeing” as one of the “Key risks for winter” but had no associated entry in the “Mitigations” box. RF then also referred to the EU transition section, noted that there would be supply chain problems, and asked whether there were sufficient mitigations for these. SB replied that the 16-week plan included a number of staff welfare initiatives and several actions had already been put in place during the COVID-19 period. SB also gave assurance that staff welfare was a priority but ideas for additional initiatives were always welcome. SB then reported that the Procurement Team had undertaken considerable work on mitigating the risks to the supply chain from the EU transition, and there was confidence that the Trust would be able to cope with the worst-case scenario.

CL then remarked that as a relative ‘outsider’ it was clear that the Trust had taken considerable action on staff welfare, but the Trust had also now appointed two mental health practitioners who had started to offer support to staff. CL however emphasised the importance of an individuals’ line manager and noted that a meeting was scheduled for w/c 26/10/20 to focus on frontline leaders. COB also highlighted the importance of considering the real life, day to day, lived experiences of staff. The point was acknowledged.

10-9 Review of nurse staffing for Ward and non-Ward areas (mid-year update)

COB referred to the relevant attachment and highlighted that it did not contain the mid-year review that had been originally intended, as that had not been feasible because of the disruption during the COVID-19 period. COB then noted that international recruitment efforts continued, and the Executive Team Meeting (ETM) was scheduled to consider a Business Case regarding such recruitment on 27/10/20. COB added that the Trust had made a bid for financial support, and was awaiting the final outcome, although she understood that some support had been confirmed. COB then elaborated on the trainee nursing associates, the staff development escalation protocol and the plans to introduce the Safe Care functionality within e-rostering.

DH commended the report and the progress made. SDu noted the Trust’s previous success with overseas recruitment but asked whether there were any plans to evaluate the difference that recruiting a significant proportion of the substantive workforce had made, in terms of the quality of

care and the impact of the introduction of different nursing practices and cultures, to inform the Trust's future plans. COB confirmed no such evaluation had been undertaken but acknowledged the benefit of reflecting on previous experiences. COB also noted that there had been cultural differences in areas such as safeguarding and the prevention of patient falls, so clinical care had to be augmented to accommodate such differences. COB added that discussions had also been held with her counterparts at other local Trusts, to reflect on, and learn from, their experiences of recruiting overseas staff. COB concluded that she would give some further thought regarding the evaluation referred to by SDu. SDu clarified that her question was focused on the large numbers of overseas staff that had been recruited, and the numbers that would be recruited in the future, to ensure that the Trust met the needs of that part of its workforce, and to help all its staff to achieve their potential and be content with working in the environment they were placed. COB acknowledged the point.

Action: Consider how the Trust's overseas nursing staff recruitment programme could be evaluated to inform the future plans to meet the needs of overseas recruits and ensure all staff were content to work in the environment in which they were placed (Chief Nurse, October 2020 onwards)

10-10 The Kent and Medway Integrated Care System (ICS) status application

DH welcomed WW to the meeting. WW then referred to the relevant attachment and highlighted the key points therein, which included that the accreditation was to obtain the 'badge' of being an ICS, but the main point was to consider what being an ICS would mean, in terms of the ICS being the vehicle to enable action to be taken on agreed priorities. WW also added that he envisaged the Clinical Commissioning Group (CCG) to be a servant of the system.

JW asked about the arrangements for scrutiny by Non-Executive Directors. WW noted that interim governance arrangements were in place, and although the sovereignty of individual organisations needed to be respected, there needed to be more common groups considering issues that applied across the system and Non-Executive Directors could play a role in that aspect. WW added that the governance situation was complicated but that did not mean a solution could not be found.

RF stated that the development felt like creeping regionalism, so asked WW what the medium-term would look like for acute hospitals. WW replied that an ICS was a partnership organisation and was not therefore the CCG becoming a Strategic Health Authority (SHA), but consideration of what the future would hold required discussion by all partners. MS added that he believed that the devolution involved in the ICS was devolution from national bodies to the ICS, and such devolution would help coordinate many of the activities that currently took place without considering the wider impact. MS also emphasised the need for the Trust Board to be clear about the responsibility that statutory bodies such as the Trust, had, as a partner within the wider system.

SO stated that he supported the desire to tackle variation across Trusts in the ICS, particularly in relation to finances, but noted that one of the issues that had recently been more understood at the Trust was the differences in quality improvement between toolset and methodology, and although there was consistency in toolset across the ICS, the same could not be said for methodology. WW acknowledged the point but commended the approach that SO and his finance counterparts had taken, in using an 'open book' approach and working collaboratively to identify solutions.

NG asked what the link would be between performance management of organisations and resource allocation, particularly for poorer performing organisations. WW confirmed that there would be a population-based allocation of resources to the CCG, and resources would then be allocated through to providers. WW added that there was however also a desire to use the mutual aid and support opportunities through the ICS, rather than just rely on a regulatory response.

MC acknowledged the iterative nature of the governance arrangements but suggested it would be beneficial for the arrangements to be published. WW clarified that such arrangements were available within the full ICS application pack. MC stated that her point was more related to the iterative nature of the arrangements. The point was acknowledged.

PM commended the fact that the ICS submission had recognised that GPs were the 'building blocks' of the system.

DH then thanked WW for attending and summarised that the Trust Board supported the ICS accreditation submission but noted the concern, particularly from the Non-Executive Directors, that the governance arrangements needed to develop from the interim structure to one that supported system working while respecting the sovereignty of the partner organisations.

10-11 To approve the Digital Transformation Strategy

DH referred to the relevant attachment and reported that it had been discussed at the Finance and Performance Committee meeting on 20/10/20 and the Committee had agreed to recommend that the Trust Board approve the Strategy. JS then highlighted the key aspects of the four chapters of the Strategy i.e. "Our eHospital", "Our Digital Future", "Supporting Our Digital Transformation Strategy" and "Delivering Our Digital Transformation Strategy".

EPM asked what feedback mechanisms were in place for the different workstreams. JS replied that a variety of feedback mechanisms were in place and elaborated on the details, which included the role of the Chief Clinical Information Officer (CCIO) and the plan to introduce a Deputy CCIO.

RF asked whether JS had access to people who understood change. JS noted that the Trust's Transformation Programme Director was involved in the strategy, as were other staff experienced in change.

KC commended the quality of the Strategy but asked for some assurance regarding governance and delivery. JS explained that the Digital Transformation Board had been established, which would consider the strategy milestones and oversee the development of a Strategic Outline Business Case, which would be submitted to the Trust Board, via the Finance and Performance Committee, in due course.

NG asked whether the resources available for training, adoption and development supported the intentions within the Strategy. CL replied that there was a good alignment with the work taking place with the top tier of leaders and the leadership development that was planned with Lane4 Management Group Ltd. SO added that the questions posed at the meeting had emphasised the need to ensure that the strategy deployment aspect of the Exceptional People Outstanding Care programme led to a clear understanding of the areas of strategic focus and priority.

DH referred to RF's point regarding change and stated that the level of change management should not be underestimated, as staff would be required to operate in a new paradigm. DH added that the transition to electronic systems needed time to settle before ways of working were changed further. DH also emphasised that there was a significant amount of change to accommodate between now and April 2021, so staff needed to understand that there was a coherent change programme. The points were acknowledged.

DM then asked whether any change in the status quo was anticipated between the availability of internal and external resources, given the need for balance between the two. JS answered that there was room for a more collaborative approach for some systems, across the region, but there was also a place for some bespoke systems.

The Trust Board approved the Digital Transformation Strategy as submitted.

Quality items

10-12 Annual Report from the Director of Infection Prevention and Control (including Trust Board annual refresher training)

SM referred to the relevant attachment and highlighted that the report had been divided according to the areas within the Hygiene Code. SM added that it was timely for the report to be considered as the Trust Board meeting was taking place within infection control week. SM added that she was very proud of the Infection Prevention and Control team, who had worked tirelessly, before and

during the onset of COVID-19. SM however clarified that the report only covered 2019/20, so had limited content relating to the COVID-19 period.

SM also referred to the Trust's first case of COVID-19, which occurred while SM was on-call on 16/03/20, and noted that the number of cases had then increased markedly over a short time period. SM then referred to the "What the Board needs to know in order to fulfil its responsibilities in respect of Infection Prevention and Control" section, which represented the Trust Board's annual refresher training. SM then highlighted the "Infection prevention and control work plan 2020/2021" section, and stated that it was likely that some aspects of the plan would not be completed.

DH commended the comprehensive nature of the report. SDu echoed DH's remarks but asked SM to elaborate on the reasons why the work plan may not be completed. SM explained the context and the factors involved, noting that some of the plan had been disrupted by the COVID-19 period. SM clarified that it would be more accurate to consider the plan as being modified.

PM also commended the report, while COB reported that the resourcing of the Infection Prevention and Control Team had been reviewed, and it had been agreed that some additional resources would be allocated, to offset the impact of the Deputy Director of Infection Prevention and Control's forthcoming secondment to NHS England.

Assurance and policy

10-13 Six-monthly update on Estates and Facilities (incl. update on the response to the external Estates and Facilities review)

DH referred to the relevant attachment, highlighted that the sections relating to the external Estates and Facilities review had been considered in detail at the Finance and Performance Committee meeting on 20/10/20, and invited questions or comments. None were received.

10-14 Approval of the Workforce Race Equality Standard (WRES) action plan

DH welcomed JG and RA to the meeting. RA introduced the item but then deferred to JG, who referred to the relevant attachment and highlighted the key actions under the four main priority areas i.e. "to increase the percentage of BME staff being recruited into the Trust using methods which actively seek to fulfil gaps in the diversity of teams"; "Starting at Executive level, provide opportunities for white staff to learn from the lived experiences of BME staff enabling them a greater understanding of the impact of discrimination on BME staff and the patients they care for"; "Increase career progression and promotion of our BME staff, including a focus on senior positions including improved access to non-mandatory training and CPD for BME staff"; and "Reduce the percentage of BME staff experiencing harassment, bullying or abuse from colleagues, patients and managers". RA then elaborated on the actions planned and the rationale, which included her pleasure that a Deputy FTSUG had been appointed.

SDu remarked that she found RA's 'comments' on page 7 of 13 very powerful, but asked where the comment that "Neither ourselves in the Network, nor, I feel the Trust in general has effectively grabbed the engagement of those staff in the lower AfC bands (1-4)" was addressed within the action plan. RA elaborated on the rationale for the comment and explained the intended approach.

The Trust Board approved the Workforce Race Equality Standard action plan as submitted.

DH then thanked RA and JW for their work.

10-15 Quarterly report from the Freedom to Speak Up Guardian

CLi referred to the relevant attachment and highlighted the key points therein, which included that although the last quarter had seen a rise in concerns, the rise had been anticipated because of the impact of COVID-19.

COB referred to the "Themes / Issues" section, and the statement that "11 of these concerns relate to infection control processes not being followed which we would relate directly to the COVID-19 pandemic. Of these, there are 6 cases relating to one specific clinical area" and asked what action

had occurred in relation to that area. CLi duly explained the issues raised in the concern and the response.

10-16 To ratify a revised Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ('Policy for Policies')

KR referred to the relevant attachment and highlighted that two main changes to the policy were proposed: firstly, to enable Trust-wide policies that had, at some point in the past, been ratified by the Policy Ratification Committee (PRC), to be allocated a further four year review date i.e. without the need for the policy to be approved or ratified again, if the policy Author and Owner confirmed that the policy was still fit for purpose; and secondly to authorise the ETM to amend, suspend or replace any Trust-wide policy during periods of exceptional disruption, such as those that occurred during the COVID-19 period. KR added that the proposed changes were 'tracked' in the report

MC commended the flowchart on page 8 of 39, but noted that KR oversaw the schedule of policy review dates, so asked whether an escalation process was in place should KR's reminders not achieve the desired effect. KR confirmed an escalation process was in place. MC asked if that process was formal or informal. KR confirmed it was formal and documented. MC asked whether the process included escalating to DH if MS did not respond in relation to a policy for which MS was the Owner. KR confirmed that would be the case but such circumstances had not occurred.

RF referred to paragraph 5.15, "Policies during periods of exceptional disruption" and confirmed he supported the proposed change, but queried whether there should be a time limit, or at least a review date allocated. KR stated that he had no objection and he would include something to that effect if the Trust Board wanted. The Trust Board duly confirmed that it wanted that addition.

Action: Amend the "Policies during periods of exceptional disruption" section of the 'Policy for Policies' to include either a time limit or review date for the arrangements (Trust Secretary, October 2020 onwards)

The Trust Board ratified the revised Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ('Policy for Policies') subject to that further amendment.

Reports from Trust Board sub-committees

10-17 Workforce Committee, 18/09/20 and 15/10/20 (including approval of proposed changes to the Committee's Terms of Reference)

EPM referred to the first relevant attachment and noted that RF had chaired the meeting. Questions were invited. None were received. EPM then referred to the second relevant attachment and highlighted the proposed changes to the Committee's Terms of Reference. EPM then proposed a further change, to replace all occurrences of "workforce" to "people". RF also proposed that "Internal communications" be added to the bulleted list of duties on page 2.

The proposed changes to the Committee's Terms of Reference were approved.

Action: Ensure that the Terms of Reference for the People and Organisational Development Committee reflected the additional changes that were approved at the Trust Board meeting on 22/10/20 (Trust Secretary, October 2020 onwards)

10-18 Quality Committee, 16/10/20

SDu reported that the meeting had been a 'deep dive' and an update had been given on maternity services, which had, in part, been prompted by the situation at East Kent Hospitals University NHS Foundation Trust, but no cause for any concerns were identified. SDu also reported that a presentation on water quality safety had been given by the Director of Estates and Facilities, while a very interesting presentation had been given by the outpatient management team on the plans to improve outpatient services, which had used the analogy of a hotel to explain the issues that needed to be addressed.

10-19 Finance and Performance Committee, 20/10/20

SDu referred to the relevant attachment, noted that she had chaired the meeting in NG's absence, and invited questions or comments. None were received.

10-20 To consider any other business

KR asked the Trust Board to delegate the authority to the 'Part 2' Trust Board meeting scheduled for later that day to approve a Business Case for Critical Care expansion, and approve a Strategic Outline Case (SOC) for Radiology Clinical Strategy Magnetic Resonance Imaging & Cross-Sectional Reporting. The requested authority was duly granted.

10-21 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

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]
10-9	Consider how the Trust's overseas nursing staff recruitment programme could be evaluated to inform the future plans to meet the needs of overseas recruits and ensure all staff were content to work in the environment in which they were placed.	Chief Nurse	October 2020 onwards	Consideration is being given as to how a survey could be undertaken of the overseas nurses that have been recruited in the last year and the staff who have supported them.

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
10-7a	Ensure that the text relating to the staff turnover rate in the "Summary" section of the "WELL LED- Operational Objective: Workforce" page of the Integrated Performance Report more accurately reflected the Director of Workforce's view of current performance.	Director of Workforce	November 2020	The Director of Workforce has updated the text in the Integrated Performance Report (IPR) to reflect the current month's performance.
10-7b	Arrange for all Non-Executive Directors to be issued with an email/link to enable them to complete the 2020 NHS Staff Survey.	Director of Workforce	November 2020	Review of the national guidance confirmed that NHS Non-Executive Directors are not eligible to complete the staff survey. The Non-Executive Directors were duly informed.
10-16	Amend the "Policies during periods of exceptional disruption" section of the 'Policy for Policies' to include either a time limit or review date for the arrangements.	Trust Secretary	November 2020	The "Policies during periods of exceptional disruption" section had the following text added: "Such amendments, suspensions or replacements will, unless otherwise stated by the Executive Team Meeting (ETM), last for the entirety of the period of exceptional disruption. However, if this period lasts longer 12 months, the ETM should review the amendments, suspensions or

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
				replacements, and either confirm their continuation for a further period (to be set by the ETM) or confirm that the policy should revert to its previous state (i.e. before the period of exceptional disruption)."
10-17	Ensure that the Terms of Reference for the People and Organisational Development Committee reflected the additional changes that were approved at the Trust Board meeting on 22/10/20.	Trust Secretary	October 2020	The Terms of Reference were amended to reflect the additional changes that were approved by the Trust Board.

Actions not yet due (and still 'open')

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

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
21/10/2020	Consultant Anaesthetist	James Falconer	Jackson	Anaesthetics	02/11/20
21/10/2020	Consultant Anaesthetist	James Matthew	Wight	Anaesthetics	To be confirmed
21/10/2020	Consultant Anaesthetist	Andrew Sanharib	Al – Rais	Anaesthetics	To be confirmed
21/10/2020	Consultant in Intensive Care	John Kim	Friis	Anaesthetics	03/11/2020

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

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

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

Report from the Chief Executive **Chief Executive**

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

1. A significant rise in Covid-19 cases in our local community means we've seen a rapid increase in coronavirus patients being admitted to our hospitals. This change in situation has meant additional measures have been implemented to help the Trust deal effectively with this second wave of infection. So far we have already introduced more limited visiting, so only people from a patient's support bubble or household can visit, and moved essential staff training back to being online only. Clinical space has also been reviewed and a number of changes and ward moves have taken place at our hospitals to ensure we have enough critical care capacity and dedicated areas to care for Covid-19 patients. If infection rates and hospital admissions continue to rise, it's likely we will need to implement additional measures and tighter restrictions.

   Critically, an important component of our coronavirus response planning and preventing the transmission of the virus is regular testing of staff. MTW is delighted to be part of the first wave of trusts (34 in total) that are rolling out a pilot of the new 'lateral flow' Covid-19 self-test to all staff, starting with our frontline staff. Staff will be required to undertake a test twice a week, with results provided within 30 minutes. It is known that some people are asymptomatic or develop symptoms after catching the virus and this pilot, which is part of the national testing programme, will help to keep staff and patients safe.

2. To reflect the need to achieve maximum flu immunity in the community this year, MTW, like all NHS trusts, is now offering vaccinations to all inpatients and outpatients who are classified as clinically at risk as well as to pregnant people. This will support national health prevention measures to ensure people keep as fit and healthy as possible during the ongoing pandemic.

3. MTW is working closely with its healthcare partners and other agencies to put preparations in place ahead of the end of the EU transition period on 31 December 2020. The Trust Emergency Planning Response and Resilience team is assessing the impact on our services of a potential no trade deal or agreement on other key issues and putting arrangements in place to mitigate any possible risks. MTW is in a strong position as a result of previous business continuity and planning work that's already been undertaken to prepare in advance for all situations. The Trust is currently assessing risks with a particular focus on making sure supply chains remain robust and putting plans together to minimise transport disruption.

4. A group led by Maidstone and Tunbridge Wells NHS Trust and Imperial has been granted over £1m by the National Institute for Health Research (NIHR) Invention for Innovation Award to develop technology to find breast cancer spread in armpit lymph nodes. MTW Consultant Breast and Oncoplastic Surgeon Karina Cox is co-lead researcher on this ground-breaking study that will help find a non-invasive alternative to armpit surgery, greatly helping patients.

5. MTW and Maidstone Borough Council (MBC) have joined forces and created a rainbow bulb garden and wildflower meadow to recognise all key workers across the borough who have worked during Covid-19. MBC's Grounds Maintenance and Park team prepared the ground and planted over 18,000 bulbs to create a flower garden at the front of Maidstone Hospital which will bloom in spring – around the anniversary of the start of the pandemic, and the wild-flower meadow will be in bloom throughout the summer. The gardens will add colour and help attract bees and other wildlife.

6. Improvements have been introduced to reduce the time it takes to test patients waiting to be admitted to hospital from our emergency departments. New equipment is now in place that will significantly reduce the turnaround times for test results to come through. Rapid Testing, which

can process up to 70 tests per day, will minimise the bed wait times for emergency patients who must be tested prior to admission, supporting and improving patient flow through our hospitals.

7. This month MTW rolled-out a new bed management system, TeleTracking, to support our plans to improve further patient flow across our hospitals. This will help us to achieve the aim that #NoPatientWaits meaning staff will be able to quickly identify available beds, reducing administrative time and therefore giving clinical colleagues more time to care and spend with patients.

8. Urgent Treatment Centres (UTC) have now gone live at both hospitals. NHS 111 is used to book appointments for patients to see a practitioner face-to-face at one of the UTCs. The centres support national NHS plans to encourage people to contact NHS 111 first so that Emergency Departments can focus on those patients needing serious and emergency help. Opening hours are 8am to 8pm seven days a week.

9. MTW has been shortlisted for Acute or Specialist Trust of the Year at the national 2020 HSJ Awards. It is a fantastic achievement which recognises the collaborative efforts and dedication of our staff to deliver improved outcomes for our patients. Over the past year the Trust has been rated as one of the best performing Trusts in the country for emergency care and cancer services. We have implemented a range of patient and staff-centred initiatives focused around our 'Exceptional People, Outstanding Care' strategic programme to improve the care and services we provide and make MTW a great place to work. This has included robust plans to boost financial sustainability, taking the trust out of Financial Special Measures; investment in staff welfare, development and facilities; successful recruitment and retention projects to bring in new talent locally and from overseas; and introducing new ideas and ways of working to make the flow of patients through our hospitals more efficient, freeing up clinicians to give compassionate care to those who need our help the most. Congratulations to everyone working at MTW.

10. The Trust has been chosen as the South East Regional Winner in The Excellence in Urgent and Emergency Care Award category of the NHS Parliamentary Awards 2020. The Emergency Department was nominated for making considerable improvements to support best patient and staff care during the Covid-19 pandemic whilst still continuing to maintain high quality and performance standards. Improvements included the development of new roles, front door assessment, direct access to SDEC, increased capacity, system working and appropriate patient streaming. For the last year the Trust has been in the top 10 best performing trusts in the country for emergency care. Well done to everyone working in our Emergency Department.

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 October 2020 (incl. an update on progress with the Perinatal Mortality Review Tool; and planned and actual ward staffing for Oct. 2020)	**Chief Executive / Members of the Executive Team**

The IPR for month 7, 2020/21, is enclosed, along with the monthly finance report, an update on progress with the Perinatal Mortality Review Tool and the latest 'planned vs actual' nurse staffing data.

Which Committees have reviewed the information prior to Board submission?

- Finance and Performance Committee, 24/11/20 (IPR)
- Executive Team Meeting, 17/11/20 (IPR)

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

Review and discussion

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report

October 2020

MTW
exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells NHS Trust

Contents

Appendices (Page 22 onwards)

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

MTW
exceptional people, outstanding care

Key to KPI Variation and Assurance Icons

Variation			Assurance			
						
Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or higher pressure due to (H)igher or (L)ower values	Common cause - no significant change	'Pass' Variation indicates consistently - (P)assing of the target	'Hit and Miss' Variation indicated inconsistency - passing and failing the target	'Fail' Variation indicates consistently - (F)ailing of the target	Data Currently unavailable or insufficient data points to generate SPC

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

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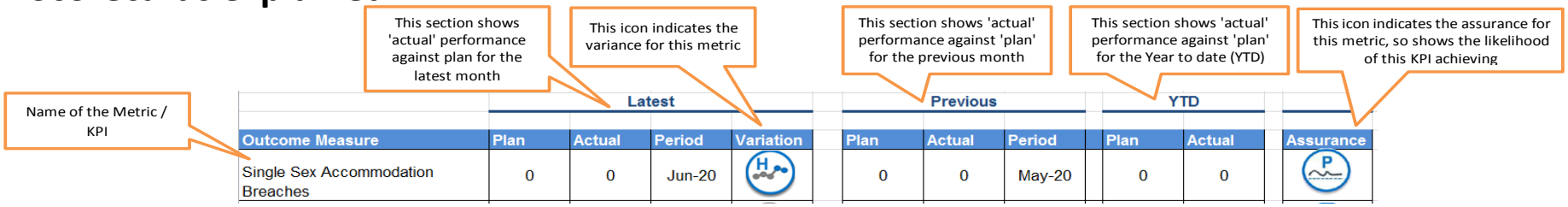
Maidstone and Tunbridge Wells NHS Trust

Escalation Rules:

Areas are escalated for reporting if:

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

Scorecards explained



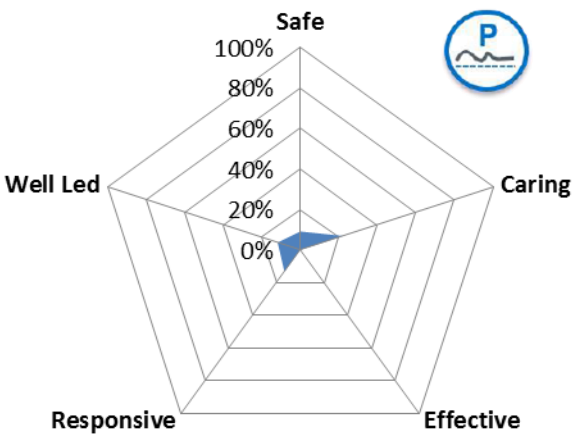
Further Reading / other resources

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

MTW exceptional people, outstanding care

Executive Summary

Consistently Passing



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

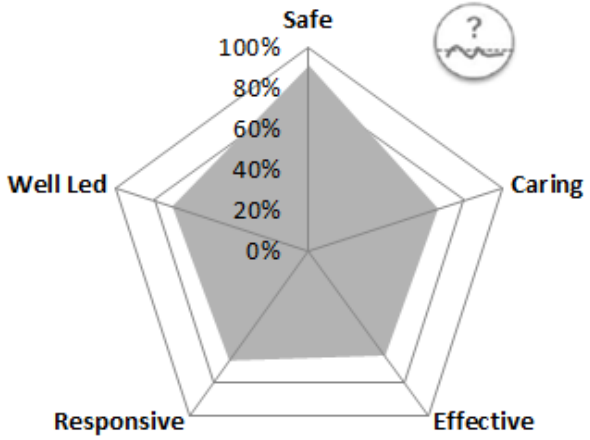
Safe:
- Trust Mortality (HMSR)

Caring:
- Mixed Sex Accommodation Compliance
- VTE Risk Assessment

Responsive:
- Cancer 62 Day Waiting Times Standard
- Cancer 2 week Waiting Times Standard

Well-Led:
- Mandatory Training Compliance
- Number of specialist services

Hit and Miss



Hit and Miss:
The following Key Performance Indicators are experiencing inconsistency (passing or failing target)

Safe:
- Safe Staffing, Infection Control Indicators, Incident Reporting, Harm Free Care Indicators

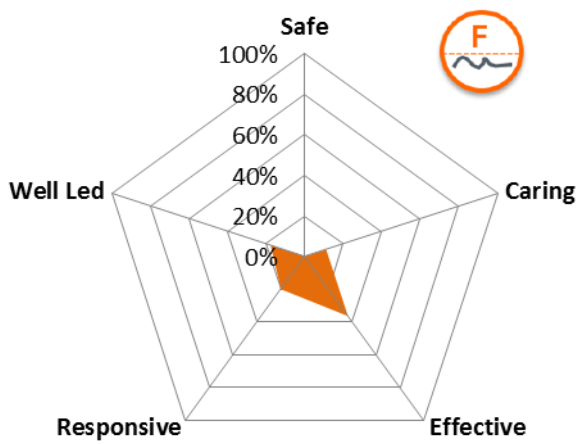
Effective:
- Outpatients DNA Rates and Hospital Cancellations, Readmissions Indicators, Stroke Indicators

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

Responsive:
- RTT performance, Diagnostics Waiting Times, Theatre Utilisation, Cancer 31 Day Standard
- A&E 4hr Standard, Ambulance Handovers, Super-Stranded Patients, Bed Occupancy, NELOS

Well-Led:
- Capital Expenditure, Cash Balance
- Sickness Rates, Vacancy Rates, Appraisals, Staff Friends & Family Rates

Consistently Failing



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

Caring:
- Friends and Family Response Rate for Inpatients

Effective:
- Percentage of Non-Face to Face Outpatient Appointments
- Outpatient Utilisation
- Outpatient – Calls answered within 1 or 3 minutes

Responsive:
- RTT Number of >40 week Waiters
- RTT Number of >52 week Waiters
- Cancer PTL – size of Backlog

Well-Led:
- Agency Staff used
- Agency Spend
- Turnover Rate

Executive Summary Scorecard

Current Month Overview of KPI Variation and Assurance Icons

	Variation					Assurance				Total
Trust Domains									No SPC	
CQC Domain Safe										
Infection Control	4							4		4
Harm Free Care	1		1					2		2
Incident Reporting	1		1					2		2
Safe Staffing	1	1						2		2
Mortality				1		1				1
Safe Total	***7***	***1***	***2***	***1***	***0***	***1***	***0***	***10***	***0***	***11***
CQC Domain Effective										
Outpatients	5	1			1		4	3		7
Quality & CQC	4							4		4
Strategy - Estates									5	5
Effective Total	***9***	***1***	***0***	***0***	***1***	***0***	***4***	***7***	***5***	***16***
CQC Domain Caring										
Complaints	2							2		2
Admitted Care	3				1	2	1	1		4
ED Care									2	2
Maternity Care	2							2		2
Outpatient Care		1						1		1
Caring Total	***7***	***1***	***0***	***0***	***1***	***2***	***1***	***6***	***2***	***11***
CQC Domain Responsive										
Elective Access	2	1	2				2	3		5
Acute and Urgent Access				3	1			4	1	5
Cancer Access	1			1	2	2	1	1	1	5
Diagnostics Access		1						1		1
Bed Management			1					1		1
Responsive Total	***3***	***2***	***3***	***4***	***3***	***2***	***3***	***10***	***2***	***17***
CQC Domain Well-Led										
Staff Welfare									5	5
Finance and Contracts	2				1		1	2	3	6
Leadership		1			1			2	1	3
Strategy - Clinical and ICC	2			3	1	1		5	1	7
Workforce	3		1	1	1	1	2	3		6
Well-Led Total	***7***	***1***	***1***	***4***	***4***	***2***	***3***	***12***	***10***	***27***
Trust Total	***33***	***6***	***6***	***9***	***9***	***7***	***11***	***45***	***19***	***82***

Corporate Scorecard by CQC Domain

Safe

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
S2	Number of cases C.Difficile (Hospital)	5	7		?
S6	Rate of Total Patient Falls	5.80	6.55	H	?
S7	Number of Never Events	0	1	H	?
S8	Number of New SIs in month	11	5		?
S10	Overall Safe staffing fill rate	93.5%	93.0%	L	?

Responsive

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
R1	Emergency A&E 4hr Wait	89.2%	96.0%	H	?
R4	RTT Incomplete Pathway	84.9%	73.3%	L	?
R6	% Diagnostics Tests WTimes <6wks	99.0%	85.1%	L	?
R7	Cancer two week wait	93.0%	96.3%	H	P
R10	Cancer 62 day wait - First Definitive	85.0%	86.1%	H	P

Effective

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
E2	Standardised Mortality HSMR	Lower conf <100	91.9	L	P
E3	% Total Readmissions	14.6%	15.0%		?
E6	Stroke: Best Practice (BPT) Overall %	50.0%	43.2%		?
R11	Average LOS Non-Elective	6.50	6.21	L	?
R12	Theatre Utilisation	90.0%	84.9%		?

Well-Led

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
W1	Surplus (Deficit) against B/E Duty	No data	No data	No SPC	No SPC
W2	CIP Savings	Suspended due to COVID-19		No SPC	No SPC
W7	Vacancy Rate (%)	9.0%	8.0%	L	?
W8	Total Agency Spend	1,717	1,736		F
W10	Sickness Absence	3.3%	3.3%		?

Caring

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
C1	Single Sex Accommodation Breaches	0	0		P
C3	% complaints responded to within target	75.0%	80.6%		?
C5	IP Friends & Family (FFT) % Positive	95.0%	102.7%	H	?
C7	A&E Friends & Family (FFT) % Positive	87.0%	No data due to COVID-19	No SPC	No SPC
C10	OP Friends & Family (FFT) % Positive	84.0%	82.1%	L	?

Variation			Assurance			
H L	H L		P	?	F	No SPC
Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or higher pressure due to (H)igher or (L)ower values	Common cause - no significant change	'Pass' Variation indicates consistently - (P)assing of the target	'Hit and Miss' Variation indicated inconsistency - passing and failing the target	'Fail' Variation indicates consistently - (F)ailing of the target	Data Currently unavailable or insufficient data points to generate SPC

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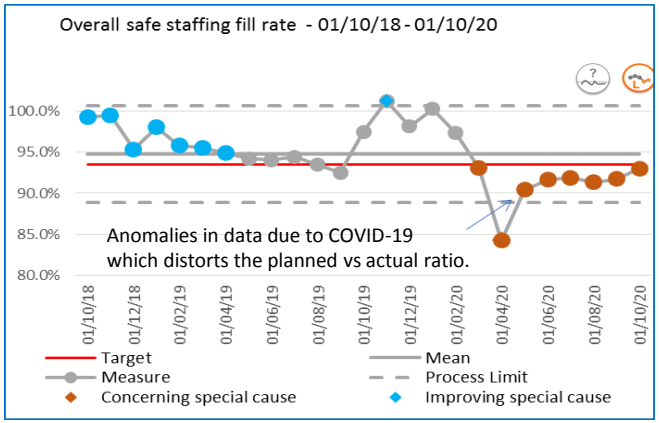
Safe - CQC Domain Scorecard

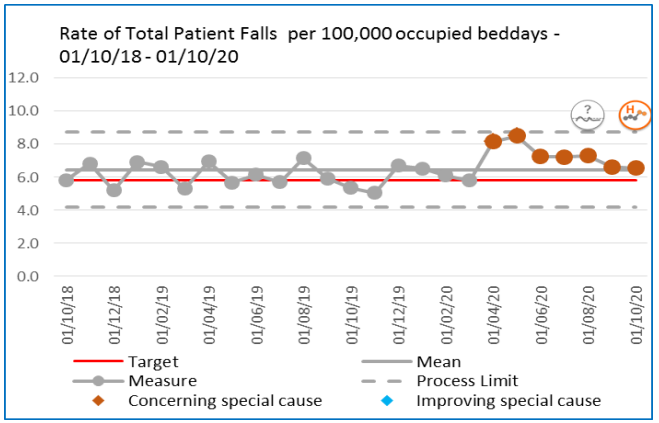
Reset and Recovery Programme: Patient and Staff Safety

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Safe Staffing Levels	93.5%	93.0%	Oct-20		93.5%	91.7%	Sep-20	93.5%	90.7%	
Sickness Rate - Covid	0.0%	0.8%	Oct-20		0.0%	0.2%	Sep-20	0.0%	0.8%	
Infection Control - Hospital Acquired Covid	0	1	Oct-20		0	0	Sep-20	0	48	
Infection Control - Rate of Hospital C.Difficile per 100,000 occupied beddays	24.4	39.8	Oct-20		24.4	12.6	Sep-20	24.7	24.1	
Infection Control - Number of Hospital acquired MRSA	0	0	Oct-20		0	0	Sep-20	0	3	
Infection Control - Rate of Hospital E. Coli Bacteraemia	63.5	17.1	Oct-20		63.5	37.7	Sep-20	35.9	27.3	
Number of New SIs in month	11.0	5.0	Oct-20		11	6	Sep-20	77	56	
Rate of Total Patient Falls per 100,000 occupied beddays	5.8	6.5	Oct-20		5.8	6.6	Sep-20	5.8	7.2	
Rate of Hospital Acquired Pressure Ulcers per 1,000 admissions	2.3	2.0	Oct-20		2.3	1.7	Sep-20	2.3	2.1	
Standardised Mortality HSMR	100.0	91.9	Oct-20		100.0	94.9	Sep-20	100.0	91.9	
Never Events	0	1	Oct-20		0	0	Sep-20	0	1	

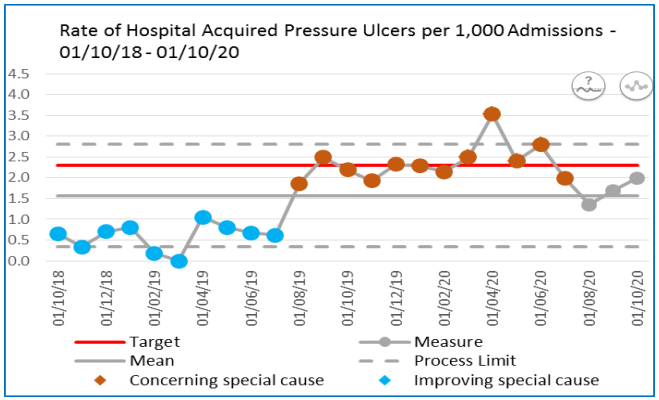
Safe - Reset and Recovery Programme: Patient and Staff Safety



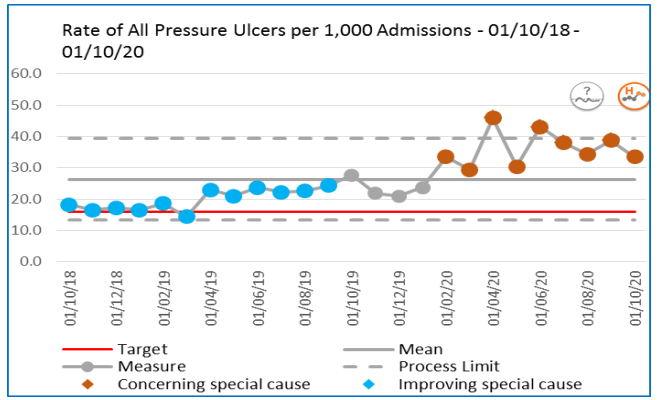
October-20
93.0%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
93.5%
Target Achievement
Metric is experiencing variable achievement



October-20
6.55
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Max Target (Internal)
5.8
Target Achievement
Metric is consistently achieving the target



October-20
2.0
Variance Type
Metric is currently experiencing common cause variation
Max Target
2.3
Target Achievement
Metric is experiencing variable achievement



September-20
33.4
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Max Target (Internal)
16.0
Target Achievement
Metric is experiencing variable achievement

Summary:

Never Event: One Never Event reported in relation to the placement of an NG Tube. This is being investigated .

Safe Staffing Fill Rate: The level reported has continued to increase but remains below usual levels by 0.5%. This metric is experiencing special cause variation of a concerning nature. There has not been any staffing level risk to wards however there has been an increase in staffing requirements to delivery care safely in line with new pathways. There continue to be some anomalies in the data that reflect operational decisions to open and close clinical areas in response to the COVID Pandemic which has distorted the planned vs actual ratio.

Falls: This indicator is experiencing special cause variation of a concerning nature. The number of Falls at Maidstone have increased in recent months, whilst those reported for TWH have decreased.

Pressure Ulcers: The level of hospital acquired pressure ulcers has remained consistent, however, the total rate of pressure ulcers continues to experience special cause variation of a concerning nature.

Actions:

Appropriate action has been put in place to prevent re-occurrence. of he Never Event reported.

Proposal to mandate Falls Prevention training that was agreed at Slips, Trips and Falls Group was taken to CNMT. This was well received and plans being worked up for a Patient Safety Training day that will incorporate Falls VTE and Pressure damage.

The Tissue Viability Service are monitoring the increased incidence of community acquired pressure damage.

We are considering appropriate actions to liaise with partner organisations regarding the increase in all pressure ulcers (including those already having pressure ulcers on admission)

We have met with the Medical PDN's to provide training, education and resources for a 'train the trainer' style system to help with skills and education in the Ward environment.

Assurance:

Monthly meetings with divisional leads and staff bank are ongoing to review temporary staffing requirements across all areas. The Trust has launched "Safe Care" to enhance the monitoring and oversight of patients acuity more effectively and support decisions around staffing requirements. Early adopter areas actively inputting data live. All staffing levels are reviewed for every shift, every day with oversight monitored by the Senior Leadership Team and appropriate redeployment to ensure safe staffing levels are met.

We continue to monitor the falls incidents to identify any themes or trends. This is discussed at Slips, trips and Falls Group to inform directorates' representatives and share any learning.

We continue to triangulate pressure ulcer incidence in COVID positive patients alongside our requirements for data collection from NHS England. International Stop the Pressure day is 19th November 2020 we have an online Tissue Viability Champions day planned with support from our industry colleagues on 13th November 2020. There are 20 clinical staff signed up to the day and there will be 6 interactive learning sessions for staff to participate in.

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%	39.1%	Oct-20	H	75.0%	43.4%	Sep-20	75.0%	48.9%	F
OP Utilisation	85.0%	51.1%	Oct-20	L	85.0%	52.3%	Sep-20	85.0%	50.1%	F
Outpatient DNA Rate	5.0%	5.5%	Oct-20		5.0%	5.6%	Sep-20	5.0%	5.2%	?
Outpatient Hospital Cancellation	20.0%	21.3%	Oct-20		20.0%	21.7%	Sep-20	20.0%	27.2%	?
Outpatient Cancellations < 6 weeks	10.0%	15.9%	Oct-20		10.0%	15.9%	Oct-20	10.0%	20.0%	?
Calls Answereed in under 1 min	75.0%	24.0%	Oct-20		75.0%	24.0%	Oct-20	75.0%	42.1%	F
Calls Answereed in under 3 min	100.0%	46.0%	Oct-20		100.0%	46.0%	Oct-20	100.0%	66.8%	F

Organisational Objectives: Quality and CQC

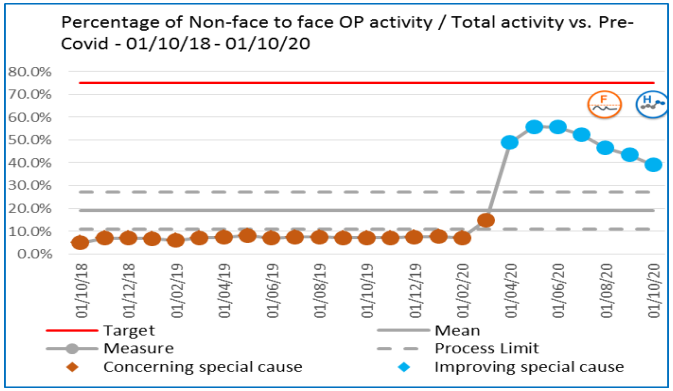
	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Total Readmissions <30 days	14.6%	15.0%	Sep-20		14.6%	15.5%	Aug-20	14.6%	15.2%	?
Non-Elective Readmissions <30 days	15.2%	15.4%	Sep-20		15.2%	16.1%	Aug-20	15.2%	15.4%	?
Elective Readmissions < 30 Days	7.9%	9.8%	Sep-20		7.9%	7.1%	Aug-20	7.9%	10.4%	?
Stroke Best Practice Tariff	50.0%	43.2%	Oct-20		50.0%	59.8%	Sep-20	50.0%	48.1%	?

Effective - CQC Domain Scorecard

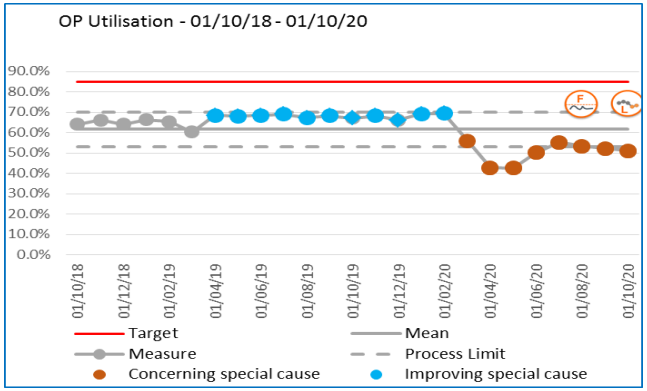
Organisational Objectives: Strategy - Estates

	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Utilised and unutilised space ratio	Under review	100:0	Oct-20	No SPC	Under review	100:0	Sep-20	Under review	100:0	No SPC
Footprint devoted to clinical care vs non clinical care ratio	Under review	4.4:1	Oct-20	No SPC	Under review	4.4:1	Sep-20	Under review	4.4:1	No SPC
Admin and clerical office space in (sqm)	Under review	5808	Oct-20	No SPC	Under review	5808	Sep-20	Under review	5808	No SPC
Staff occupancy per m2	Under review	23.5	Oct-20	No SPC	Under review	23.6	Sep-20	Under review	23.6	No SPC
Energy cost per staff	Under review	£ 815.38	Oct-20	No SPC	Under review	£ 612.91	Sep-20	Under review	£ 681.9	No SPC

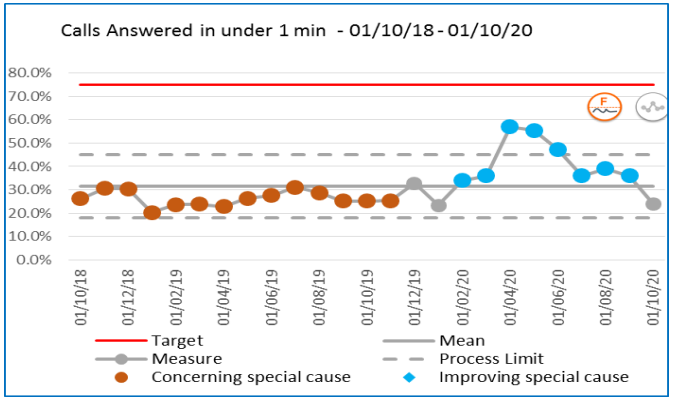
Effective - Reset and Recovery Programme: Outpatients



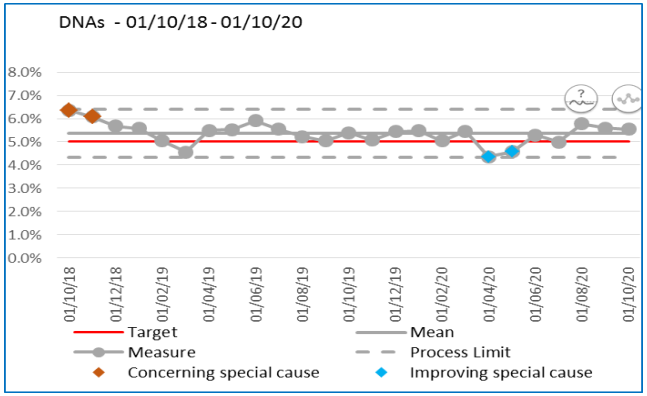
Oct-20
39.1%
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Target (Internal)
75%
Target Achievement
Metric is constantly failing the target



Oct-20
51.1%
Variance Type
Metric is currently experiencing special cause variation of a worsening position
Target (Internal)
85%
Target Achievement
Metric is constantly failing the target



Oct-20
24%
Variance Type
Metric is currently experiencing common cause variation
Target (Internal)
75%
Target Achievement
Metric is constantly failing the target



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

Summary:

As the number of Covid-19 patients decreased, the number of face to face outpatient appointments has been able to increase again and therefore the percentage that are being seen virtually has decreased. However the overall level of activity being seen virtually or face to face has increased.

As expected due to the COVID-19 pandemic outpatient utilisation levels have decreased and remain lower than usual levels.

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.

Actions:

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

The Trust is reviewing the demand and capacity as part of the Reset and Recovery Programme for Outpatients.

Assurance:

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. Weekly monitoring of this is being undertaken in the performance meetings to ensure achievement of the target.

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	Oct-20		0	0	Sep-20	0	0	P
Rate of New Complaints	3.9	3.4	Oct-20		3.9	2.7	Sep-20	3.0	2.3	?
% complaints responded to within target	75%	80.6%	Oct-20		75%	80.8%	Sep-20	75%	77.2%	?
IP Resp Rate Recmd to Friends & Family	25%	8.7%	Oct-20		25%	7.4%	Sep-20	25%	7.6%	F
IP Friends & Family (FFT) % Positive	95%	102.7%	Oct-20	H	95%	96.5%	Sep-20	95%	98.8%	?
A&E Resp Rate Recmd to Friends & Family	15%	No data due to COVID-19	Oct-20	No SPC	15%	No data due to COVID-19	Sep-20	15%	No data due to COVID-19	No SPC
A&E Friends & Family (FFT) % Positive	87%		Oct-20	No SPC	87%		Sep-20	87%		No SPC
Mat Resp Rate Recmd to Friends & Family	25%	21.1%	Oct-20		25%	28.2%	Sep-20	25%	28.3%	?
Maternity Combined FFT % Positive	95%	100.0%	Oct-20		95%	99.1%	Sep-20	95%	99.3%	?
OP Friends & Family (FFT) % Positive	84%	82.1%	Oct-20	L	84%	80.3%	Sep-20	84%	81.3%	?
% VTE Risk Assessment	95%	97.1%	Oct-20		95%	97.1%	Sep-20	95%	96.5%	P

Responsive- CQC Domain Scorecard

Reset and Recovery Programme - Elective Care

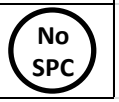
	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
RTT (Incomplete Pathways) performance against trajectory	84.9%	73.3%	Oct-20	L	84.9%	66.7%	Sep-20	84.9%	73.3%	?
Number of patients waiting over 40 weeks	0	1673	Oct-20	H	0	1742	Sep-20	0	9558	F
52 week breaches (new in month)	5	147	Oct-20	H	5	145	Sep-20	35	902	F
Access to Diagnostics (<6weeks standard)	99.0%	85.1%	Oct-20	L	99.0%	85.1%	Sep-20	99.0%	85.1%	?
Average for new appointment	10.0	10.3	Oct-20		10.0	10.6	Sep-20	10.0	10.3	?
Theatre Utilisation	90.0%	84.9%	Oct-20		90.0%	80.0%	Sep-20	90.0%	80.5%	?

Reset and Recovery Programme – Acute & Urgent Care

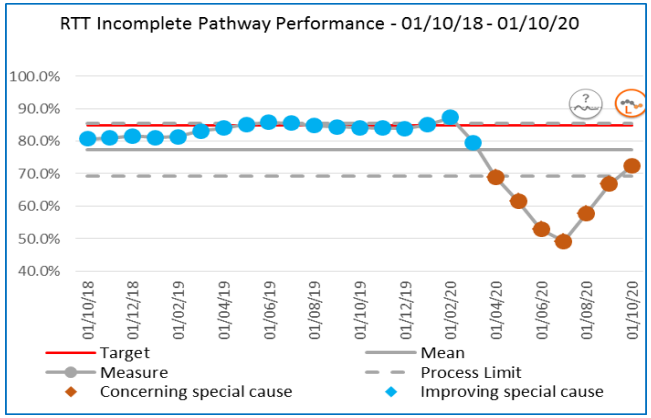
	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Referrals to ED from NHS 111	Coming December 20		Oct-20	No SPC	Coming December 20		Sep-20	Coming December 20		No SPC
A&E 4 hr Performance	89.2%	96.0%	Oct-20	H	89.2%	96.9%	Sep-20	89.2%	97.2%	?
Super Stranded Patients	80	69	Oct-20	L	80	69	Sep-20	80	69	?
Ambulance Handover Delays Rate > 30mins	7.0%	3.5%	Oct-20	L	7.0%	3.2%	Sep-20	7.0%	3.5%	?
Bed Occupancy	90.0%	88.6%	Oct-20	H	90.0%	85.8%	Sep-20	90.0%	66.1%	?
NE LOS	6.5	6.2	Oct-20	L	6.5	6.0	Sep-20	6.5	5.8	?

Responsive - CQC Domain Scorecard

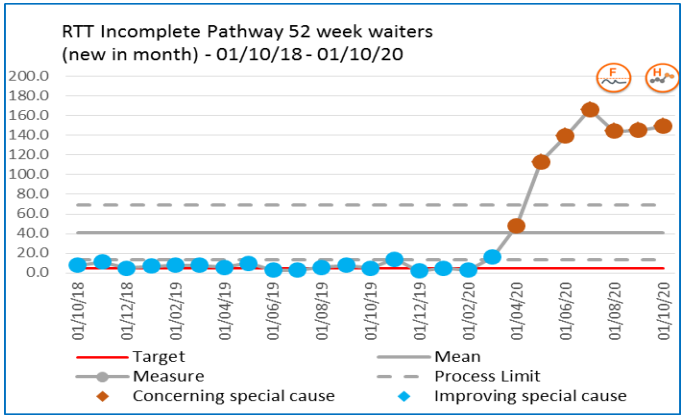
Reset and Recovery Programme – Cancer Services

	Latest				Previous			YTD		
Outcome Measure	**Plan**	**Actual**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Cancer - 2 Week Wait	93.0%	96.3%	Sep-20		93.0%	96.3%	Aug-20	93.0%	96.3%	
Cancer - 31 Day	96.0%	97.8%	Sep-20		96.0%	97.8%	Aug-20	96.0%	97.8%	
Cancer - 62 Day	85.0%	86.1%	Sep-20		85.0%	86.1%	Aug-20	85.0%	86.1%	
Size of backlog	30	51	Sep-20		30	51	Aug-20	30	51	
28 day Target	Coming Soon		Sep-20		Coming Soon		Aug-20	Coming Soon		

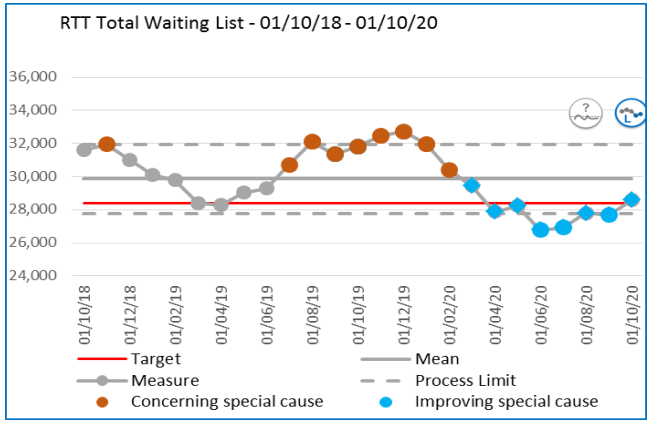
Responsive- Reset and Recovery Programme: Elective



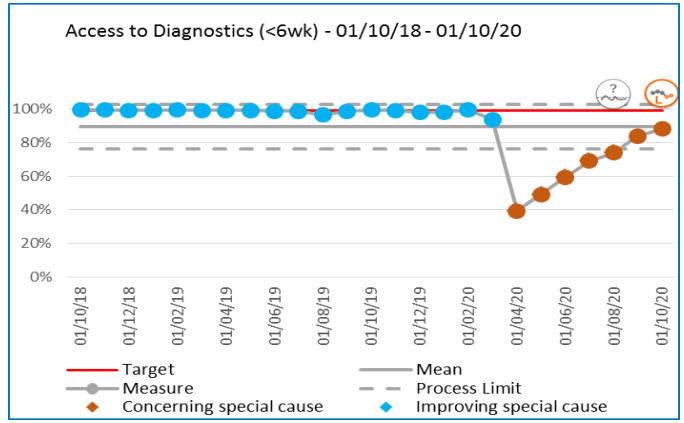
Oct-20
73.35%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target (Internal)
86.3%
Target Achievement
Metric is experiencing variable achievement



Oct-20
147
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Max Target (Internal)
8
Target Achievement
Metric is consistently failing the target



Oct-20
28,457
Variance Type
Metric is currently experiencing special cause variation of an improving nature
Target (Internal)
28,412
Target Achievement
Metric is experiencing variable achievement



Oct-20
85.1%
Variance Type
Metric is currently experiencing special cause variation of a concerning nature
Target
99%
Target Achievement
Metric is experiencing variable achievement

Summary:

Although elective activity levels have significantly increased in October, due to the COVID-19 pandemic the YTD activity remains low for both elective and outpatient appointments which have adversely impacted the RTT performance. However the October performance has improved to 73.35% and has now moved to variable achievement of the target. The Total Waiting List has risen slightly as the level of referrals increase.

The elective activity levels have increased by 12% (excluding IS activity) in October compared to September and OP New Activity has increased by 2%. Large scale cancellations of elective activity has resulted in admitted electives & daycases reducing by 47% on normal levels YTD but with an improvement in October 2020 and New Outpatient activity has reduced by around 28% & follow up by around 8% YTD on normal activity levels, improved in October.

Following the significant decrease in performance for diagnostic waiting times due to the COVID-19 Pandemic this has been improving for both endoscopy and imaging and is now at 88% in October (un-validated figure).

Actions:

To increase elective activity to pre Covid levels - ongoing

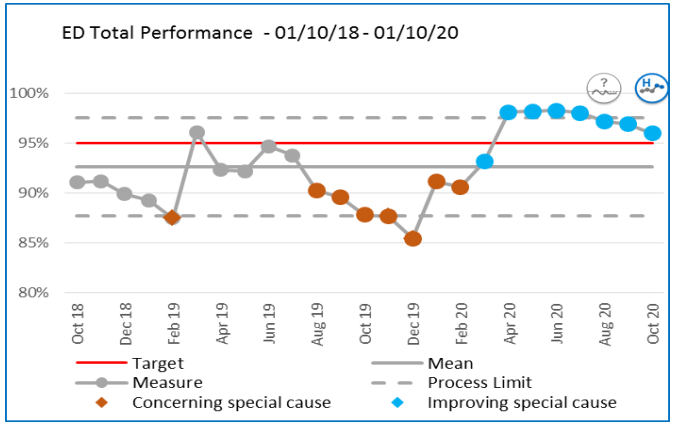
To decrease long waiting patients - ongoing

Assurance:

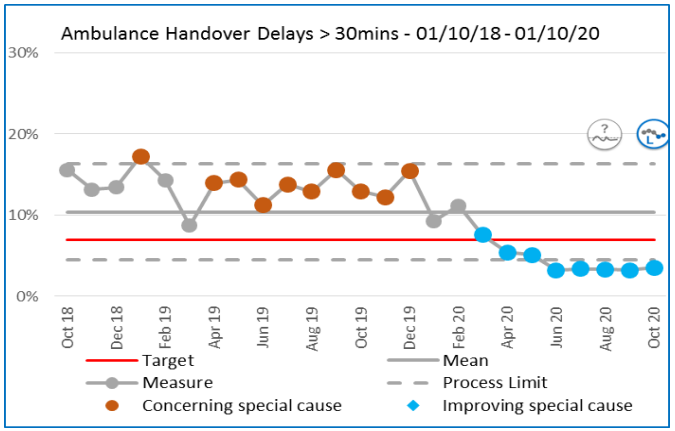
All theatres remain open and the recovery plan is in progress to increase elective activity back to pre-covid levels. Whole patient pathways continue to be transferred to the IS and suitable backlog patients are also being transferred in line with available IS capacity.

Long waiting patients continue to be reviewed and treatment plans implemented. Daily PTL's continue in order to have daily oversight of these patients and scheduled activity. Patient cancellations are also being monitored on a daily basis to gather intelligence in line with Covid prevalence in the community. 40+ week harm review audit completed and is being presented to the Quality committee.

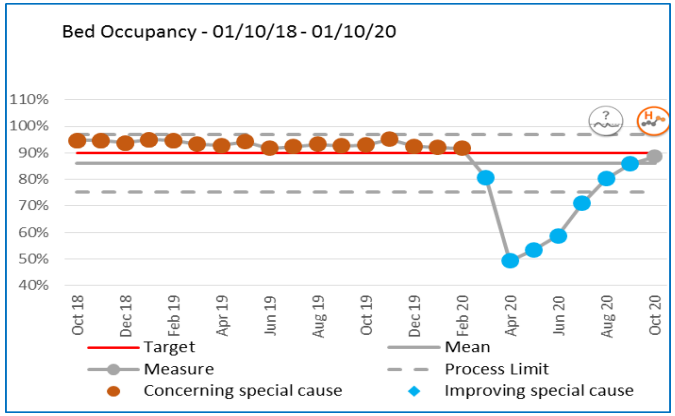
Responsive - Reset and Recovery Programme: Emergency Care



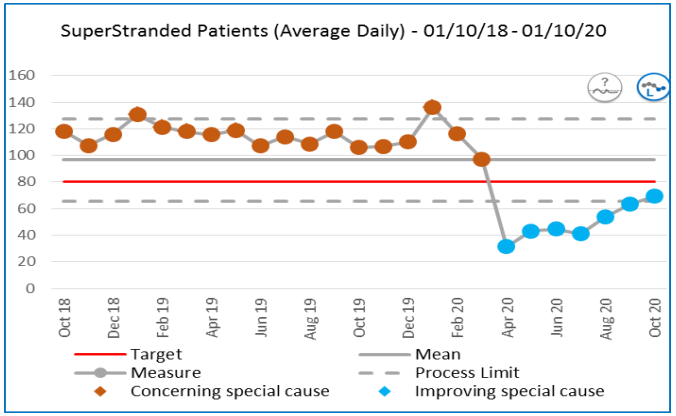
Oct-20
95.98%
Variance Type
Metric is currently experiencing Special Cause Variation of an improving nature
Target
95%
Target Achievement
Metric is experiencing variable achievement



Oct-20
3.5%
Variance Type
Metric is currently experiencing Special Cause Variation of an improving nature
Max Limit (Internal)
7.0%
Target Achievement
Metric is experiencing variable achievement



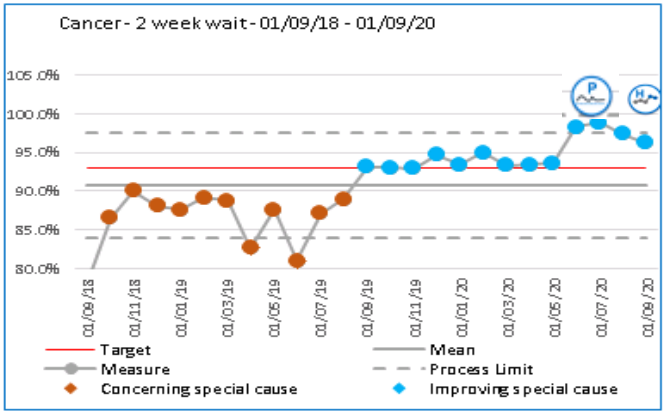
Oct-20
88.6%
Variance Type
Metric is currently experiencing Special Cause Variation of a concerning nature
Max Limit (Internal)
90%
Target Achievement
Metric is experiencing variable achievement



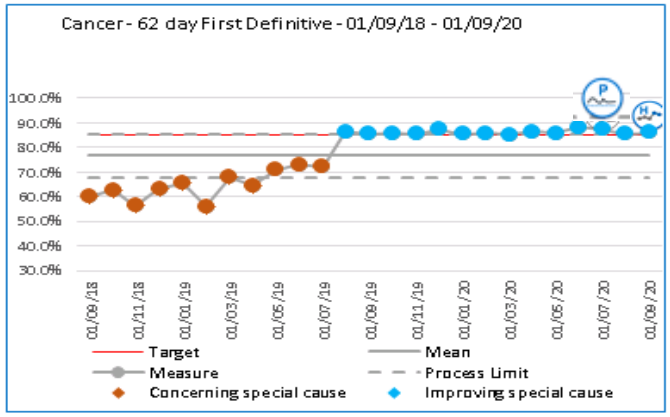
Oct-20
69.5
Variance Type
Metric is currently experiencing Special Cause Variation of an improving nature
Max Limit (Internal)
80
Target Achievement
Metric is experiencing variable achievement

Summary:	Actions:	Assurance:
- ED arrivals (Type 1) dropped by 55-60% at the height of the pandemic. October came in at 18.0% below model - ED 4hr performance (inc MIU) had been above 98.0% for 4 months, but dipped to 95.98% in October - Ambulance delays have been generally improving since New Year, with 3.5% of all handovers delayed 30 mins or longer in October - Total bed occupancy dropped to under 50% during the pandemic, and is recovering. 88.6% in October - SuperStranded patients came down to less than half it's previous levels, but rose to 69.5 in October	Developing RAP administrator role at MH into Flow Coordinator through conversion of vacancy money to further support flow at MH Working towards implementation of UTC on both sites and Sevenoaks from mid Nov to provide additional UTC clinic capacity. Perfect Patient Pathway from 16/11 to develop a number of areas including SDEC. Scrutiny by Triumvirate into breaches and inter Divisional meetings to support improved handover	Development of plans to support 2nd wave / winter pressures. Papers presented to CQC to highlight processes in place with good feedback received. Think 111 First to be implemented from Nov to support triage by minors patients by 111.

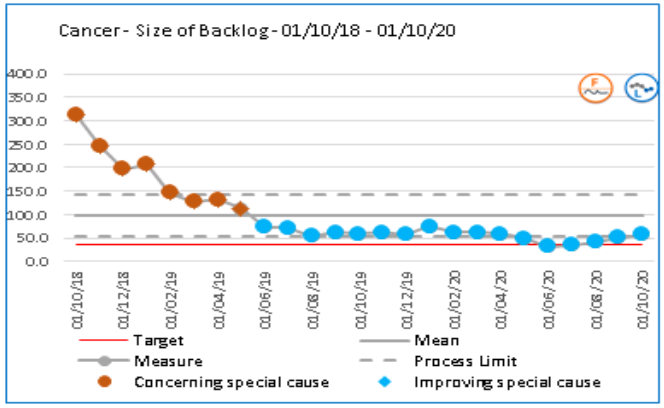
Responsive- Reset and Recovery Programme: Cancer



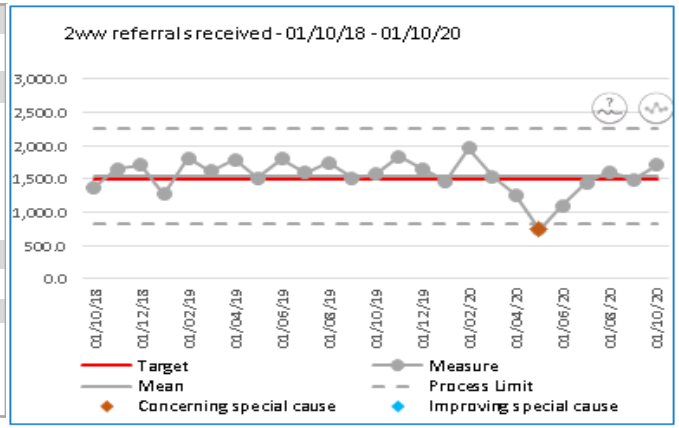
Sept-20
96.3%
Variance Type
Metric is currently experiencing Special Cause Variation of an improving nature
Max Target (Internal)
93%
Target Achievement
Metric is currently achieving the target



Sept-20
86.1%
Variance Type
Metric is currently experiencing Special Cause Variation of an improving nature
Max Target (Internal)
85%
Target Achievement
Metric is currently achieving the target



Oct-20
58
Variance Type
Metric is currently experiencing Special Cause Variation of an improving nature
Max Target
45
Target Achievement
Metric is consistently failing to achieve the target set



Oct-20
1831
Variance Type
Metric is currently experiencing Common Cause Variation
Max Target (Internal)
1500
Target Achievement
Metric is experiencing variable achievement

Summary:

The Trust has continued to achieve both the 62 day First Definitive treatment and the 2 week wait first seen targets, with 86.1% and 96.3% respectively

The number of incoming 2ww referrals has continued to rise in October and the average is now 104% of pre Covid-19 numbers compared to January / February 2020

Although the Total PTL numbers have risen to above 1500, the overall size of the backlog is being maintained with an average of 58 patients in October (which remains at 4.1% of the total PTL)

Actions:

Ongoing work is needed engage all services further and 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 STT nursing roles to support the new pathways that have been developed, and scoping the need for additional roles to support the sustainability of the cancer 62 day target.

Assurance:

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	688	Oct-20	No SPC	Improving Quarterly	738	Jun-20	Improving Quarterly	738	No SPC
Climate Survey - Percentage of staff who feel fully supported in their role		67.0%	Oct-20	No SPC		72.0%	Jun-20		72.0%	No SPC
Climate Survey - Percentage of staff who feel the Trust has a genuine concern for their safety		68.0%	Oct-20	No SPC		71.0%	Jun-20		71.0%	No SPC
Climate Survey - Percentage of staff who feel able to cope with the demands that are being		69.0%	Oct-20	No SPC		76.0%	Jun-20		76.0%	No SPC
Health and Wellbeing metrics	Coming Dec-20		Oct-20	No SPC	Coming Nov-20		Jun-20	Coming Dec-20		No SPC

Organisational Objectives: Workforce

	Latest				Previous			YTD		
Outcome Measure	**Plan**	**Actual**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Sickness	3.3%	3.3%	Oct-20		3.3%	2.9%	Sep-20	3.3%	4.2%	
Turnover	10.0%	12.3%	Oct-20	H	10.0%	12.0%	Sep-20	10.0%	12.3%	F
Vacancy Rates	9.0%	8.0%	Oct-20	L	9.0%	8.6%	Sep-20	9.0%	8.0%	
Use of Agency	0	237	Oct-20		0	225	Sep-20	0	237	F
Appraisal Completeness	95.0%	86.8%	Oct-20		95.0%	72.9%	Sep-20	95.0%	86.8%	
Stat and Mandatory Training	85.0%	90.3%	Oct-20	H	85.0%	89.4%	Sep-20	85.0%	90.3%	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		Oct-20	No SPC	No data		Sep-20	No data		No SPC
CIP Savings	Suspended		Oct-20	No SPC	Suspended		Sep-20	Suspended		No SPC
Cash Balance	59,403	58,144	Oct-20	H	59,403	61,878	Sep-20	59,403	58,144	?
Capital Expenditure	2,155	1,771	Oct-20		2,155	568	Sep-20	10,048	6,088	?
Agency Spend	1,717,298	1,735,554	Oct-20		1,717,298	1,587,849	Sep-20	6,328,068	9,601,283	F
Use of Financial Resources	3	No data	Oct-20	No SPC	3	No data	Sep-20	No data		No SPC

Reset and Recovery Programme: ICC

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Nursing vacancies	13.5%	10%	Oct-20	L	13.5%	12.4%	Sep-20	13.5%	0.0%	?
Covid Positive - number of patients	0	23	Oct-20		0	5	Sep-20	0	365	?

Well Led - CQC Domain Scorecard

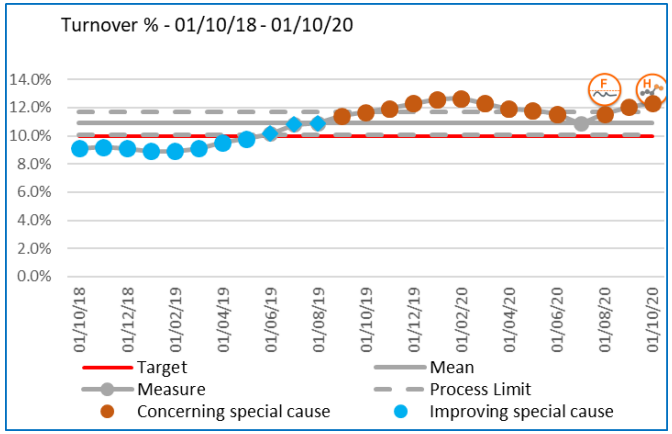
Organisational Objectives - Strategy – Clinical

	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Number of specialist services	35	30	Oct-20	L	35	30	Sep-20	35	210	P
Elective Spells in London Trusts from West Kent	329	303	Jul-20	L	329	439	Jun-20	329	2,029	?
Service contribution by division	Coming December 20		Oct-20	No SPC	Coming December 20		Sep-20	Coming December 20		No SPC
Research grants (£)	114	141	Oct-20		114	137	Sep-20	114	682	?
Number of advanced practitioners	25	31	Oct-20	H	25	31	Sep-20	25	31	?

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%	Sep-20	L	57.0%	72.2%	Aug-20	57.0%	72.2%	?
Staff Friends and Family % recommended care	80.0%	77.8%	Sep-20		80.0%	77.8%	Aug-20	80.0%	77.8%	?
Equality, Diversity and Inclusion reducing inequalities metrics / dashboard	Coming April 21		Sep-20	No SPC	Coming April 21		Aug-20	Coming April 21		No SPC

Well Led - Operational Objective: Workforce



October-20

12.3%

Variance Type

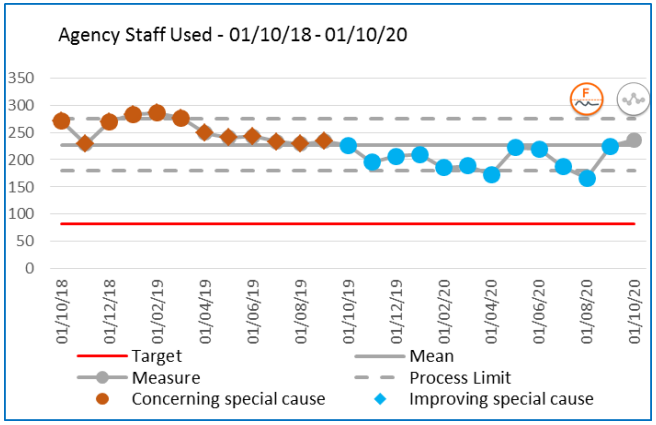
Metric is currently experiencing Special Cause Variation of a concerning nature

Max Target (Internal)

10%

Target Achievement

Metric is consistently failing the target



October-20

237

Variance Type

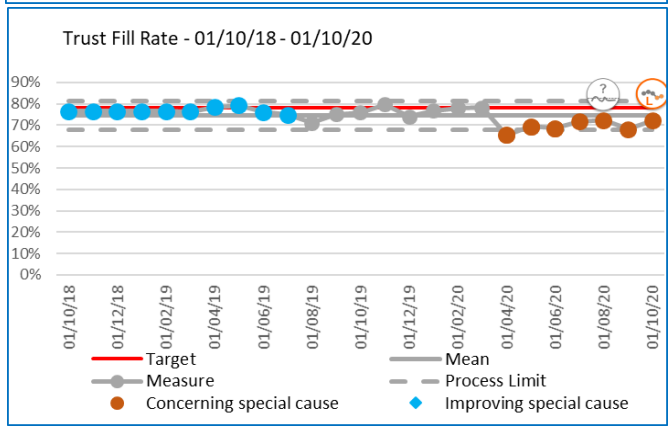
Metric is currently experiencing Common Cause Variation

Max Target (Internal)

81

Target Achievement

Metric is consistently failing the target



October-20

72.3%

Variance Type

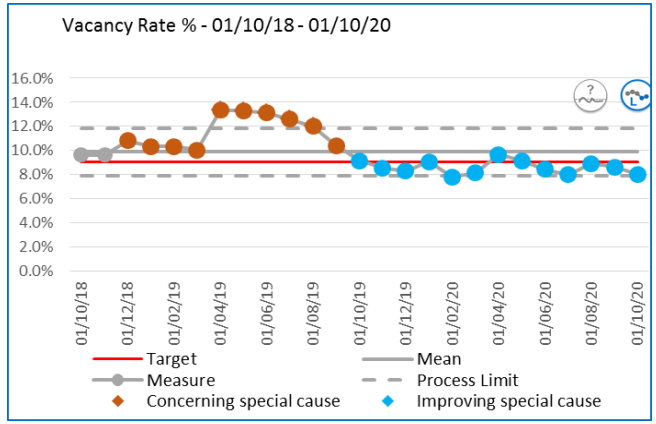
Metric is currently experiencing Special Cause Variation of a concerning nature

Target (Internal)

78%

Target Achievement

Metric is experiencing variable achievement



October-20

8.0%

Variance Type

Metric is currently experiencing Special Cause Variation of an improving nature

Max Limit (Internal)

9.0%

Target Achievement

Metric is experiencing variable achievement

Summary:

The Turnover rate for the last 12 months is increasing and is experiencing special cause variation of a concerning nature.
The level of Agency staff used is consistently higher than plan.
The Trust fill Rate is below the target level of 78% and is experiencing special cause variation of a concerning nature.
This has been affected by the Nursing Staff Fill Rate . There are anomalies in the data that reflect operating decisions to open and close clinical areas in response to the COVID Pandemic which distorts the planned vs actual ratio.
The Vacancy Rate remains below the Trust maximum limit and is therefore experiencing special cause variation of an improving nature.

Actions:

Turnover - The increase and trend in turnover indicates we need better intelligence on turnover as while 12.3% is not relatively concerning, how it is comprised and hotspot areas to worry about is important. We're refining our survey approach to build on the success of the Climate survey to use similar approaches in refreshing exit surveys and new joiner (onboarding) surveys. We're now using Climate survey data to drive local interventions to aid retention. Turnover can be impacted by quality of managers and leaders. We are gathering plans around front line leadership development below Band 8 (Band 8a + are in scope for the Exceptional Leaders programme). We continue our Ward Manager Programme.

Agency usage, although higher than plan has continued to reduce year on year with ongoing plans to migrate agency staff. Bank fill within Nursing has continued to increase month on month with an 18.9% increase in fill rate.

Fill rate / vacancy rates - Ongoing Business as Usual recruitment and delivery of international nurse recruitment programme continues. We are working in partnership with HRBPs to identify vacancy hotspots in order to deliver targeted recruitment solutions within these areas.

Assurance:

Delivery of 2020/21 Workforce plans are supported by the HRBP and workforce information teams. Divisions are reviewing existing workforce and recruitment plans in light of changes driven by COVID reset and recovery work.

Staff engagement and retention work is supported by divisional action plans for the national staff survey and local pulse checks. Progress against these action plans is reviewed in Divisional Performance reviews. Ongoing.

We have been successful in bidding for money from the centre for international nurse recruitment. HRBP have started to work up plans on recruitment hotspot areas across all areas, not solely focusing on nursing. Within this they are working with the leadership teams to look at alternative solutions. For example trailblazing the Consultant Nurse Role in an area which previously struggled to recruit an oncology consultant. Additionally, the recruitment team have encouraged & worked with the Wingman Volunteers leading to their successful recruitment to MTW.

There are areas which continue to challenge MTW due to the roles being on the shortage occupation list. We continue to work with colleagues to consider innovative solutions for MTW. Bank team continue to work hard to fill shifts and work closely with the site team on finding solutions.to reduce agency spend.

Appendices

Supporting Narrative

Executive Summary

The Trust has achieved the both the National Cancer 62 Day FDT Standard and the 2 week wait standard each month for over a year now, throughout the Covid-19 pandemic, reporting 86.1% and 96.3% respectively for September 2020. In addition, September performance remained high at 95.98% for the A&E 4hr standard, with the Trust remaining one of the best performing Trusts in the UK. The RTT and Diagnostics Waiting Times performance increased further in October as we continue with the Trust's Reset and Recovery Programme. RTT is now experiencing variable achievement of the target. Whilst the activity levels remained lower than usual in October both the elective activity and first outpatient attendances have increased (+12% for Elective and +2% for Outpatients compared to September). The lower activity levels continue to adversely impact the RTT performance and of the constitutional standards the RTT and Diagnostics standards remain the most at risk 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 were 7 cases of C.Diff reported in October 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 lower than last year. The Trust has admitted 23 patients with Covid-19 infection during October, including one case of hospital acquired infection. Awareness of the importance of compliance with PPE, Social Distancing and Hand Hygiene has been raised with staff.
- **Falls:** The rate of Falls is experiencing special cause variation of a concerning nature with the last seven months performance being above the mean. The rate of Falls at Maidstone has increased in recent months, whilst the rate for TWH has decreased. The rate per 1,000 occupied bed days was 6.55 for October and YTD remains above the maximum limit of 5.8 at 7.2. The level of occupied bed days remained lower in October due to COVID-19 (11% increase from September). Occupied beds are now at 86% of the level in October last year. Proposal to mandate Falls Prevention training that was agreed at Slips, Trips and Falls Group was taken to CNMT. This was well received and plans being worked up for a Patient Safety Training day that will incorporate Falls VTE and Pressure damage.
- **Pressure Ulcers:** The level of hospital acquired pressure ulcers has remained consistent and is experiencing common cause variation. International Stop the Pressure day is 19th November 2020. An online Tissue Viability Champions day took place on 13th November 2020. There were 20 clinical staff signed up to the day and there were 6 interactive learning sessions for staff to participate in. The rate of all pressure ulcers (including those who already had a pressure ulcer on admission) remains a concern and we are considering appropriate actions to liaise with partner organisations.
- **Never Events:** There was one Never Event reported for the month in relation to the placement of an NG Tube. This is being investigated and appropriate action has been put in place to prevent re-occurrence.
- **Stroke:** Performance for October dipped below the 50% Best Practice internal target at 43.2% in October (may increase with late data recording). All of the three stroke indicators continue to experience common cause variation and inconsistency.
- **A&E 4 hour Standard:** Performance in October reduced slightly to 95.98% but remains high. 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 September with a dropt o around 82% in October Minor attendances have been reduced more than major attendances and ambulance arrivals are now almost back to normal levels. 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 88.6% in October.
- **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 3.5% 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 both the elective activity and first outpatient attendances have increased (+12% for Elective and +2% for Outpatients compared to September). This has adversely impacted the RTT performance. October performance has improved further to 73.35% and due to the increases in performance over the last three months has moved from consistently failing the target to variable achievement of the target. Diagnostics waiting < 6 weeks performance has increased to 85.1% in October.

- **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.

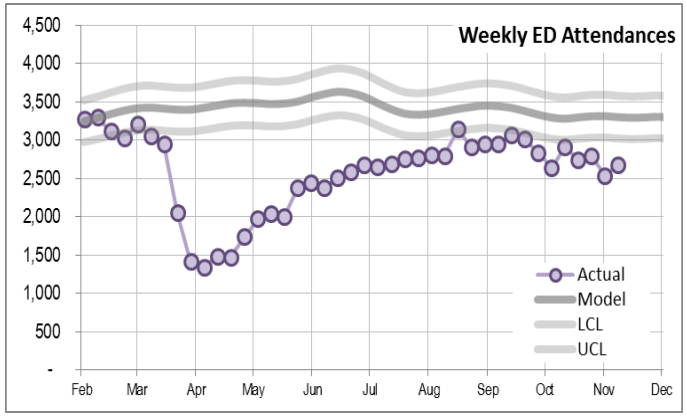
- **Cancer 62 Day:** The Trust has continued to achieve the 62d standard throughout the Covid-19 pandemic, reporting 86.1% for September 2020. Treatment numbers have increased through September with 97 accountable treatments which is 85% of the average monthly accountable treatments from 2019-20

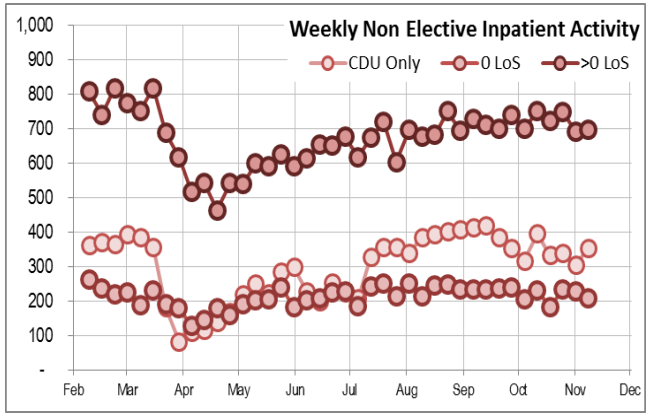
- **Cancer 2weeks (2ww):** The Trust has maintained achievement of the 2ww standard reporting 96.3% September 2020. This is based on an increased number of 1st seen appointments of almost 106% over the average monthly 1st seen appointments from 2019-20. However, Breast Symptoms did not achieve the standard for September, reporting 80.6% over a slight increase in numbers (102%) from 2019-20

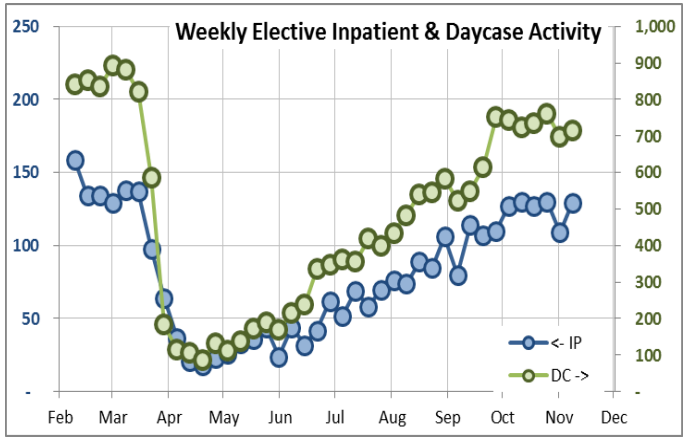
- **Cancer 2weeks (2ww) Referrals:** After the drop in referral numbers at the beginning of April due to COVID-19, the Kent & Medway Cancer Alliance predicted a significant increase in referral numbers through September 2020. Although this significant increase has not been seen at MTW, the referral numbers have continued to increase weekly through October and we are receiving up to 108% of the average daily referrals from January / February 2020. This will be monitored as we go into a further 4 week National lockdown through November 2020.

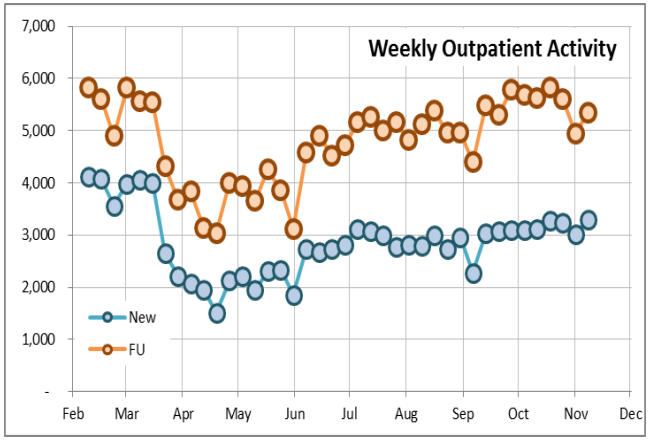
- **Finance:** The Trust has delivered the year to date financial plan generating a £2.2m surplus. The Trusts financial plan is broken into two elements based on two different financial regimes. In the first 6 months of the financial year the Trust received retrospective top income support up to a breakeven position however this has now changed (from 1st October) to a traditional budget approach where the Trust needs to deliver the financial plan set on the 22nd October which is based on a fixed level of income from commissioners his plan includes an allocation to fund COVID related spend (£11.2m). The Trusts underlying variance excluding the impact of COVID costs and retrospective funding (Month 1-6) is £8.2m favourable to plan, the key variances to plan are: Drugs (£2.5m) mainly due to reduction in Oncology and Ophthalmology high cost drugs, pay underspends (£4.7m) mainly within Nursing (£1.6m), STT (£1.8m), A&C (£1.3m) and Support to clinical staff (£0.8m) staff groups due to higher than planned vacancies, £1.2m underspend within clinical supplies due to reduction in elective activities, £0.3m underspend within independent sector usage and £0.8m relating to delays in investment associated with Stroke, ITU extension and Recovery and Reset developments . These underspends are partly offset by pressures associated with Car Parking (£0.3m), Laundry (£0.2m increase in dilapidation reserve), EPR project costs (£0.3m), income reductions within Diagnostics relating to independent sector activity (£0.3m), investments associated with Ive and Teletracking (£0.3m), increase in reserves(£0.1m) and £0.1m 2019/20 clinical income contract settlement
- **Workforce - Various:** The Safe Staffing Nursing Fill Rate has continued to increase but remains below usual levels by 0.5%. This has impacted on the overall fill rate experiencing special cause variation of a concerning nature. There has not been any staffing level risk to wards. Agency staff usage has increased and remains above the desired levels. There are some areas which continue to challenge the Trust due to the roles being on the shortage occupation list, and we continue to work with colleagues to consider innovative solutions for the Trust. The Turnover rate has increased and is consistently failing the target. Sickness levels have increased in October to 3.3% but are still achieving the target. However, the Trust are anticipating a further increase given a potential second wave for COVID-19. October Vacancy rate reduced slightly to 8% and is experiencing special cause variation of an improving nature. Performance for Statutory and Mandatory Training has improved further and is now experiencing special cause variation of an improving nature and consistently achieving the target.

Escalation: COVID-19









ED Attendances: Attendances fell by around 60% against model at the height of the pandemic. Numbers had been recovering steadily, but began to fall back in October, and are now 18-20% down on model.

A combination of increased pandemic restrictions and a developing national reconfiguration of emergency services to the UTC model are driving numbers down, and we are assuming the 15-20% below model situation will remain into the winter

Emergency Admissions: Non-zero emergency admissions have been around 9% 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 being down.

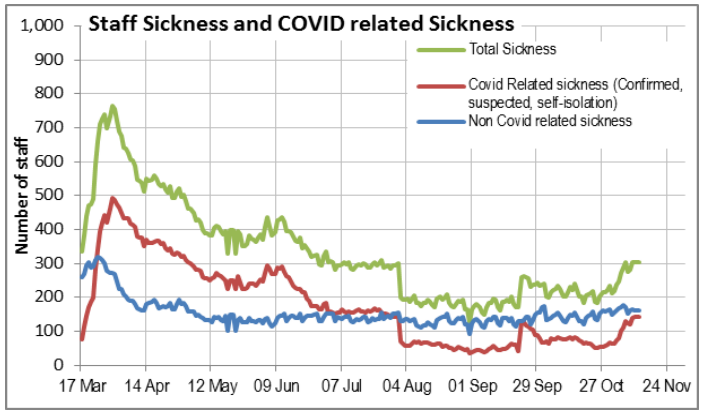
Elective / Daycase Activity: Large scale cancellations of elective activity has resulted in admitted electives reducing by 75-80% on normal levels, and daycases also 80-85%. They have both recovered steadily – both are now just 10-15% down on where they would normally be expected to be.

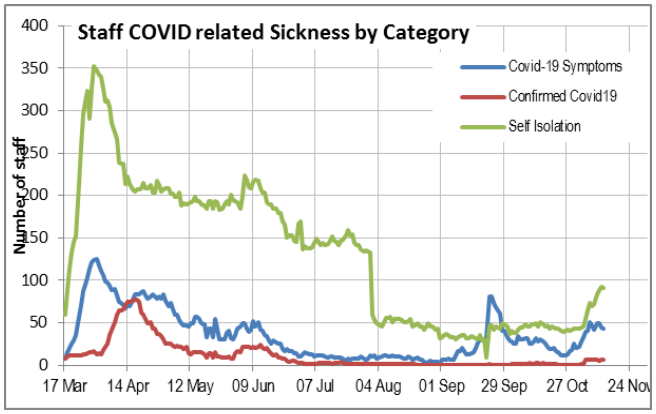
Outpatient Activity: New Outpatient activity is slowly recovering, and is around 20% of normal, whilst FU is coming back up, and is around 5% down, though some of this may be subject to an undercount, with some uncashed appointments still in the system. As with elective activity, the week-by-week reduction has been slower than seen in emergency activity.

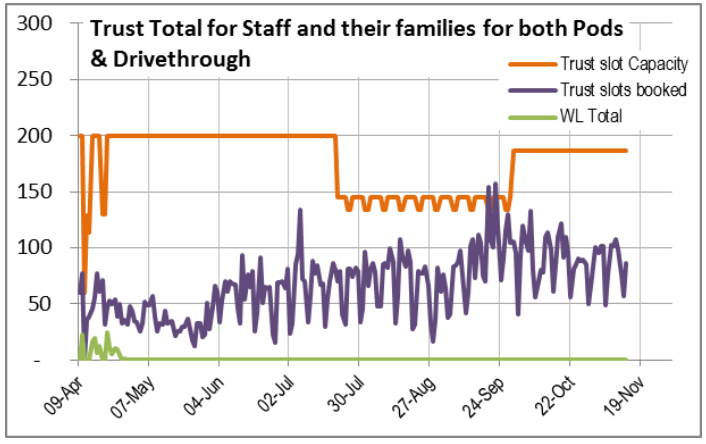
Summary : All activity is down, but recovering steadily

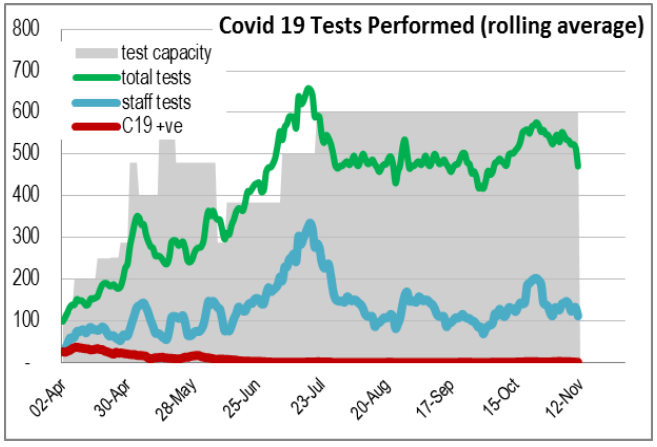
- ED attendances now 15-20% down
- Emergency admissions down around 5%
- Daycase 15% down & elective 10-15% down
- Total Outpatient activity down 10-15%, with new down a little more than FU

Escalation: COVID-19









Staff Non-Covid related sickness peaked at just over 300 in late March, came down to normal in Summer but is now back up to 150-175 per day.

Covid-19 Related Sickness: This includes confirmed cases, suspected cases & self-isolation Peaked at just under 500 at the end of March, fell back in Summer, but is now back over 300. Step changes on 01-Aug & 22-Sep suggest changes in counting methodology

Self-Isolation: Similar to Covid related sickness, this peaked in early April (~350), fell through the Spring & Summer, but has shown a sharp uptick since the beginning of November. Currently stands at just under 100

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 spiked in late September, but have since stabilised

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 had dropped to zero, but is now nudging back up

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

Additional Metrics – in development

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

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

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

REVIEW OF LATEST FINANCIAL PERFORMANCE

- The Trust delivered the year to date and October's financial plan by achieving a £2.2m surplus.
- The Trusts financial plan is broken into two elements based on two different financial regimes. In the first 6 months of the financial year the Trust received retrospective top income support up to a breakeven position however this has now changed (from 1st October) to a traditional budget approach where the Trust needs to deliver the financial plan set on the 22nd October which is based on a fixed level of income from commissioners. This plan includes an allocation to fund COVID related spend (£11.2m).
- In line with NHSE/I reporting guidance the values reported in this month exclude any impact associated with the Elective incentive scheme. It is currently anticipated this will be managed at a system level.
- The Trust has identified financial pressures (increase in costs and reduction in income) due to COVID 19 of £21.6m year to date (£2.2m in October).
- The Trusts underlying variance excluding the impact of COVID costs and retrospective funding (Month 1-6) is £8.2m favourable to plan, the key variances to plan are:
  - Drugs underspend mainly due to reduction in Oncology and Ophthalmology high cost drugs (£2.5m)
  - Pay underspends mainly within Nursing (£1.6m), STT (£1.8m), A&C (£1.3m) and Support to clinical staff (£0.8m) staff groups due to higher than planned vacancies (£4.7m)
  - Clinical supplies underspend (£1.2m) due to reduction in elective activities.
  - Delay in investments associated with Stroke, ITU extension and Recovery and Reset (£0.8m)
  - Reduction in independent sector usage (£0.3m)
  - 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)
  - Investments associated with Ive programme and Teletracking (£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 £0.2m adverse to plan. The Trust in October identified £2.2m of costs associated with COVID 19 this was £0.2m less than the income incorporated into the plan.
  - Other Operating Income excluding pass-through costs were on plan in October however the level of Car Parking income anticipated from visitor charges was £65k less than plan which was offset by over performance within Private Patients which achieved the highest income levels this financial year (£125k).
  - Pay budgets adjusted for pass-through items were £0.7m favourable in October which was mainly a result of underspends against the central held budgets for Stroke, ITU Extension and Recovery and Reset developments (£0.6m). Scientific and Technical staff groups underspent by £0.2m, this was mainly within the Diagnostics and Clinical support Division due to higher number of vacancies.
  - Non Pay budgets adjusted for pass through items overspent by £0.4m in October. The key variances in the month were Drugs (£0.4m) which was across all specialties, the spend in October was back to pre COVID levels, the budget phasing assumed this would happened from November therefore this is a one off pressure. Clinical supplies overspent by £0.5m in October which was mainly due to increase in COVID spend (£0.2m), and pressures within pacemakers (£0.1m) and Surgery (£0.1m). These pressures were offset by underspends mainly relating to central held budgets associated with Stroke, ITU extension and Recovery and Reset developments (£0.8m) and a reduction in doubtful debt (£0.2m).

- The closing cash balance at the end of October 2020 is £58.1m which is slightly lower than the plan cash balance of £59.4m. The higher than normal balance is due to the Trust receiving a double block SLA payment in April from the six main CCG's as per the national agreement totalling c.£36.6m. The Trust is assuming the repayment of the "advance" element of the block

income in March 2021 within the cash flow forecast. Funding arrangements from month 7 to year end results in the Trust receiving block payments which include an amount to reflect the higher operational costs of the current situation but will flex each month to reflect delivery against the patient treatment goals. Additionally due to the delay in receiving approval for Covid 19 capital spend items and the local system STP review of capital during the planning process, together with the process of approval of the capital plan from NHSEI, there has been a delay in the approval and commencement of capital projects. Therefore the cash flow phasing for the spending is back-ended which also contributes to the high current cash balance.

- Capital spend by the end of month seven is £6.08m of which £2.7m relates to Covid-19 equipment, ICT and estates costs – these costs have all been submitted to NHSEI Regional team as part of the funding claims. NHSEI have notified the Trust that £322k has been approved by DHSC. The remaining Phase 1 schemes (£2.5m) are still under consideration along with the Phase 2 bids, we have been informed that the Phase 1 spend will take priority for additional funding. The Trust has received £412k of CRL relating to the 2019/20 C-19 spend, this reduces the risk of the remaining funding requirement to £2.1m. The main other areas expenditure are £1.16m related to the ongoing EPR programme, £1m relating to the IVE Programme, £0.3m related to Estates schemes running across the year end (e.g. the RAP scheme in A&E) and £0.4m relating to equipment schemes.
- In addition to the previously notified national PDC awards, the Trust has also been notified of £1.7m of capital PDC for endoscopy equipment and £0.1m for Cyber Security. The STP has confirmed to the Trust an additional £2.4m of system capital funding (a combination of release of ring fenced reserve and slippage in other Trusts) to cover critical care, ophthalmology and radiology homeworking schemes and this has been included in the month 7 outturn.

- The Trust is forecasting to deliver a breakeven position however this includes £0.4m of mitigations relating to a recruitment phasing review. Additional mitigations may also be required to offset potential additional costs associated with the following:
  - Space review - The forecast does not include any additional costs associated with the outcome of the space review programme
  - Independent Sector usage, the forecast includes £3.2m of costs associated with the use of the independent sector for both Prime Provider and backlog activity. The Trust is working with the system to secure this additional funding from national allocations therefore fully mitigating this risk.
  - COVID 19 additional costs, the Trust has £11.2m funding included in the baseline from commissioners for month 7 to 12, any costs incurred above this value will require savings elsewhere to be achieved.
  - Nursing Bank review, due to the current high number of nursing vacancies a review of the bank rates is being undertaken on hard to fill areas on a temporary basis over winter. This is currently not incorporated into the forecast.
  - EU Exit – The forecast does not include an additional costs associated with EU Exit.

Maidstone and Tunbridge Wells NHS
IS Trust

1. Dashboard

October 2020/21

	Current Month						Year to Date						Annual Forecast			
	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*	*Actual* £m	*Plan* £m	*Variance* £m	*RAG*
Income	46.5	46.7	(0.2)	0.1	(0.3)		306.1	300.6	5.5	(0.9)	6.3		542.4	534.8	7.6	
Expenditure	(41.8)	(42.0)	0.2	(0.1)	0.3		(286.6)	(280.5)	(6.1)	0.9	(7.0)		(516.6)	(508.4)	(8.2)	
EBITDA (Income less Expenditure)	4.7	4.7	(0.0)	(0.0)	(0.0)		19.6	20.2	(0.6)	(0.0)	(0.6)		25.8	26.4	(0.6)	
Financing Costs	(2.5)	(2.6)	0.0	0.0	0.0		(17.7)	(18.0)	0.4	0.0	0.4		(31.9)	(32.3)	0.4	
Technical Adjustments	0.0	0.0	(0.0)	0.0	(0.0)		0.3	0.0	0.2	0.0	0.0		1.1	0.9	0.2	
Net Surplus / Deficit (Incl Top Up funding	**2.2**	**2.2**	**0.0**	**(0.0)**	**0.0**		**2.2**	**2.2**	**0.0**	**(0.0)**	**0.0**		**(5.0)**	**(5.0)**	**(0.0)**	
Cash Balance	58.1	59.4	(1.3)		(1.3)		58.1	59.4	(1.3)		(1.3)		1.0	1.0	0.0	
Capital Expenditure (Incl Donated Assets)	1.8	2.2	0.4		0.4		6.1	10.0	10.0		10.0		26.6	18.4	(8.2)	

Summary Current Month:

- The Trust delivered the financial plan in October by achieving a £2.2m surplus position. In line with national guidance this included £ 0.8m additional income support associated with COVID swabbing and testing.
- The Trust in October has identified £2.2m of costs associated with COVID 19 this was £0.2m less than the income incorporated into the plan.
- The key pressures against plan are: Drugs (£0.4m) which was across all specialties, the spend in October was back to pre COVI D levels, the budget phasing assumed this would happen from November therefore this is a one off pressure. Clinical supplies overspent by £0.5m in October which was mainly due to increase in CO VID spend (£0.2m), and pressures within pacemakers (£0.1m) and Surgery (£0.1m). These pressures were offset by delay in investments associated with Stroke, ITU extension and Recovery and Reset developments (£0.8m) and a reduction in doubtful debt (£0.2m).

Year to date overview:

- The Trust has delivered the financial plan generating a £2.2m surplus. The Trusts financial plan is broken into two elements based on two different financial regimes. In the first 6 months of the financial year the Trust received retrospective top income support up to a breakeven position however this has now changed (from 1st October) to a traditional budget approach where the Trust needs to deliver the financial plan set on the 22nd October which is based on a fixed level of income from commissioners his plan includes an allocation to fund COVID related spend (£11.2m).
- The Trusts underlying variance excluding the impact of COVID costs and retrospective funding (Month 1-6) is £8.2m favourable to plan, the key variances to plan are:

Drugs (£2.5m) mainly due to reduction in Oncology and Ophthalmology high cost drugs, pay underspends (£4.7m) mainly within Nursing (£1.6m), STT (£1.8m), A&C (£1.3m) and Support to clinical staff (£0.8m) staff groups due to higher than planned vacancies, £1.2m underspend within clinical supplies due to reduction in elective activities, £0.3m underspend within independent sector usage and £0.8m relating to delays in investment associated with Stroke, ITU extension and Recovery and Reset developments . These underspends are partly offset by pressures associated with Car Parking (£0.3m), Laundry (£0.2m increase in dilapidation reserve), EPR project costs (£0.3m), income reductions within Diagnostics relating to independent sector activity (£0.3m), investments associated with Ive and Teletracking (£0.3m), increase in reserves(£0.1m) and £0.1m 2019/20 clinical income contract settlement.

Key Points:

- The financial regime has changed from the 1st October and as a result the Trust will no longer receive retrospective top up to a breakeven position. The Trust will be required to deliver the financial plan submitted on the 22nd October which was £5m deficit. This deficit relates to a potential annual leave accrual relating to any annual leave carried over into 2021/22 financial year.

Risks:

- The Trust won't be notified by NHSI/E of the final retrospective top up value for September until the mid November.
- NHSE/I will review and validate the costs (£0.8m) incurred in October associated with COVID swabbing and testing and will not be notified until Mid December of this funding.
- In line with national guidance the financial position does not reflect any impact (positive or negative) associated with the Elective Initiative Scheme (EIS). This scheme will impact the level of income the Trust can recognise and is dependent on delivering the activity levels.

2. COVID 19 Expenditure and Income Impact

2020/21 Summary of Cost Reimbursement

Total Revenue (£000s):	18,490

Breakdown by Allowable Cost Type	£000s
Expanding medical / nursing / other workforce	1,314
Sick pay at full pay (all staff types)	229
COVID-19 virus testing (NHS laboratories)	3,204
Remote management of patients	2
Support for stay at home models	34
Direct Provision of Isolation Pod	7
Plans to release bed capacity	0
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	1,517
Segregation of patient pathways	6,597
Enhanced PTS	0
Business Case (SDF) - Ageing Well - Urgent Response Accelerator	0
Existing workforce additional shifts	1,030
Decontamination	0
Backfill for higher sickness absence	1,734
NHS 111 additional capacity	0
Remote working for non patient activites	314
National procurement areas	1,886
Other	363
Decontamination	260

Summary: Loss of income

Total (£000s):	3,127

Breakdown by income type	£s
Car parking income	1,332
Catering	218
Pathology Trade Income	120
Private Patient Income	946
Research and Development	200
Other	311

Grand Total

Total (£000s):	21,616

Commentary:
The Trust has identified the financial impact relating to COVID to be £21.6m, which includes £18.5m associated with additional expenditure and £3.1m 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 will be notified in December of the final retrospective top up funding for relating to September (£4.6m).

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST
Women's and Children's
Perinatal Mortality report
October 2020
Covering Quarter 2 2020/2021

Main author: Rachel Thomas, Deputy Head of Midwifery and Gynaecology

Division: Women's and Children's

Specialty: Maternity

1. Introduction

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

The tool supports:

- Systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care;
- Active communication with parents to ensure they are told that a review of their care and that of their baby will be carried out and how they can contribute to the process;
- A structured process of review, learning, reporting and actions to improve future care;
- Coming to a clear understanding of why each baby died, accepting that this may not always be possible even when full clinical investigations have been undertaken; this will involve a grading of the care provided;

- Production of a report for parents which includes a meaningful, plain English explanation of why their baby died and whether, with different actions, the death of their baby might have been prevented;

- Other reports from the tool which will enable organisations providing and commissioning care to identify emerging themes across a number of deaths to support learning and changes in the delivery and commissioning of care to improve future care and prevent the future deaths which are avoidable;

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

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

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

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

2. Overview:

During this quarter there have been 2 third trimester losses at 33+5 days and 32+6 days. In addition there was one NND at 13 days of age at Medway hospital.

The mother of the stillborn baby gave birth in a car park away from the hospital. She and her husband called TWH for assistance and were advised to call an ambulance and to stay on the line until help arrived. The father commenced the resuscitation on instruction from the midwife until the emergency services arrived. The ambulance crew were able to see that the baby has been dead for some time prior to birth but continued with the resuscitation until arrival at the hospital when the baby was pronounced dead. The PMRT meeting will take place in November.

The stillbirth at 32+6 weeks sadly had a prenatal diagnosis of Edward's Syndrome which is incompatible with life. The high chance of fetal demise before full term was discussed during the antenatal period and a plan for care involving fetal medicine at TWH and Medway and

the bereavement team was made. The mother was induced following diagnosis of an intrauterine death at 32+6.

In the case of the neonatal death, the mother had a fall at 23 weeks and 1 day and came into Triage. She was admitted and observed overnight and was an inutero transfer to Medway where the baby was born and subsequently died. Medway will undertake the PMRT and MTW will join and give details on the antenatal care.

During lockdown, due to availability of sonographers and capacity, the regimen of 4 weekly growth scans has been reduced from 5 scans to 2 scans. However individual risk assessments have been made and where appropriate, some women will have received more scans if were high risk or if the growth velocity was noted to be slowed during an antenatal appointment and an urgent scan requested. It is interesting to note that despite this reduced surveillance, there has been only one third trimester stillbirth this quarter compared to 5 in the same period in 2019. However, the numbers are small and it unwise to draw any conclusions from this.

2020 Cases

Date	Case type	SI declared	PMRT COMPLETED
15/01/20	25+6 Stillbirth	No	PMRT complete
07/02/20	35 Stillbirth	No	PMRT complete
25/02/20	29+3 Stillbirth	No	PMRT complete
26/02/20	41+5 Stillbirth	No	PMRT complete
10/03/20	40 Stillbirth	No	PMRT complete
27/03/20	Term stillbirth. Exact gestation unknown	No	PMRT not required according to MBBRACE as concealed pregnancy, delivery at home with no antenatal care. Learning required from outside agencies, CCG monitoring this learning.
17/08/20	IUD 33+5	No	PMRT report complete
25/08/20	25+6w NND @13 days old at Medway	No	MTW to contribute to Medway's PMRT meeting
11/9/20	IUD 32+6 Fetal abnormality, incompatible with life	No	PMRT report complete
13/10/20	IUD 34+5 Sudden Uterine Rupture		Scheduled for December's meeting
19/10/20	22+4		Late miscarriage scheduled for December meeting

4. Learning from cases

Learning from cases 2019	Action	Action required/Completed	Completed
Adequate documentation of review of ultrasound scans.	If ultrasound scans are carried out for women thought to have underlying risk factors then there	1. Rachel Thomas to email the community team leads and the Antenatal clinic team lead to ensure that midwives know that this is the expectation	Completed 20/3/2020

	needs to be clear documented evidence that there has been reviewed and any appropriate action taken. Community midwives are to ensure that there is documented evidence that scan results have been reviewed either by themselves if normal or appropriate obstetric referral if necessary.	By 31st March 2. Invigorated training for Gap and Grow needs to be undertaken. This will be led by the new in post Fetal Wellbeing midwives that are due to start in April. Till then there is a focus on the online training compliance and feedback to individuals where issues have been identified. <u>Update 15/6/20</u> Fetal Wellbeing Team in place and have commenced virtual and limited numbers in house for Gap and Grow training. An infographic will be sent out shortly as an aid to Midwives in plotting SFH as an interim measure until compliance is up to standard.	Fetal Wellbeing Midwives commenced in May 2020. Training figures for midwives have improved from 25 % in May to October 49% Overall compliance for all 3 elements for Gap and Grow is currently 51% across all staff groups. Work is continuing with the team to improve compliance especially among the medical team. <u>Completed</u> Emailed to all midwives
Apparent capacity issues in obstetric antenatal clinics and lack of clarity amongst midwives over how to escalate this if necessary	Review of process followed to obtain antenatal clinic review appointments Review of agreed process of escalation if difficulty experienced by community midwife in obtaining obstetric review appointment. Involvement of assistant General Manager in this review	1. Nathan Sims/Sarah Mander-McGregor/ Alison Mendes to formulate pathway should there be lack of antenatal clinic appointments Update 15/6/20 This action was on hold due to Covid 19 but is now being addressed. AM has left the organisation and so SMM will lead. This is due to be completed by 15th July 2020 Update 19/11/2020 SMM currently unavailable and will check this has been completed with Matron for ANC/Community	Evidence of completion needed
The mother should have had an interpreter at every visit and especially at booking. However it was not clear on the referral what language was spoken by the mother and so the midwife would not have known to book one. It is unclear whether the mother understood the	Matrons to be aware of the case and cascade to teams the importance of booking a face to face interpreter. It is difficult when no language is specified on the booking however the appointment should	Email to ensure awareness that interpreters are necessary at every visit Community midwives leads to do an audit to assess whether partners are being used as interpreters. This will be fed back through the Maternity Forum in September	<u>Completed 11/2/2020</u> <u>November 2020:</u> Action: RT to chase audit

information about smoking cessation as she declined intervention.it is documented that she was waiting for a prescription for aspirin at 20w which suggests that she had not fully understood that process for obtaining aspirin and the importance of taking it from 12 weeks. Every effort should be made by the maternity service to ensure that an interpreter is present or that language line	be rebooked with an interpreter is necessary		
The mother had investigations on the antenatal ward and was discharged before the results were available. There is no pathway for ensuring the results are communicated to the woman until the next contact with a health professional who would be relied upon to look up them up.	The Antenatal ward should formulate a robust system for following up test results and communicating them to the women	Majority of women will have their results before they are discharged. There is a results book now on Antenatal ward which is the responsibility of the Band 7 to check each day to see if any results are communicated. As a failsafe, women are also told to call Triage if they do not hear about their results	Completed 20/3/2020 Louise Jarvis, Deputy Antenatal Ward Manager
Symphysis Fundal Height not correctly plotted on Gap and Grow chart	Invigorate training for Gap and Grow. New Fetal Wellbeing Midwives to start in April who will undertake the training. Random audits to be undertaken by community leads	Fetal Wellbeing midwife will include SFH training in their remit. In the meantime, midwives are reminded to use the correct methods by their team leads. Update 15/6/20. Delay in commencement of new Fetal Wellbeing team due to Covid 19 and recruitment issue. The new Gap and Grow training package adapted for Covid 19 has now been launched as a virtual and in house learning. Fetal Wellbeing Team will produce an infographic tool to advise on correct plotting of SFH. This will be in addition to the training package and will support Midwives until all staff are compliant.	Completed Training package has now been launched. Completed 20/3/2020 Email sent to team leads Completed and circulated to all midwives
Inadequate assessment on	Feedback to	Maggie Matthews Consultant	November Update: MM

Triage when presenting with abdominal pain at 25+4w	individual doctor	Obstetrician	has now retired and DM will ensure that this feedback has occurred and will confirm with evidence
Understanding the correct route of administration of Mifepristone on initial dose. Error made by staff member, administered vaginally instead of orally	Internal review completed Action plan made. Duty of Candour to patient.	Staff member responsible to write reflective practice and discuss with educational supervisor. Fetal loss guideline to be adjusted to reflect that mifepristone must be given orally. Feedback to pharmacy lead to ensure that correct route of administration is documented on drug chart prior to dispensing.	<u>Completed</u> Reflective work completed by staff member <u>Completed 5/3/20</u> Guideline adjusted to emphasise route of administration. <u>Completed</u> These learning actions were completed prior to PMRT meeting as the case was reviewed through an internal risk review and learning identified and actioned.
Incorrect plotting of Gap and Grow Chart	Feedback to Midwife Gap and Grow training has been reinvigorated during Training		<u>Completed</u> Action complete and midwife to do further e-training

There was no further learning required following the review of the remaining 2020 cases.

5. Summary

The Directorate is underwent a “deep dive” of PMRT cases, SIs, Complaints, Legal cases and HSIB cases which has been initiated as a response to the investigation being undertaken at East Kent hospital. All PMRT cases from 2018 and 2019 were collated and reviewed to detect any common themes and learning points. These were non adherence to the induction of labour policy and not following the Gap and Grow protocols. There is an action plan to address these issues and others that were highlighted from the Deep Dive review.

All families that have had a PMRT review were asked for their questions and these were all included in the terms of reference for the review. Families are given feedback from the review and it is discussed where possible at the postnatal follow up appointment with the

obstetrician. Where possible, the obstetrician is present at the PMRT review so that they are fully informed of the discussion around the case.

There are 2 new bereavement midwives in post. This is due to one resignation and the current band 7 moving to provide a new bereavement counselling service as a pilot for the Trust. This will be commencing before the end of the year.

In 2 cases of the 5 reviews there was an external person involved. This is a requirement of the CNST standard. We have a network of individuals from neighbouring Trusts and SECAMB which help us gain an independent perspective. Our common standard of practice is to have an external person present however the reviews were carried out in the height of the pandemic which posed a challenge. However in the 3 cases where there was no external person present there were 2 Obstetric Consultants and 4 senior Midwives present to complete the review.

Oct-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	93.9%	106.8%	-	100.0%	109.8%	121.6%	-	-	44.2%	52.9%	442	29.40	124	8.1	0.0%	0.0%	19	1	Falls threshold under review for ASU.	274,745	303,529	(28,784)
MAIDSTONE	Cornwallis (M) - NS959	104.2%	93.6%	-	100.0%	98.9%	136.0%	-	-	22.7%	10.5%	44	2.89	1	12.9	0.0%	0.0%	1	0	bed occupancy between 7-14.Increased CSW fill rate at night due to enhanced care requirements.	79,076	88,371	(9,295)
MAIDSTONE	Culpepper Ward (M) - NS551	92.7%	99.6%	-	-	98.1%	96.8%	-	-	17.7%	21.9%	57	3.96	5	8.0	100.0%	91.3%	1	0		109,802	107,237	2,565
MAIDSTONE	John Day Respiratory Ward (M) - NT151	101.5%	104.3%	-	-	100.0%	112.9%	-	-	38.4%	18.5%	125	8.77	18	7.0	33.3%	92.9%	7	0	2 x falls above threshold. Bed occupancy between 25-30. Increased CSW fill at night due to enhanced care requirements throughout the month however, temparay demand not always filled.	146,351	151,910	(5,559)
MAIDSTONE	Intensive Care (M) - NA251	83.5%	103.1%	-	-	78.9%	76.2%	-	-	10.9%	1.4%	128	8.30	59	67.7	180.0%	100.0%	0	0	Staffing in line with bed occupancy.	176,442	173,159	3,283
MAIDSTONE	Pye Oliver (Medical) - NK259	102.4%	87.7%	-	-	117.4%	123.7%	-	-	30.9%	42.2%	132	8.39	30	6.7	34.4%	90.9%	7	1	2 x falls above threshold. Reduced CSW fill rate during the day due to unavailability of temporary staff .	120,984	131,300	(10,316)
MAIDSTONE	Chaucer Ward (M) - NS951	0.0%	0.0%	-	-	0.0%	0.0%	-	-	0.0%	No hours	No Demand	No Demand	No Demand		0.0%	0.0%		0	Chaucer bed occupancy recorded however, now part of overall ASU. See increased fill rate for ASU.	33,846	23,763	10,083
MAIDSTONE	Whatman Ward - NK959	88.8%	77.6%	-	100.0%	148.4%	119.4%	-	-	37.4%	15.4%	115	7.90	15	8.7	10.3%	100.0%	6	0	Bed occupancy of 20 throughout the month with onging Night escalation .RN fill rate at night to ensure safe staffing levels	105,263	103,231	2,032
MAIDSTONE	Lord North Ward (M) - NF651	88.7%	118.9%	-	100.0%	98.9%	106.5%	-	-	24.0%	12.3%	57	3.98	8	8.6	50.0%	100.0%	3	1	1 x fall above threshold. Reduced RN fill rate due to unavailability of temporary stffing. Increased CSW rate to support enhanced care requirements	99,780	113,447	(13,667)
MAIDSTONE	Mercer Ward (M) - NJ251	101.6%	94.3%	-	-	107.5%	98.4%	-	-	14.5%	24.0%	42	2.90	7	6.5	23.1%	88.9%	4	1	RMN requirements across 9 days / nights.	120,121	106,008	14,113
MAIDSTONE	Edith Cavell (M) - NS459	77.2%	76.8%	-	100.0%	84.5%	190.2%	-	-	58.3%	35.3%	144	9.99	6	7.6	0.0%	0.0%	1	0	Bed occupancy between 15-22. Reduced fill rates reflected of bed occupancy and acuity levels.Increased fill rate whereby staff redeployed to support other areas.	143,841	94,263	49,578
MAIDSTONE	Acute Medical Unit (M) - NG551	88.2%	93.8%	-	-	134.8%	166.3%	-	-	24.7%	34.1%	113	7.57	28	12.7	0.4%	100.0%	2	0	Increased fill rate at night due to ongoing escalation.	147,015	139,618	7,397
TWH	Ward 22 (TW) - NG332	96.2%	126.7%	-	100.0%	115.1%	105.6%	-	-	46.3%	36.0%	163	11.29	30	6.6	20.6%	90.9%	4	0	Bed occupancy between 27 - 32. RMN requirements requested across 11 days / nights. Reduced RN fill rate with 30 unfilled shifts reported.	142,269	168,197	(25,928)
TWH	Coronary Care Unit (TW) - NP301	117.4%	89.2%	-	-	110.9%	-	-	-	29.1%	24.9%	79	4.93	16	13.1	80.0%	100.0%	1	1	1 x fall above threshold. Bed occupancy between 4-11. Increased fill rate at night to support unit escalation. 16 unfilled shifts	110,164	78,131	32,033
TWH	Ward 33 (Gynae) (TW) - ND302	100.1%	97.4%	-	-	100.0%	100.0%	-	-	19.8%	3.1%	70	4.15	7	18.9	33.1%	100.0%	1	0	1 x fall above threshold. Some staff sickness resulting in 7 unfilled shifts	111,169	114,956	(3,787)
TWH	Intensive Care (TW) - NA201	128.4%	223.1%	-	-	122.3%	167.7%	-	-	19.1%	4.1%	145	9.07	8	56.7	0.0%	0.0%	0	0	Increased fill rate to support Red, Amber and Green COVID pathways.	238,845	250,467	(11,622)
TWH	Acute Medical Unit (TW) - NA901	93.6%	78.7%	-	100.0%	98.9%	105.3%	-	-	20.7%	31.7%	174	11.90	65	9.7	0.0%	0.0%	8	0	2 x falls above threshold. Bed occupancy between 16 -32. RMN requirements reports across 5 episodes of care. Reduced CSW fill rate due to lack of available temporary staff.	194,428	186,648	7,780
TWH	Surgical Assessment Unit (TW) - NE701	115.2%	155.6%	-	-	133.9%	129.0%	-	-	38.9%	12.7%	57	3.91	12	128.8	0.0%	0.0%	0	0	Increased fill rate to support unit escalation throughout the month reported from the 8th Oct.	68,191	78,584	(10,393)
TWH	Ward 32 (TW) - NG130	104.1%	102.1%	-	100.0%	91.1%	80.4%	-	100.0%	14.8%	3.2%	29	1.94	3	9.4	0.0%	0.0%	2	1		131,644	124,717	6,927
TWH	Ward 10 (TW) - NG131	116.9%	94.9%	-	100.0%	104.8%	122.6%	-	-	23.4%	12.3%	79	5.18	3	7.3	29.5%	97.2%	0	0		124,141	136,940	(12,799)
TWH	Ward 12 (TW) - NG132	110.1%	80.4%	-	100.0%	124.7%	104.7%	-	-	28.4%	35.0%	107	7.16	22	7.1	6.6%	100.0%	11	1	5 x falls above threshold. Increased RN fill rate to support skill mix adjustment to cover CSW shift.	126,668	138,087	(11,419)
TWH	Ward 20 (TW) - NG230	188.7%	112.3%	-	No Hours	119.0%	115.3%	-	-	54.5%	32.5%	185	12.66	40	6.9	28.9%	83.3%	7	0	Increased fill rates to support acuity and dependancy levels throughout the month.Increased demnad in temporary staffing requirements recorded.	151,966	155,384	(3,418)
MAIDSTONE	Foster Clarke Ward - NR359	-	-	-	-	-	-	-	-	28.9%	61.7%	52	3.24	38		0.0%	0.0%		0	Staffing request in line with escalation plan for Foster Clarke opening later in the month.	-137	-280	143
TWH	Ward 21 (TW) - NG231	97.4%	102.0%	-	100.0%	99.4%	101.6%	-	-	26.4%	20.8%	111	7.29	15	7.2	10.0%	100.0%	7	1	1 x fall above threshold. Bed occupnacny between 26-30. 15 unfilled RN shifts recorded.	143,551	143,208	343
TWH	Ward 2 (TW) - NG442	106.7%	100.7%	-	100.0%	114.0%	125.5%	-	100.0%	34.3%	15.1%	129	8.53	39	8.6	0.0%	0.0%	6	0	Increased fill rate reported due to RMN requirements across 13 episodes of care and 7 episodes of enhanced care requirements.	138,330	138,095	235
TWH	Ward 30 (TW) - NG330	103.1%	98.7%	-	100.0%	100.0%	106.5%	-	-	22.3%	20.5%	80	4.78	22	8.1	0.0%	0.0%	8	2	3 x falls above threshold. Bed occupancy between 25-30 throughout the month.Staff sickness reported resulting in unfilled shifts	139,933	139,065	868
TWH	Ward 31 (TW) - NG331	98.5%	92.9%	-	100.0%	99.2%	101.1%	-	-	27.5%	7.7%	114	6.60	20	7.3	0.0%	0.0%	3	2		149,938	139,895	10,043
Crowborough	Crowborough Birth Centre (CBC) - NP775	72.9%	95.0%	-	-	97.0%	96.8%	-	-	6.9%	0.0%	22	1.50	0		0.0%	0.0%		0	Reduced fill rate during the day due to lack of available temproary staff but a considered action to prioritise the night with Community teams support during the day.	84,530	79,946	4,584
TWH	Midwifery (multiple rosters)	83.1%	55.6%	-	-	93.0%	87.1%	-	-	11.8%	3.7%	447	25.56	85	20.3			0	0	Reduced fill rate due to lack of available temporary staff. Delivery suite prioritised to ensure safe staffing levels. Increase in unfilled shifts this month.	682,204	674,343	7,861
TWH	Hedgehog Ward (TW) - ND702	115.9%	141.7%	-	-	133.5%	-	-	-	45.7%	73.4%	238	16.47	31	14.0	0.0%	0.0%	0	0	Increased fill rate to support increased requirements for Mental Health care in acute setting	193,997	196,636	(2,639)
MAIDSTONE	Maidstone Birth Centre - NP751	91.4%	73.8%	-	-	95.3%	90.0%	-	-	22.1%	0.0%	32	1.97	0		0.0%	0.0%	0	0		73,531	77,547	(4,016)
TWH	SCBU (TW) - NA102	73.9%	3845.2%	-	100.0%	88.6%	-	-	-	12.1%	0.0%	88	4.73	1	14.6	0.0%	0.0%		0	Fill rate in line with bed occupancy which is reported between 6- 14 throughout the month. 7 x amber days 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	177,213	168,630	8,583
TWH	Short Stay Surgical Unit (TW) - NE901	29.5%	23.6%	-	-	9.5%	0.0%	-	-	7.7%	11.3%	41	2.90	22	1.2	0.0%	0.0%	0	0	Staffing in line with levels of activity. Location moved to facilitate COVID pathways.	23,537	27,532	(3,995)
MAIDSTONE	Accident & Emergency (M) - NA351	108.2%	74.5%	-	-	136.6%	173.3%	-	-	46.1%	28.9%	358	23.60	62		0.0%	0.0%	3	0	MH - 3 x falls above threshold. Increased fill rate to support COVID pathways however, 62 unfilled RN shifts. TWH - 9 falls above threshold. Increased RN demand due to managing COVID pathways. Redcued fill rate with 87 shifts unfilled due to lack of temporary staff and new vacanices.	303,333	272,714	30,619
TWH	Accident & Emergency (TW) - NA301	92.9%	101.7%	-	100.0%	109.1%	129.0%	-	-	43.8%	38.5%	474	33.08	87		0.0%	0.0%	9	0		431,553	446,399	(14,846)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	65.9%	86.5%	-	-	90.5%	-	-	-	17.0%	2.4%	34	2.23	1		0.0%	0.0%	1	0	1 x fall above threshold. Staffing in line with bed occupancy between 0- 8 with planned weekend closures.Staff redeployed to support other areas when closed.	56,893	57,082	(189)
MAIDSTONE	Peale Ward COVID - ND451	73.6%	73.4%	-	100.0%	91.4%	74.2%	-	-	17.1%	20.1%	65	4.21	22	20.8	0.0%	0.0%	0	0	Staffing in line with bed occupancy and planned temporary move whilst reconfiguration estates works are completed.	185,040	76,066	108,974
MAIDSTONE	Chronic Pain Escalation - NE959	90.4%	60.2%	-	100.0%	100.2%	25.8%	-	-	4.2%	0.0%	9	0.49	1	25.9	0.0%	0.0%	0	0	Staffing in line with occupancy and supporting Red and Amber pathways. Bed occupancy between 1-5.	77,833	83,050	(5,217)
MAIDSTONE	Short Stay Surgery Unit (M) - NE751	98.6%	80.6%	-	-	85.7%	-	-	-	23.0%	16.3%	43	2.98	9	28.8	0.0%	0.0%	1	0	1 x fall above threshold	44,037	49,602	(5,565)
																				Total Established Wards	5,869,123	5,738,266	130,857
																				Additional Capacity Cath Labs	48,416	46,594	1,822
																				Whatman	0	0	0
																				Ward 32 (Wells Suite) (TW) - PP010	-530	0	-530
																				Other associated nursing costs	3,881,078	3,750,314	130,764
																					9,798,087	9,535,174	262,913

Checks

RAG Key

Under fill

Overfill

Green: Greater than 90% but less than 110%

Amber Less than 90% OR greater than 110%

Red Less than 80% OR greater than 130%

NHS Maidstone and Tunbridge Wells NHS Trust

Update on Phase three (of NHS response to COVID-19) performance and 16-week plan (incorporating the winter plan)	**Chief Operating Officer and Colleagues**

The enclosed report provides information on Phase three (of NHS response to COVID-19) performance and 16-week plan (incorporating the winter plan). It also includes an update on Infection Prevention and Control in relation to COVID-19.

Which Committees have reviewed the information prior to Board submission?

- Finance and Performance Committee, 24/11/20 (in part)
- Executive Team Meeting (ETM), 24/11/20 (in part)

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

Phase 3 Activity

Weekly Exec Update

November 2020

Electives
Diagnostics
Outpatients
Cancer

MTW

NHS
Maidstone and Tunbridge Wells
NHS Trust

Summary

Electives	Outpatients	Diagnostics	Cancer
• 52 week patients continue to decrease – total number below trajectory for October • Last minute cancellations continue to affect delivery of activity targets for November • Moving to OPEL 3 status could affect activity targets	• Target is to achieve 100% of activity (compared to 2019 activity) • October performed just under target due to school holiday DNA's and consultant isolation. • November has currently booked in 90% of activity. 100% of follow ups booked in. • Patient cancellations and DNA rates have slightly increased due to second lockdown.	• CT – exceeded target for October • NOUS – on track depending on recruitment • Endoscopy have made significant progress and are now on track to meet 80-90% for October (target is 90%). • MRI – increasing capacity using temporary mobile scanner and outsourcing.	• Referrals are back up to pre-Covid levels and are on average 108% compared to 2019. • Every patient that had their treatment postponed due to Covid has now been treated. • We achieved 85.6% in August, against a national standard of 85%. We are one of only four Trusts in the country to have hit the standard for 12 months in a row.

Elective Activity

What is the objective?

Phase 3: "In October at least 90% of their last year's activity for both overnight electives and for outpatient/daycase procedures, ri8ing to 100% in November (while aiming for 80% in September);"

How have we performed so far?

- October Activity is currently at 88% against a target of 90%.
- Current surgical actual activity for November is at 66% (not all activity booked has been uploaded to theatre man)
- Daily PTL's continue to monitor performance and long waiting patients.

		Target for Oct at 90% of Oct-19	Var from 90% Oct-19 Target	% achieved of Oct-19 Actual	Target for Nov at 100% of Nov-19	Var from 100% Nov-19 Target	% achieved of Nov-19 Actual
Division	**Specialty**	90%	Oct-20	Oct-20	100%	Nov-20	Nov-20
Surgery Total		**1522**	**-157**	**81%**	**1642**	**-407**	**75%**
Medicine & Emergency Care Total		**650**	**84**	**102%**	**729**	**-350**	**52%**
Women, Children and Sexual Health Total		**234**	**39**	**105%**	**286**	**-48**	**83%**
Cancer Services Total		**137**	**-5**	**87%**	**52**	**3**	**106%**
Diagnostics & Clinical Support Services Total		**193**	**-23**	**79%**	**200**	**-200**	**0%**
Total (excluding endoscopies)		**2735**	**-61**	**88%**	**2909**	**-1002**	**66%**
(incl Endos)	GENERAL SURGERY	959	142	103%	1064	-586	45%
(incl Endos)	GASTROENTEROLOGY	716	-221	62%	791	-490	38%
Nurse Led/WLI/Insourcing Endoscopies							
Total (including endoscopies)		**4136**	**-221**	**85%**	**4458**	**-1855**	**58%**

Electives - November

Are we on track for November ?

- We anticipate November being a challenging month due to the increase in last minute cancellations due to COVID in the community whilst in the National Lockdown.

What is the plan to address any shortfall?

- Surgical Division plan being mobilised (not all activity booked has been uploaded to theatre man) delivering 100% of Phase 3 plan anticipated to be a challenge
- Focus on activity with daily activity and theatre utilisation remains in place
- Paediatric POA and reduced bed capacity remain a challenge – W&C working with Surgery to find a solution
- Vascular Surgery has not yet restarted due to national guidance
- Further challenges with the increase in OPEL status to 3 affecting activity through theatres

		Nov-19 Actuals (Excl Endos)	Target for Nov at 100% of Nov-19	Weekly Aim	Actual Activity (exc IS Activity)	
Division	Specialty		100%		15-Nov	% of 2019
	UROLOGY	193	193	48	27	56%
	ENT	156	156	39	16	41%
	PAIN MANAGEMENT	122	122	31	0	0%
	ORTHOPAEDIC PAEDS	32	32	8	5	63%
	BREAST SURGERY	72	72	18	13	72%
	VASCULAR SURGERY	7	7	2		
	GYNAECOLOGICAL ONCOLOGY	30	30	8	4	53%
Surgery Total		1642	1642	411	208	51%
Medicine & Emergency Care	GENERAL MEDICINE	300	300	75	66	88%
(excl Endos)	GASTROENTEROLOGY	70	70	18	23	131%
	CARDIOLOGY	145	145	36	33	91%
	THORACIC MEDICINE	37	37	9	0	0%
	CARE OF THE ELDERLY	8	8	2	1	50%
	RHEUMATOLOGY	131	131	33	34	104%
	NEUROLOGY	13	13	3	1	31%
	STROKE MEDICINE	0	0	0	1	
	ENDOCRINOLOGY	25	25	6	4	64%
Medicine & Emergency Care Total		729	729	182	163	89%
Women, Children and Sexual Health	GYNAECOLOGY	199	199	50	50	101%
	PAEDIATRICS	87	87	22	9	41%
Women, Children and Sexual Health Total		286	286	72	59	83%
Cancer Services	ONCOLOGY	34	34	9	13	153%
	HAEMATOLOGY	18	18	5	10	222%
Cancer Services Total		52	52	13	23	177%
Diagnostics & Clinical Support Services	INTERVENTIONAL RADIOLOGY	200	200	50	0	0%
Diagnostics & Clinical Support Services Total		200	200	50	0	0%
Total (excluding endoscopies)		2909	2909	727	453	62%
(incl Endos)	GENERAL SURGERY	1064	1064	266	134	50%
(incl Endos)	GASTROENTEROLOGY	791	791	198	83	42%
Total (including endoscopies)		4458	4458	1115	606	54%

RTT Weekly Performance – 52 week patients

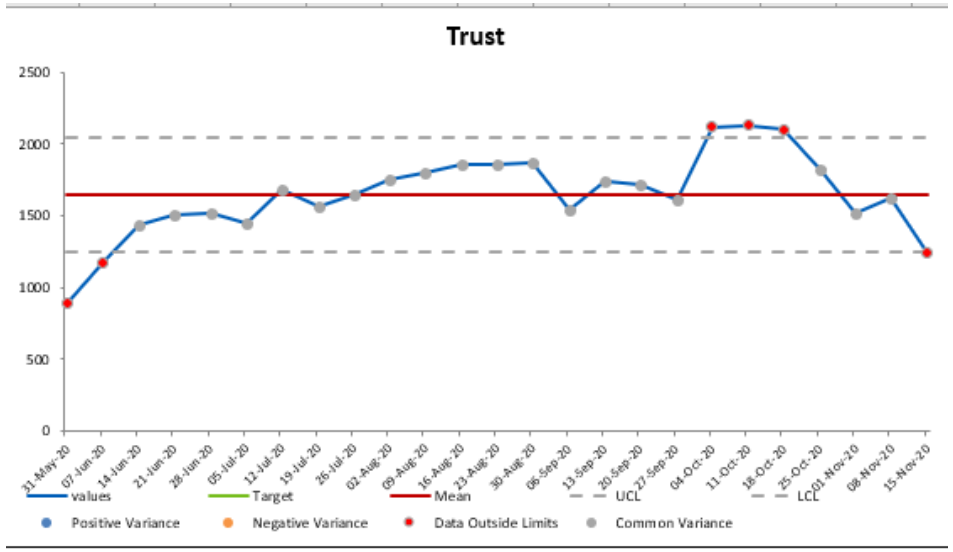
	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Trajectory	396	386	355	372	331	314	278	209
Actual	380	318	276					

Monthly performance		
Waiting list size	Backlog	Performance
28,457	7,585	73.35%

40 plus week waits	05/10/2020	20/11/2020
40-52	1842	1581
Over 52 weeks	373	264

- October performance increased again this month by 7% to 73.35%
- 52 week breaches continue to decrease 276 against the trajectory of 355
- Mapped treatment plans for 52 week patients
- Focus remains on managing and treating patients over 40 weeks
- National Clinical Prioritisation Programme being rolled out to directorates

Weekly referrals SPC chart



Date recorded is date of referral, some referrals not on PAS yet. Reduction in last few weeks is likely to be due to time delay rather than true reduction.

RTT Performance – Trajectory and IS

The tables on the right show the RTT trajectory for the current financial year, including a best case scenario if we can secure additional funding to create additional capacity in IS.

Best?- Assumes a reduced level of internal capcity and demand in early months ramping up (and new level being sent to IS) but also additional capacity (in IS)													
Scenario 4	Feb-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Total Waiting List	30414	27869	28220	26765	26924	27796	27678	21900	20324	19482	18209	17961	18309
Total Backlog	3817	8675	10865	12613	13701	11728	9210	7294	6516	6337	6269	6580	7200
% Performance	87.4%	68.9%	61.5%	52.9%	49.1%	57.8%	66.7%	66.7%	67.9%	67.5%	65.6%	63.4%	60.7%

The tables below show MTW activity carried out in the Independent Sector (IS) - split into surgery only in IS and whole pathway (first outpatient appt and treatment). The numbers are rolling and will only be updated when a patient is discharged and the information is sent back to MTW.

SURGERY ONLY Activity by Independent Sector	Plan per week	Plan per week Q4	06/09/2020	13/09/2020	20/09/2020	15/11/2020	22/11/2020	29/11/2020	06/12/2020	13/12/2020	20/12/2020	27/12/2020
TOTAL KIMS	52	43	33	31	58	55	49	40	4	1	1	0
TOTAL NUFFIELD	19	5	5	15	4	0	22	4	12	4	6	0
TOTAL HORDER	10	3	0	7	8	1	1	6	0	2	0	0
TOTAL SPIRE TWH	25	4	0	0	0	11	11	8	10	8	7	3
TOTAL BENENDEN	16	12	0	0	1	6	3	0	6	3	5	0
TOTAL SPIRE ALEX	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL MCINDOE	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL BMI CHELSFIELD PARK	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL WILL ADAMS	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	122	67	38	53	71	73	86	58	32	18	19	3

NEW OPA WHOLE PATHWAY ONLY Activity by Independent Sector	Plan per week	Plan per week Q4	15/11/2020	22/11/2020	29/11/2020	06/12/2020	13/12/2020	20/12/2020	27/12/2020
TOTAL KIMS	18	15	15	8	16	3	4	5	2
TOTAL NUFFIELD	15	11	4	17	6	9	7	0	0
TOTAL HORDER	22	12	14	8	23	4	13	0	0
TOTAL SPIRE TWH	12	4	1	0	0	3	1	4	2
TOTAL BENENDEN	17	15	6	2	13	10	14	3	3
TOTAL SPIRE ALEX	4	4	0	1	1	0	1	2	0
TOTAL MCINDOE	7	0	0	0	0	0	0	0	0
TOTAL BMI CHELSFIELD PARK	0	0	4	4	4	6	3	2	0
TOTAL WILL ADAMS	7	1	0	0	0	0	0	0	0
TOTAL	102	62	45	40	63	35	43	16	7

Endoscopy Activity

October Total: Achieved 90% of last year's activity for endoscopy.

	Oct-19 Actuals	Target for Oct at 100% of Oct-19	Var from 100% Oct-19 Target	% achieved of Oct-19 Actual	Oct-19 Actuals excl Bowel Scope	Target for Oct at 100% of Oct-19	Var from 100% Oct-19 Target	% achieved of Oct-19 Actual
Specialty		100%	Oct-20	Oct-20		100%	Oct-20	Oct-20
Colonoscopy	732	732	-117	84%	732	732	-117	84%
Flexi Sigmoid	339	339	-8	98%	183	183	148	181%
Gastroscopy	532	532	115	122%	532	532	115	122%
Total	1603	1603	-10	**99.4%**	1447	1447	146	**110.1%**

	Nov-19 Actuals	Target for Nov at 100% of Nov-19	Var from 100% Nov-19 Target	% achieved of Nov-19 Actual	Nov-19 Actuals excl Bowel Scope	Target for Nov at 100% of Nov-19	Var from 100% Nov-19 Target	% achieved of Nov-19 Actual
Specialty		100%	Nov-20	Nov-20		100%	Nov-20	Nov-20
Colonoscopy	728	728	-269	63%	728	728	-269	63%
Flexi Sigmoid	395	395	-149	62%	213	213	32	115%
Gastroscopy	469	469	12	103%	469	469	12	103%
Total	1592	1592	-406	**74.5%**	1410	1410	-225	**84.1%**

On the Day Cancelations:

CAU team are now delivering a 7 day cover enabling the department to contact patients easier to ensure all capacity booked and anticipate a reduction in DNA's

Week Commencing 19/10/20-23/10/20	
Too Short Notice	18
Does not want to come to hospital due to COVID	7
Inconvenience of swabbing/self-isolating	12
Pt has another date/ other hospital	5
Work Commitments	10
No Transport	7
Half Term/Child Care	30
Alternative Date	4
Busy	4
On Holiday	5
Unwell	9
Can't attend swab	2
Doesn't regularly check post	1
Declined- does not want procedure	2
Already Booked	2
Not stopped Tablets/not taken prep	2
Total	120

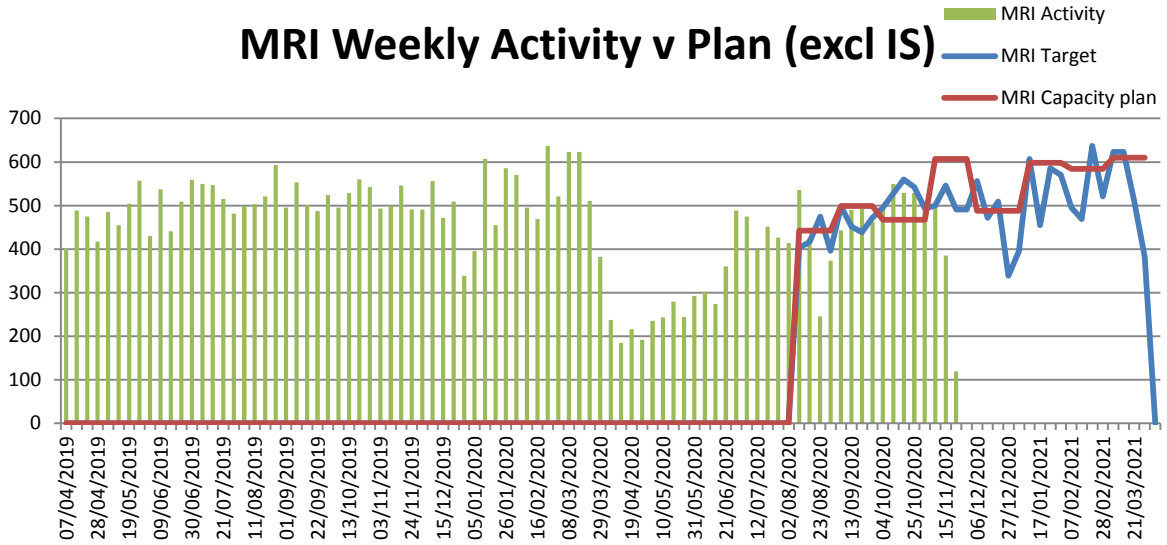
Diagnostic Activity – Trend

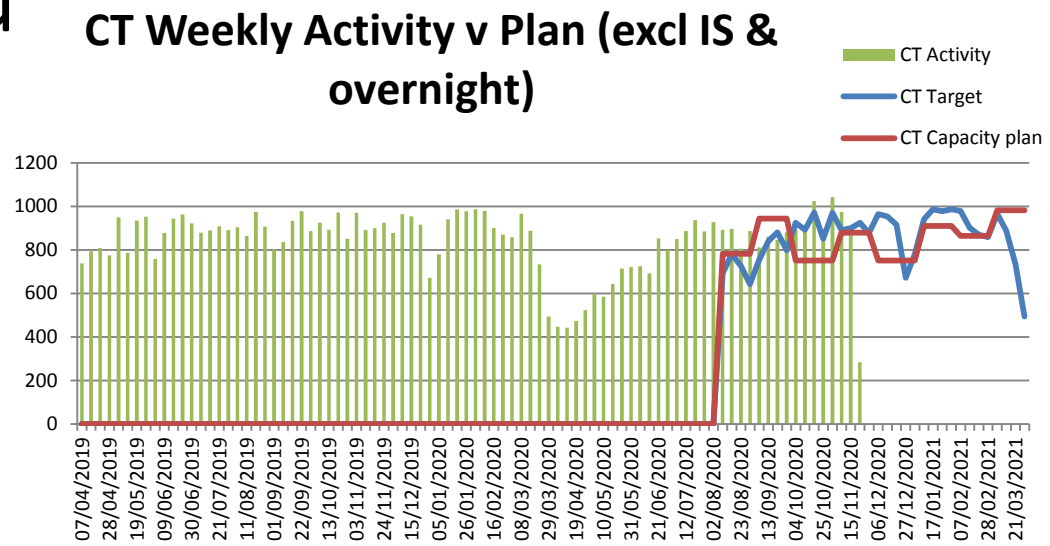
What was the objective?

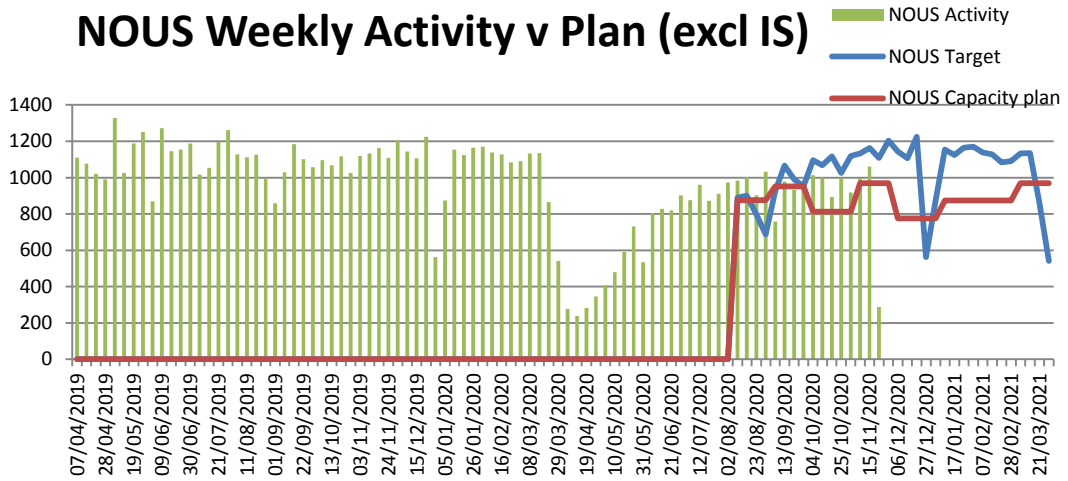
Phase 3: "This means that systems need to very swiftly return to at least 90% of their last year's levels of MRI/CT and endoscopy procedures, with an ambition to reach 100% by October."

How have we performed so far?

- CT and non-obstetric ultrasound activity were above plan and met the 90% target in August and September. CT achieved over 100% for Octobers activity.
- MRI activity was above the 90% target in September, however slightly below 100% target for October.







Diagnostic Activity

Week Beginning	MRI			CT			NOUS		
	Actual	Target Based on 1920	% of 1920 Actuals Achieved	Actual	Target Based on 1920	% of 1920 Actuals Achieved	Actual	Target Based on 1920	% of 1920 Actuals Achieved
21/09/2020	462	472	88.2%	880	798	99.2%	952	951	90.1%
28/09/2020	494	495	99.8%	895	925	96.8%	1013	1096	92.4%
05/10/2020	550	528	104.2%	909	892	101.9%	1001	1068	93.7%
12/10/2020	529	560	94.5%	1024	972	105.3%	893	1117	79.9%
19/10/2020	529	542	97.6%	897	851	105.4%	998	1025	97.4%
26/10/2020	489	493	99.2%	1042	970	107.4%	919	1119	82.1%
02/11/2020	508	500	101.6%	975	890	109.6%	998	1133	88.1%
09/11/2020	385	546	70.5%	894	899	99.4%	1061	1163	91.2%
16/11/2020	119	491	88.2%	283	925	99.2%	288	1108	90.1%
23/11/2020		491			878			1204	

Next steps for radiology:

- Deep dive into turnaround times and how efficiency can be improved.
- Review of administrative bookings process
- Discussion with CCG regarding extra funding for additional MRI capacity
- Recruit more staff for cleaning in between ultrasounds to reduce slot time from 30 mins to 20 mins

Outpatients Activity - October

Are we on track for October?

- We are on track to meet the Phase 3 target (100% - to carry out the same level of OP appointments as October 2019).
- As a live snapshot, we have booked in 95% of 2019's activity for October, with cashing up and retrospective bookings being included this.

Where are the current shortfalls?

- The weekly snapshot on the right is an underestimate, as some appointments, especially nurse-led and echo clinics in cardiology and respiratory, are recorded on Allscripts retrospectively so added after.
- The last week of October is lower than the 100% target due to annual leave, sickness and self isolation.
- The annual leave policy is now being reviewed by specialties.

	03/10/2020		10/10/2020		17/10/2020		24/10/2020		31/10/2020	
Phase 3	Booked in	% of 2019	Booked in	% of 2019	Booked in	% of 2019	Booked in	% of 2019	Booked in	% of 2019
General Surgery	410	111%	955	110%	989	114%	919	106%	921	106%
Urology	164	89%	498	116%	471	109%	472	109%	478	111%
Trauma & Orthopaedics	362	91%	805	87%	875	94%	848	92%	718	77%
Ear, Nose & Throat (ENT)	104	58%	289	69%	270	65%	355	85%	288	69%
Ophthalmology	626	90%	1449	89%	1614	100%	1575	97%	1304	80%
General Medicine	12	70%	22	55%	20	50%	30	75%	27	68%
Gastroenterology	63	66%	214	96%	216	97%	214	96%	141	64%
Clinical Haematology	49	66%	151	87%	261	150%	179	103%	193	111%
Cardiology	137	91%	321	91%	350	100%	409	116%	274	78%
Thoracic Medicine	67	60%	215	83%	257	99%	291	112%	251	97%
Neurology	99	109%	253	119%	237	111%	262	123%	179	84%
Rheumatology	62	59%	251	102%	237	96%	244	99%	270	110%
Paediatrics	251	92%	743	116%	633	99%	593	93%	591	92%
Geriatric Medicine	48	133%	91	108%	104	123%	100	118%	89	105%
Gynaecology	150	102%	391	114%	400	117%	350	102%	390	114%
OtherTFCs	278	63%	715	69%	896	86%	795	77%	794	77%
Total	2882	85%	7363	94%	7830	99%	7636	97%	6908	88%

*Other includes: gynae-onc, audiology, diabetes, endocrinology, pain management, cardiothoracic surgery

Outpatients Activity - November

Are we on track for November?

- As a live snapshot, on Thursday 19th November, we have booked in 90% of 2019's activity for November.
- 100% of follow up activity has been booked.

Where we at currently?

- Paediatrics percentage should increase as the nurse led clinics are added retrospectively.
- Due to the second lockdown we are monitoring the patient cancellation rates and DNA's. We are seeing slightly higher DNA rate especially in Paediatric clinics.
- Also seeing more patient last minute cancellations due to self isolation and track and trace.

	07/11/2020		14/11/2020		21/11/2020		28/11/2020		05/12/2020	
Phase 3	Booked in	% of 2019	Booked in	% of 2019	Booked in	% of 2019	Booked in	% of 2019	Booked in	% of 2019
General Surgery	1031	121%	1058	124%	966	113%	688	80%	111	45%
Urology	537	119%	408	91%	553	123%	537	119%	139	108%
Trauma & Orthopaedics	904	100%	789	87%	738	82%	624	69%	101	39%
Ear, Nose & Throat (ENT)	334	79%	426	101%	383	91%	406	96%	45	38%
Ophthalmology	1565	97%	1535	95%	1604	99%	1458	90%	290	63%
General Medicine	27	84%	32	100%	17	53%	2	6%	2	22%
Gastroenterology	197	101%	187	96%	217	111%	214	110%	50	89%
Clinical Haematology	207	154%	167	125%	224	167%	276	206%	79	208%
Cardiology	368	102%	291	81%	237	66%	221	61%	27	26%
Thoracic Medicine	281	112%	250	99%	246	98%	182	72%	45	63%
Neurology	224	122%	202	110%	179	97%	148	80%	56	108%
Rheumatology	227	108%	231	110%	243	116%	251	120%	57	95%
Paediatrics	594	86%	535	78%	448	65%	399	58%	79	40%
Geriatric Medicine	83	108%	77	100%	92	119%	95	123%	0	0%
Gynaecology	409	124%	345	105%	364	111%	212	64%	35	37%
OtherTFCs	935	92%	865	85%	730	72%	641	63%	124	43%
Total	7923	103%	7398	96%	7241	94%	6354	82%	1240	56%

*Other includes: Gynae-onc, audiology, diabetes, endocrinology, pain management, cardiothoracic surgery

Cancer Performance

Wait to First Seen (2 week wait) 93% national standard

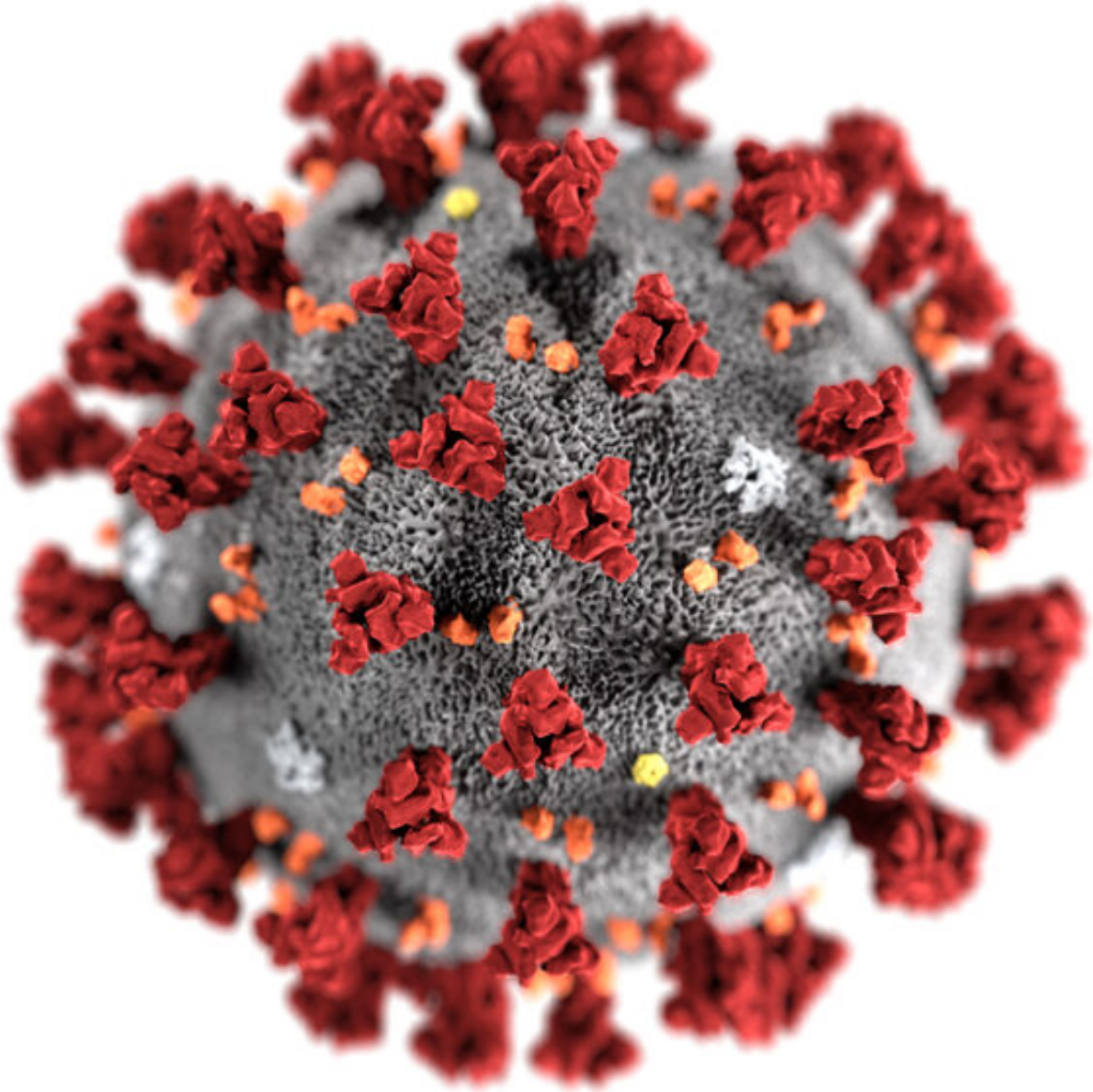
- We have increased capacity to ensure patients referred in can be seen within 14 days, despite the increasing number of referrals.
- We have seen an increase in referrals from other areas in Kent, which we are currently auditing to identify specific numbers and where they are coming from.
- In September we achieved the 2ww target for the 13th month in a row with 96.3% of patients seen within 14 days of referral.
- Referrals are back up to pre-Covid levels and are on average 108% compared to 2019.

62 day First Definitive Treatment

- We have now achieved the cancer 62 day standard for 14 months in a row, submitting our September performance at 86.1%.
- Every patient that had their treatment postponed due to Covid has now been treated.
- Key areas of focus:
  - Oncology – IPT process across Kent and Medway and plan to keep booking timeframes between 7-10 days.
  - Radiology capacity – CT guided biopsy capacity in line with cancer demand
  - Working with tertiary centres to understand changes in services as a result of lockdown and increased NHS pressure.

28 day Faster Diagnosis (shadow monitoring)

- Performance against the 28 day FDS is a key focus for the next 2 months this year. This will involve working with the clinical services to ensure two things: 1) we improve data completeness by ensuring they have the processes in place to identify how/when patients are told they do or do not have cancer within 28 days, and 2) implementing new and innovative ways of maximising front end pathway efficiency to ensure that the patient is contacted with a yes / no diagnosis of cancer within the expected timeframe.
- The introduction of this standard was delayed at a national level but we have continued to monitor performance internally.



NHS
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IPC Covid-19 update

MTW
exceptional people, outstanding care

Key Actions: It is the Board's responsibility to ensure that:

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1. Staff consistently practice good hand hygiene and that high touch points are decontaminated multiple times per day

2. Staff maintain social distancing in the workplace, when travelling to work and are reminded to follow PHE advice outside the workplace

3. Staff wear the right level of PPE when in clinical settings and face masks in non-clinical settings

4. Patients are not moved until at least two negative results are obtained unless clinically justified

5. Daily data submissions are signed off by the CEO, Chief Nurse or Medical Director and the Board Assurance Framework is reviewed

6. Where bays with high numbers of beds are in use, these must be risk assessed and where 2m cannot be achieved, physical separation of patients is considered and wards are sufficiently ventilated

MTW exceptional people, outstanding care

7. Testing - twice weekly lateral flow antigen testing for NHS patient facing staff is implemented
- additional testing where the nosocomial rate is high

8. Patient testing – all patients tested on admission
- patients who develop symptoms after admission to be tested
- repeat testing at day 3 and day 5-7 for all negative patients
- patients tested 48 hours prior to discharge to residential care. Result must be available prior to discharge
- elective patients tested 3 days prior to admission and then self-isolate until admission

9. Ensure that IPC interventions are optimal, the BAF is complete and agreed actions are delivered

10. Review system performance and data, offer peer support and take steps to intervene as required

Ref: online Covid-19 guidance. www.england.nhs.uk/coronavirus

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Capital funding and expenditure for 202021 Chief Finance Officer

The enclosed report provides the latest position on the capital funding and expenditure for 202021.

Which Committees have reviewed the information prior to Board submission?

- Finance and Performance Committee, 24/11/20 (albeit via a different report)
- Executive Team Meeting (ETM), 24/11/20 (albeit via a different report)

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

1. CAPITAL RESOURCES (Month 7 2020)

1.1 The table below sets out the forecast resource position of £26.6m. The "STP system control total" is the MTW share of the overall allocation set for the Kent and Medway Sustainability and Transformation Partnership (STP) patch. This includes both internally generated resource and also a proportion of additional external "emergency capital", now given as Public Dividend Capital (PDC). In addition to the STP managed capital allocation, Trusts can access nationally managed scheme funding, and MTW has been notified of a number of additional allocations since the July plan was submitted.

1.2 The STP emergency capital PDC and the internal asset sale resource will need to be applied for to NHS England/Improvement (NHSE/I) in order to obtain Department of Health and Social Care agreement for the resource and cash. The process to undertake this is now published.

1.3 The central Covid-19 capital claims are still in process with the national C-19 team.

1.4 National PDC schemes – an additional allocation of £97k for Cyber Security was notified to MTW during Month 7.

Capital Resource @ Month 7	**Source**	**Forecast Resource £'000**	**Plan Status**
Depreciation less loan/PFI repayment	Internal	5,493	July Plan
Plus: asset sales (NBV)	Internal	2,000	July Plan
Net internal resource available		**7,493**	
Salix loans	Loan	175	July Plan
STP emergency PDC capital - initial agreed	STP PDC	5,827	July Plan
STP emergency PDC capital - additional recycled	STP PDC	2,830	Additional
Total STP system external resource		**8,832**	
Total STP system control total		**16,325**	
Additional to Control Total e.g. National Schemes			
ICT- HSLI (Kent Medway Care Record)	PDC	190	July Plan
Urgent & Emergency Care Programme	PDC	2,817	Additional
Think 111 (UEC)	PDC	500	Additional
Diagnostic Equipment Replacement	PDC	771	Additional
Adopt & Adapt (Endoscopy)	PDC	1,700	Additional
Cyber Security	PDC	97	Additional
Covid -19 Phase 1 spend	PDC	2,856	July Plan
Other			
PFI Lifeycle (IFRIC 12)	Capital Resource Limit (CRL)	976	July Plan
Donated assets/Charitable funds	Donated	400	July Plan
Total Additional Resource		**10,307**	
Total Forecast Capital Resource		**26,632**	

2. CAPITAL EXPENDITURE COMMITMENTS

2.1 Capital expenditure incurred or committed as at the end of September (M7) is a total of £19.6m. Further work is being undertaken to confirm the prioritisation of the available uncommitted funding taking into account reset and recovery requirements alongside

operational and emergency replacement needs. The various proposals will be considered by the Executive Team for final agreement. Any further reset and recovery requirements would then have to be met by from slippage that occurs on any of the schemes, or by repurposing the scheme funding.

3. CONCLUSION

There are elements of the funding sources for the capital programme that remain unconfirmed at present e.g. the finalisation of the Covid-19 funding. The prioritisation of the proposed schemes to take forward within the available funding need to be confirmed including the finalised costs and, critically, deliverability within the 2020/21 timeframe.

The finalised programme will be therefore be reported to the Trust Board in due course.

NHS Maidstone and Tunbridge Wells NHS Trust

To approve a Business case for a replacement Linear Accelerator (LinAc) at Kent and Canterbury Hospital	Chief Finance Officer / Director of Strategy, Planning and Partnerships

The enclosed Business Case for a replacement linear accelerator (LinAc) at Kent and Canterbury Hospital follows on from the Trust Board's approval of a Strategic Outline Case (SOC) for the provision of oncology services in East Kent in January 2020, and the strategy on the aging LinAC at Kent & Canterbury Hospital (LA3C) transition plan that was considered by the Finance and Performance Committee in March 2020.

The costs involved in the Business Case require the Trust Board's approval. The Finance and Performance Committee has therefore been asked to consider the enclosed document and recommend that the Trust Board approves the Business Case at its meeting on 26/11/20. The outcome of the review by the Finance and Performance Committee will be reported to the Trust Board after the Finance and Performance Committee meeting.

Which Committees have reviewed the information prior to Board submission?

- Finance and Performance Committee, 24/11/20 (am)
- Executive Team Meeting (ETM), 24/11/20 (pm)

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

Approval

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

Maidstone and Tunbridge Wells NHS Trust

BUSINESS CASE

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

Title: **The replacement of LA3C at Canterbury**

Issue date/Version number	19/11/20 V1
ID reference	ID756
Division	Cancer
Directorate	Oncology
Department/Site	Medical Physics
Author	Stephen Duck
Clinical lead/Project Manager	Stephen Duck

Approved by	**Name**	**Signature**	**Date**
General Manager/Service Lead	Victoria Banks		
Finance manager	Gemma Paling		
Clinical Director	Dr Justin Waters		
Executive sponsor			
Division Board	Katherine Goodwin		
Supported by	**Name**	**Signature**	**Date**
Estates and Facilities Management (EFM)	Doug Ward		
ICT	Sue Forsey		
Deputy Chief Operating Officer	Lynn Gray		
Diagnostics and Clinical Support Services (DCSS)	Neil Bedford		
Emergency Planning	John Weeks		
Human Resources (HR) Business Partner	Angie Collison		
Procurement	Bob Murray		
EME Services Manager	Michael Chalklin		

Business Case Summary

Strategic background context and need

The Kent Oncology Centre's radiotherapy service in east Kent is under significant operational and delivery pressures because one of the three linacs on the Canterbury site was decommissioned earlier in the year.

The decision to decommission LA3C took into account the concerns expressed by NHS England that the 17 year old linac no longer met the radiotherapy service specification and followed a thorough risk assessment process that identified operating the Canterbury service on the remaining two linacs could leave the KOC vulnerable and presents a significant risk to service provision in east Kent, with the likely knock-on impact on cancer performance and the achievement of our activity plan.

The case for the replacement of the obsolete linac (LA3C) was identified in the Trust approved business case for the Kent Oncology Centre's linac replacement program for 2017 – 2020. The case identified that the uncertainties in the future of the Canterbury site should be evaluated when considering the linacs to replace and also identified the costs associated with the replacement at the time of writing the original case.

The strategic outline case for a new build cancer centre in east Kent was approved by MTW's Board in January with the outline business case to follow. The current estimate for the delivery of a new build facility in east Kent is sometime in 2023 and it is, therefore, appropriate to review the current context regarding the replacement of LA3C and to recommend a preferred option along with the associated costs.

This business case is about maintaining current activity and is not a case for the growth of the radiotherapy service.

Objectives -

1. Ensure that the radiotherapy service at Canterbury is able to deliver a resilient, safe and effective service that meets the needs of patients in east Kent.

2. Ensure that the project reflects the wider strategic direction for the Canterbury site.

3. Ensure that the choice of replacement linac meets the current and future needs of the service at Canterbury.

The preferred option.

The preferred option is to replace LA3C with a Truebeam linac, undertaking the minimal bunker enabling works required to install the linac, and then to move the linac into a new build facility at a later date.

Estates

Item	Description	Cost (inc. VAT)
Enabling works	Remove LA3C and dispose, upgrade and refurbish linac bunker to minimum required to take the replacement linac. The linac will be commissioned to deliver 6MV x-rays only to avoid the additional costs in bringing the bunker up to a specification for the more penetrating 10MV x-rays. The project will be a turnkey.	£215,280

Equipment requirements

Equipment	Description	Cost (inc.VAT)
Truebeam linac	A Varian Truebeam linac would be installed.	£1,800,000[1]
Commissioning equipment	Verification film	£3,000
	myQA Platform Software Upgrade (Win10)	£43,000[2]
Dosimetry equipment	Dosimetry PC	£800
	Instrumentation cabling	£1,000
Imaging equipment	TrueBeam Upgrade v2.7 (LA2C2)	£20,000
Patient equipment	Patient communications system	£2,400
	Additional CCTV cameras	£2,500
	H&N Overlay Board	£5,000
Aria upgrade	Virtual Server Infrastructure	£250,000
	Win 7 & OBI Upgrades (LA1C, LA2R, LA3R)	£105,000
	Aria Thick Client Upgrade (x3)	£5,000
	Aria Workstations (x12)	£10,000
Treatment planning equipment	FAS (x2)	£50,000
	TPS Licences (Eclipse x3)	£108,000

Medical Physics workforce costs

Medical physics workforce costs to commission, maintain and repair the linac include:

Commissioning workforce	Capitalisation of linac commissioning physicist, 0.2 wte x B7 and overtime	£20,000
	Weekend working for Varian, treatment and medical physics staff to enable the Aria 15 upgrade to proceed on the Canterbury site	£20,000
Linac Training	Additional training for our engineering team to support the linac once it is clinically operational.	£51,860

Transporting, installing and commissioning the linac into the new facility

Transport and installation	Uninstall, package, move, install and recommission the linac in the new build.	£178,800
Storage	The linac chiller and base frame that come with the linac will not be used during the temporary installation but will be stored for installation into the new build.	£10,000
Commissioning	Commissioning of the remaining features upon transfer to new build	£20,000

[1] Awaiting final quotation from NHS Supply Chain
[2] May be funded by Project Ive

Summary of costs

Item	Comments	
Linac	A Varian Truebeam linac would be installed.	£1,800,000[1]
Enabling works	Minimal enabling works required to install the Truebeam (operating at 6MV only) before transfer to the new build facility.	£215,280
Commissioning and dosimetry equipment	This equipment will transfer to the new cancer centre.	£47,800
Imaging equipment	An upgrade is required to an existing Canterbury machine to ensure compatibility with the replacement linac – this equipment may not transfer to the new facility.	£20,000
Patient equipment	Equipment required on the linac for patient treatment – this equipment would transfer to the new centre.	£9,900
Aria upgrade	The Aria upgrade is centre-wide and supports the radiotherapy service across the Canterbury and Maidstone sites. Aria will continue to support the whole radiotherapy service when Canterbury moves into a new build.	£370,000
Treatment planning	Required to support RapidArc planning and would continue to support the service when it moves to a new build.	£158,000
Workforce capital	Covers installation and commissioning of the linac.	£40,000
Workforce - revenue	Covers linac engineering training.	£51,860
Transfer of linac - revenue	The linac will be transferred to the new build facility at a later date and fully commissioned. Includes additional commissioning costs.	£208,800

Main benefits associated with the investment

Key Performance Indicator (KPI)	Baseline Position	Future Outcome
Number of fractions delivered on the Canterbury linacs.	1600 fractions/month – based on months 1-9 of 2019/20 (pre- Covid)	1600 fractions/month – assuming a return to pre-Covid activity

Main risks associated with the investment

Risk of not doing it

Canterbury will continue to operate on two linacs for an indefinite period or until such time as a new cancer centre comes on-line.

Whilst Canterbury has operated before on two linacs for periods of around 10 months, extrapolation to a much longer period of reliance on two linacs may not be warranted:

- the service may be subject to short-notice linac breakdowns resulting in delay in patient treatments, loss of confidence in our services and reputational damage.
- asking staff to work extended days and to cover weekend/bank holiday working indefinitely is likely to be de-motivating and impact on sickness levels and recruitment and retention of staff across all groups/professions.
- the dis-investment in cancer services in east Kent could have consequences on cancer performance, loss of commissioner confidence and may encourage/require other radiotherapy suppliers to take on the east Kent service.

Delivery risk

Enabling works

The Kent and Canterbury accommodation is not purpose built for radiotherapy machines and suffers inherent infrastructure issues often present in buildings which are over 80 years old.

The Varian turnkey team have significant expertise in installing and replacing linacs across the UK and have replaced linacs on the Kent and Canterbury site before. We are also supported by the MTW Estates team and are engaging positively with the EKHUFT Estates team to ensure that the project runs smoothly and to time.

It is difficult to fully assess the infrastructure before works begin which may mean that additional costs are incurred.

The impact of Brexit on the supply chain and costs is currently unknown.

There are no other significant risks to delivering the project.

Transferring the linac into the new build

To assess the overall risk in transferring the linac into the new build (at a later date) the process was discussed with Varian - the linac suppliers - and the local engineering teams who maintain and repair the equipment. The teams are confident that the process will be carefully managed to minimise the risk to the linac and the removal teams:

- the specialist moving company used by Varian for the delivery and installation of their linacs will undertake the process of removing and transferring the linac.
- Varian engineers will oversee the process and radiotherapy physics will carry out the necessary safety and acceptance tests before proceeding to commission the additional features that were not required during the interim installation.

Residual Risk

If the new build cancer centre did not proceed:

- the Canterbury site will continue without a 10MV backup machine,
- the bunker fixtures, fittings and decorations will require a higher-level of-going decorative work to maintain the environment. Additionally, ancillary services may also need a higher level of maintenance and repair as their service life is also extended.

Financial impact of the preferred option – include VAT unless recoverable

CAPITAL COSTS	**(£)**	**Funding source**	**(£)**
Linac machine	1,800,000	20/21 Trust capital plan	2,170,000
Aria Upgrade	370,000	21/22 proposed capital plan	490,980
Sub total	**2,170,000**		
Enabling works (turnkey)	215,280	**Additional Info:**	
Commissioning and dosimetry equipment	47,800	Any combination of the enabling works, commissioning & dosimetry equipment and the imaging & treatment planning equipment costs could be done in 20/21, if capital funding becomes available. Otherwise, they would need to be commitments in 21/22.	
Imaging & treatment planning equipment	227,900		
Sub total	**490,980**		
GRAND TOTAL	**2,660,980**		

Timetable

The timetable below assumes that capital funding will be available to complete the enabling works and install the replacement linac and Aria hardware by 31st March 2021.

The critical dates along with the associated capital spend required to achieve this are shown below:

Critical dates

Task	Critical date	Capital commitment
Place the order for the linac	27 Nov 2020	£1,800,000[1]
Place the order for the Aria upgrade	27 Nov 2020	£370,000
The following are based on availability of capital funding in 20/21:		
Place the order for the enabling works	07 Dec 2020	£215,280
Place the order for the commissioning and dosimetry equipment	02 Jan 2021	£47,800
The remaining imaging and treatment planning equipment could be ordered for delivery around 1st April 2021.	01 Apr 2021	£227,900

Timetable

Milestones	Date
Orders placed for the linac to guarantee delivery by 31st March 2021.	27 Nov 2020
Schedule the Aria upgrade with Varian and order the Aria hardware.	27 Nov 2020
Order the bunker enabling works (last date to ensure the enabling works are completed by 31st March)	07 Dec 2020
Commence the enabling works program.	08 Feb 2021
Enabling works completed and linac installed.	28 March 2021
Acceptance and commissioning of the replacement linac completed. The installation and commissioning program is anticipated to take a total of 14 weeks.	05 Jul 2021
Replacement linac introduced into clinical use.	12 Jul 2021
Install the Aria hardware	08 March 2021
Test upgrade	12 April 2021
Clinical upgrade commences	14 June 2021
Complete the installation of Aria	21 June 2021

The Business Case

1. Strategic context

The Kent Oncology Centre's radiotherapy service in east Kent is under significant operational and delivery pressures because one of the three linacs on the Canterbury site was decommissioned earlier in the year.

The decision to decommission LA3C took into account the concerns expressed by NHS England that the 17 year old linac no longer met the radiotherapy service specification and followed a thorough risk assessment process that identified operating the Canterbury service on the remaining two linacs could leave the KOC vulnerable and presents a significant risk to service provision in east Kent, with the likely knock-on impact on cancer performance and the achievement of our activity plan.

The case for the replacement of the obsolete linac (LA3C) was identified in the Trust approved business case for the Kent Oncology Centre's linac replacement program for 2017 – 2020. The case identified that the uncertainties in the future of the Canterbury site should be evaluated when considering the linacs to replace and also identified the costs associated with the replacement at the time of writing the original case.

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This business case is about maintaining current activity and is not a case for the growth of the radiotherapy service.

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

1. Ensure that the radiotherapy service at Canterbury is able to deliver a resilient, safe and effective service that meets the needs of patients in east Kent.
2. Ensure that the project reflects the wider strategic direction for the Canterbury site.
3. Ensure that the choice of replacement linac meets the current and future needs of the service at Canterbury.

Objective 1 – Ensure the delivery of a resilient, safe and effective radiotherapy service

Current situation:

- The radiotherapy service on the Canterbury site is currently running on business continuity following the decommissioning of LA3C.

Problems / risks of current situation:

- The service is vulnerable to short notice breakdowns which requires patients to be delayed and may involve weekend/bank holiday treatments to catch up.
- Staff are being asked to cover an extended working day and at weekends to cover the service and ensure the linacs are fully serviced and tested.

- Access to modern radiotherapy, including RapidArc dose painting and on-board imaging, is limited.

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

- A replacement linac at Canterbury needs to be installed to restore radiotherapy treatment capacity.

The expected benefits of achieving the change:

- Improved radiotherapy service resilience and minimal risk of disruption to patients undergoing radiotherapy.

- Patients will have even better access to Rapidarc dose painting and on-board imaging which can improve outcomes.

- Staff will no longer need to regularly work evenings and weekends which will improve their work life balance and reduce their levels of stress.

Objective 2 – ensure that the project reflects the wider strategic direction for the Canterbury site

Current situation:

- The strategic direction for radiotherapy services in east Kent is to relocate to a purpose built facility in 2023 (at the earliest) when this replacement linac would be around two years into its recommended ten year life.

- The project will need to consider how the linac replacement will be managed as part of this wider strategic plan.

Problems / risks of current situation:

- Whilst the final location/configuration of the new build facility has not been agreed, it is unlikely that maintaining a linac in the existing 1937 building whilst the rest of the radiotherapy service relocates to the new build will provide a satisfactory patient experience or be effective operationally over the remaining eight years of the linacs projected lifetime.

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

- The replacement program identifies a costed option to transfer the linac into a new build facility at a later date if this is required.

The expected benefits of achieving the change:

- Service resilience in east Kent will be maintained in the interim whilst the new build comes on-line and there is then the option of transferring the replacement linac into the new facility if required.

Objective 3 – ensure that the choice of replacement linac meets the current and future needs of the service at Canterbury

Current situation:

- There are two platforms that could be considered for the replacement linac, a Truebeam or a Halcyon – each offers advantages in terms of flexibility, compatibility with existing equipment, improvements in adaptive dose delivery and increased throughput.

Problems / risks of current situation:

- Radiotherapy technology is ever evolving and it is important to review new platforms as they become available to ensure that the centre is able to offer the treatment improvements that patients and commissioners will ultimately demand as they become more widely available.

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

- Ensure that Oncology has reviewed potential linac platforms and selected a linac for east Kent that best meets the current and future needs of the service, accounting for potential service configuration options that may form part of the wider strategic case.

The expected benefits of achieving the change:

- Compatibility with the existing equipment and sufficient flexibility to support the potential configuration options for the east Kent strategy.

- Opportunity to review the linac platform as part of the strategic case for the new build facility.

3. Constraints and dependencies

The linac will be installed into the Kent Oncology Centre on the Kent and Canterbury Hospital site which is part of EKHUFT. The support of EKHUFT is, therefore, essential to the delivery of this project.

4. Short list of options

Three options were short-listed for consideration:
1. Do nothing.
2. Install a temporary Truebeam replacement into Canterbury.
3. Upgrade the existing bunker and install a Truebeam permanently into Canterbury.

Option 1 Continue to run on two linacs at Canterbury – do nothing

Description:

Do not install a replacement linac at Canterbury and continue to operate at risk. There will be no change in activity.

The service will continue to work overtime, weekends and bank holidays to maintain a safe service delivery for which the associated costs are:

Item	Annual cost
Overtime for radiotherapy and medical physics staff	£9,750
Weekend working for medical physics servicing and QA	£12,600
Varian weekend servicing costs	£10,000
Radiotherapy treatment and bank holiday working	£24,931
TOTAL	£57,281

Non-financial risk associated with the option:

Canterbury will continue to operate on two linacs for an indefinite period or until such time as the new cancer centre comes on-line and, therefore, this option does not meet the benefits identified in the objectives above.

Non-financial benefits associated with the option:

No non-financial benefits have been identified with this option.

Option 2 Undertake a minimal bunker refurbishment at Canterbury and replace the linac – the preferred option

Description:

To undertake a minimal bunker refurbishment at Canterbury so that it is able to support a replacement linac until the new build cancer is complete.

The radiotherapy service has reviewed the choice of linac platforms available and selected the Truebeam because it is the most compatible platform with the existing linacs and offers greater flexibility which would complement alternative treatment platforms that may be installed in the new build facility.

The following assumptions have been made to minimise enabling works costs:

- the Truebeam linac will be commissioned for 6MV x-rays only so as to avoid additional costs in bringing the bunker up to specification for the more penetrating 10MV x-rays that are available on the Truebeam,
- the 10MV x-rays along with the electron modalities would be commissioned once the unit is rehoused in the new build facility.

There will be no change in activity.

Non-financial risk associated with the option:

There may be delays during the enabling works given the age of building but the minimal refurbishment does not require extensive works on the bunker.

Non-financial benefits associated with the option:

This option achieves the benefits identified in the objectives defined above:

- improved radiotherapy service resilience and minimal risk of disruption to patients undergoing radiotherapy,

- patients will have even better access to Rapidarc dose painting and on-board imaging which can improve outcomes,

- staff will no longer need to regularly work evenings and weekends which will improve their work life balance and reduce their levels of stress,

- minimal investment is required to ensure service resilience in east Kent whilst the new build comes on-line and there is then the option of transferring the replacement linac into the new facility if required,

- compatibility with the existing equipment and sufficient flexibility to support the potential configuration options for the east Kent strategy,

- opportunity to review the linac platform as part of the strategic case for the new build facility.

Option 3 Undertake a full refurbishment and upgrade at Canterbury and replace the linac

Description:

Undertake a complete refurbishment of the bunker at Canterbury so that it is able to fully support a replacement linac offering the full range of treatments available on the Truebeam.

There will be no change in activity.

Non-financial risk associated with the option:

There may be delays during the enabling works given the age of building, particularly given the extensive refurbishment works on the bunker that would be involved in this option.

Non-financial benefits associated with the option:

This option achieves the benefits identified in the objectives defined above:

- improved radiotherapy service resilience and minimal risk of disruption to patients undergoing radiotherapy,

- patients will have even better access to Rapidarc dose painting and on-board imaging which can improve outcomes,

- staff will no longer need to regularly work evenings and weekends which will improve their work life balance and reduce their levels of stress,

- service resilience in east Kent is maintained whilst the new build comes on-line and there is then the option of transferring the replacement linac into the new facility if required,

- compatibility with the existing equipment and sufficient flexibility to support the potential configuration options for the east Kent strategy,

- opportunity to review the linac platform as part of the strategic case for the new build facility.

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

Non - monetary benefits and risks of each option - *Summarise the non-monetary benefits and risks of each option*		
Option	**Benefits and risks**	**Option benefit and risk score and/or rank**
Option 1 **Do nothing**	No benefits have been identified within this option. The service will continue to operate at risk on two linacs which will impact on resilience and patient care.	Overall score = 0 Does not meet the stated objectives. Rank 3 (lowest)
Option 2	The benefits of this option include improved service resilience and patient care on the Canterbury site along with an option to move the linac into a new build facility at a later date. The Truebeam platform offers flexibility and is compatible with the other linacs in within the service. The Truebeam would complement alternative linac platforms that may form part of the new build facility. If the new build does not go ahead then the centre will not have a 10MV x-ray back up which may require some patients to be re-planned for 6MV if there is a breakdown. There may be delays during the enabling works given the age of building but the minimal refurbishment does not require extensive works on the bunker.	Overall score = 80 Benefit score: 10 Meets all of the stated objectives. Risk score: 2 There may be an occasional need to re-plan a patient. **Rank 1 (highest)**
Option 3	The benefits of this option include improved service resilience and patient care on the Canterbury site - along with the full use of all of the energy modalities available on the linac - includes an option to move the linac into a new build facility at a later date. The Truebeam platform offers flexibility and is compatible with the other linacs in within the service. The Truebeam would complement alternative linac platforms that may form part of the new build facility. There may be delays during the enabling works given the age of building, particularly given the extensive refurbishment works on the bunker that would be involved in this option.	Overall score = 48 Benefit score: 8 Meets most of the objectives but does not fully align with the strategic direction. Risk score: 4 There is an increased risk of project delay. Rank 2

4b. Summary of information on each option

Category	**Option 1**	**Option 2**	**Option 3**
Capital costs *(One off upfront costs)*	--	£2,660,980	£3,259,300
Benefits *(non-financial)* score *and or rank of option*	0	10	8
Risks score *and or rank of option*	0	2	4

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

The costs, benefits and risks of all the options considered in this business case have been reviewed by the clinical and operational teams within the Oncology Directorate.

The Directorate decision is to support option 2 - the temporary installation of a replacement linac into an existing bunker on the Canterbury site – because this option reduces the risks of delays in patient treatments, allows the Canterbury site to move out of the interim business continuity arrangements and fits in with the overall strategic direction for the service in east Kent to move to a new facility.

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

5. Commercial considerations (preferred option)

5.a. Services and/or assets required

IT Infrastructure

The supporting Arai and treatment planning systems have been specified to ensure that there is sufficient capacity to manage the increase in requirements to support more patients accessing the RapidArc dose painting and on-board imaging that was not available on LA3C (but is available on the other linacs).

The upgraded systems will be installed into the current facilities and there will be no impact on the existing IT infrastructure.

Estates Infrastructure

The bunker enabling works for the new linac on the Canterbury site will be signed off by the EKHUFT team.

5.b. Procurement route

The linac and the equipment identified in this case will be purchased by the Trust's Procurement team using NHS Supply Chain.

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

The replacement of LA3C will not affect current activity levels.

The Specialist Commissioners have been involved in the discussions regarding the decommissioning of LA3C and the mitigation plans for the service, including the temporary replacement of LA3C.

5.d. Workforce impact

No work force changes are required for this case because the service is already established to support three linacs at Canterbury.

There will, however, be a reduction in staff overtime and travel costs once the linac is operational and the Canterbury site returns to normal operations.

6. Financial impact of the preferred option –
Full year effect – include VAT unless recoverable

CAPITAL COSTS	(£)	Funding source	(£)
Linac machine	1,800,000	20/21 Trust capital plan	**2,170,000**
Aria Upgrade	370,000	21/22 proposed capital plan	**490,980**
Sub total	**2,170,000**		
Enabling works (turnkey)	215,280	**Additional Info:**	
Commissioning and dosimetry equipment	47,800	Any combination of the enabling works, commissioning & dosimetry equipment and the imaging & treatment planning equipment costs could be done in 20/21, if capital funding becomes available.	
Imaging & treatment planning equipment	227,900		
Sub total	**490,980**		
Grand TOTAL	**2,660,980**		

7. Quality Impact Assessment **(preferred option)**

Clinical Effectiveness	
Have clinicians been involved in the service redesign? If yes, list who.	
Dr Henry Taylor, Dr Charlotte Abson, Dr Kannon Nathan.	
Has any appropriate evidence been used in the redesign? (e.g. NICE guidance)	
Yes – this is a replacement linac required to support existing activity and offer more patient access to modern radiotherapy techniques.	
Are relevant Clinical Outcome Measures already being monitored by the Division/Directorate? If yes, list. If no, specify additional outcome measures where appropriate.	
Yes – radiotherapy monitors a number of patient outcomes across all treatment sites including treatment delays, overall treatment time and changes to the patient prescription which can impact on survival. These will continue to be monitored.	
Are there any risks to clinical effectiveness? If yes, list	
None identified.	
Have the risks been mitigated?	
None identified.	
Have the risks been added to the departmental risk register and a review date set?	
None identified.	
Are there any benefits to clinical effectiveness? If yes, list	
There will be a reduction in the delay or disruption to individual patient treatments which can affect outcomes.	
Patient Safety	
Has the impact of the change been considered in relation to:	
Infection Prevention and Control?	Y~~/N~~
Safeguarding vulnerable adults/ children?	Y~~/N~~
Current quality indicators?	Y~~/N~~
Quality Account priorities?	Y~~/N~~
CQUINS?	Y~~/N~~
Are there any risks to patient safety? If yes, list	
No - this project is about installing a standard linac which is already in use within the cancer centre for which there are standard treatment protocols in place.	
Have the risks been mitigated?	
None identified.	
Have the risks been added to the departmental risk register and a review date set?	
None identified.	
Are there any benefits to patient safety? If yes, list	
None identified - this project is about installing a standard linac which is already in use within the cancer centre for which there are standard treatment protocols in place.	
Patient experience	
Has the impact of the redesign on patients/ carers/ members of the public been assessed? If no, identify why not.	
Yes.	

Has the impact of the change been considered in relation to: • Promoting self-care for people with long-term conditions? • Tackling health inequalities?					
Yes.					
Does the redesign lead to improvements in the care pathway? If yes, identify					
No changes in the current care pathway identified.					
Are there any risks to the patient experience? If yes, list					
None identified.					
Have the risks been mitigated?					
None identified.					
Have the risks been added to the departmental risk register and a review date set?					
No risks identified.					
Are there any benefits to the patient experience? If yes, list					
Reduction in disruption and delay to patient treatment schedules along with improved access to modern radiotherapy techniques.					
Equality & Diversity					
Has the impact of redesign been subject to an Equality Impact Assessment?					
Yes.					
Are any of the 9 protected characteristics likely to be negatively impacted? (If so, please attach the Equality Impact Assessment)					
No.					
Has any negative impact been added to the departmental risk register and a review date set?					
None identified.					
Service					
What is the overall impact on service quality? – please tick one box					
Improves quality	√	Maintains quality		Reduces quality	
Clinical lead comments					

8. Project management arrangements

Timetable

The timetable below assumes that capital funding will be available to complete the enabling works and install the replacement linac and Aria hardware by 31st March 2021.

The critical dates along with the associated capital spend required to achieve this are shown below:

Critical dates

Task	Critical date	Capital commitment
Place the order for the linac	27 Nov 2020	£1,800,000
Place the order for the Aria upgrade	27 Nov 2020	£370,000
The following are based on availability of capital funding in 20/21:		
Place the order for the enabling works	07 Dec 2020	£215,280
Place the order for the commissioning and dosimetry equipment	02 Jan 2021	£47,800
The remaining imaging and treatment planning equipment could be ordered for delivery around 1st April 2021.	01 Apr 2021	£227,900

Timetable

Milestones	Date
Orders placed for the linac to guarantee delivery by 31st March 2021.	27 Nov 2020
Schedule the Aria upgrade with Varian and order the Aria hardware.	27 Nov 2020
Order the bunker enabling works (last date to ensure the enabling works are completed by 31st March)	07 Dec 2020
Commence the enabling works program.	08 Feb 2021
Enabling works completed and linac installed.	28 March 2021
Acceptance and commissioning of the replacement linac completed. The installation and commissioning program is anticipated to take a total of 14 weeks.	05 Jul 2021
Replacement linac introduced into clinical use.	12 Jul 2021
Install the Aria hardware	08 March 2021
Test upgrade	12 April 2021
Clinical upgrade commences	14 June 2021
Complete the installation of Aria	21 June 2021

9. Arrangements for post project evaluation (PPE)

Complete the following section now

Name of Division/Directorate	*Cancer / Oncology*
Evaluation manager	*Stephen Duck*
Project Title & Reference	*The replacement of LA3C at Canterbury*
Total Cost	
Start date	*November 2020*
Completion date	*July 2021*
Post project evaluation Due Date	November 2021

Complete this section by PPE due date

Section 1 INTRODUCTION

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

SECTION 2: PROJECT PROCESS EVALUATION

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

SECTION 3: ACHIEVEMENT OF OBJECTIVES

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

SECTION 4: BENEFITS

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

SECTION 5: VALUE FOR MONEY

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

SECTION 6: RECOMMENDATIONS AND LESSONS LEARNED

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

NHS
Maidstone and Tunbridge Wells NHS Trust

Communications resourcing plan **Director of Strategy, Planning and Partnerships**

The enclosed "Communications resourcing plan" has been developed in relation to the recent developments within the Trust's Communications Team and requests from members of the Trust Board.

Which Committees have reviewed the information prior to Board submission?
- Executive Team Meeting (ETM), 17/11/20

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

MTW Communications

Trust Board Update
26th November 2020

MTW

NHS
Maidstone and Tunbridge Wells NHS Trust

Background to MTW Communications function

- The Communications Team is a small team **responsible for a broad range of communications activities across the organisation**. These include external media relationships, working with the other NHS organisations in the county, internal communications, advising on campaigns, patient first magazines, website and Intranet.
- This **report focusses on the Internal communications function**, but it should be seen in the context of the significant workload undertaken by the team to support the Trust during COVID 19.
- The team has undergone **considerable changes over the past year** including recruitment of an apprentice, new leadership & additional Band 6 Communications Officer. The **Head of Communications has resigned**, and a new Head of Communications is being recruited.

Although this paper focusses on Internal issues it is worth emphasising that there has been a **significant increase in output from the Communications Team** – these statistics are for the 3 months to start of June

- 28% increase in visits to the website – more views of news articles
- 66 videos created
- 168 intranet news stories
- 40 press releases including national media engagement om BBC, ITV and Channel 4.
- 314 mentions in the media
- 7.2K followers on facebook with over 142K engagements
- 4.1K followers on Instagram
- 4.4K followers on Twitter
- Over 1 million accounts reached with facebook
- All social media platforms are seeing a month on month rise in followers

We are improving how we engage with patients through both print and online channels

- We are working with key partners to secure space in both their print media and online communications (e.g. local Facebook groups) to spread our key messages
- The primary message we are conveying to patients is that MTW is a safe place to come to and to prepare them for the safety measures we have put in place (e.g. restrictions on visitors)
- We are also focusing on thanking both our extraordinary staff many of whom are consumers of the media and also thanking the wider community for their efforts and generosity during the COVID pandemic

HOMES AND COMMUNITIES

THANK YOU!

MAIDSTONE KEY WORKERS

Covid-19 has seen key workers across the borough, such as teachers, supermarket staff, volunteers, NHS staff, the emergency services and MBC teams, doing an amazing job during challenging times. Communities have also pulled together, from collecting shopping and medicines for those shielding to people standing on their doorsteps clapping for key workers to show their appreciation for all their hard work.

To ensure the borough's amazing response to the pandemic is recognised year after year, MBC and Maidstone Hospital joined forces to create a rainbow bulb garden and wild-flower meadow. Planting of over 18,000 bulbs began in November so the flower garden at Maidstone Hospital will bloom in spring - around the anniversary of the start of the pandemic, and the wild-flower meadow will be in bloom throughout the summer. The gardens will add colour and help attract bees and other wildlife.

Miles Scott, Chief Executive of Maidstone and Tunbridge Wells NHS Trust, said:

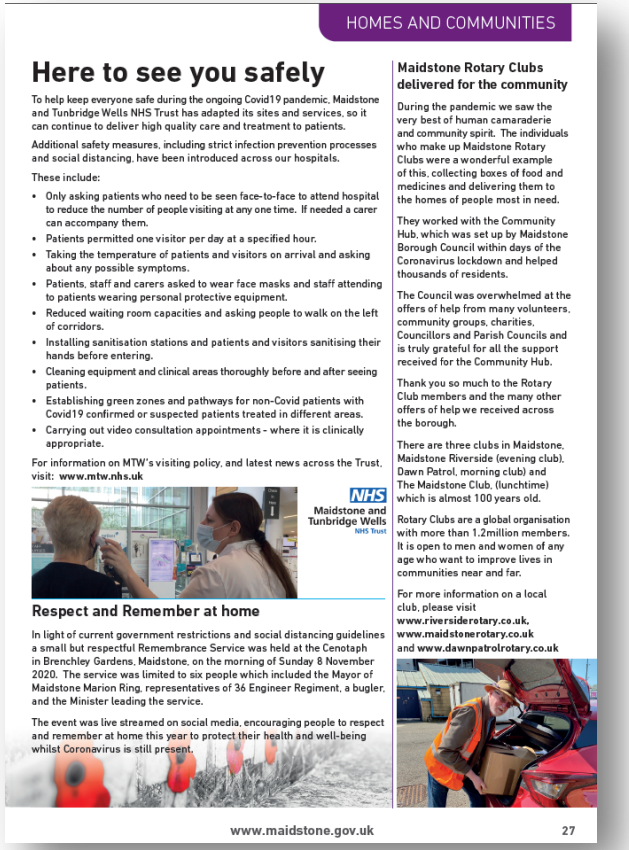
"I am extremely proud of the way our staff responded to the pandemic and I know they have been very grateful for all the help and support they have received from the local community – from schools and local businesses to individuals, it has been truly amazing.

"Planting a rainbow bulb garden and a wild-flower meadow is a wonderful way of marking the pandemic in the long term and I, along with the rest of the Trust are pleased to be involved with this initiative."

Council Grounds Maintenance and Parks teams prepared the ground and planted bulbs around the Hospital to ensure that the gardens make an impact for staff, patients and visitors.

MBC would like to ask everyone who can, to create their own flower garden - it doesn't matter what size big or small to celebrate all key workers. Whether it is a piece of land, a small garden patch, flowerpot or window box, whatever you can do to commemorate their work would be great and we'd love to see them! Please send your pictures to us so that we can share them on our social media channels and in the next edition of Borough Insight: **competition@maidstone.gov.uk** with the subject heading **Keyworker Garden**.

26 www.maidstone.gov.uk



HOMES AND COMMUNITIES

Here to see you safely

To help keep everyone safe during the ongoing Covid19 pandemic, Maidstone and Tunbridge Wells NHS Trust has adapted its sites and services, so it can continue to deliver high quality care and treatment to patients.

Additional safety measures, including strict infection prevention processes and social distancing, have been introduced across our hospitals.

These include:

- Only asking patients who need to be seen face-to-face to attend hospital to reduce the number of people visiting at any one time. If needed a carer can accompany them.
- Patients permitted one visitor per day at a specified hour.
- Taking the temperature of patients and visitors on arrival and asking about any possible symptoms.
- Patients, staff and carers asked to wear face masks and staff attending to patients wearing personal protective equipment.
- Reduced waiting room capacities and asking people to walk on the left of corridors.
- Installing sanitisation stations and patients and visitors sanitising their hands before entering.
- Cleaning equipment and clinical areas thoroughly before and after seeing patients.
- Establishing green zones and pathways for non-Covid patients with Covid19 confirmed or suspected patients treated in different areas.
- Carrying out video consultation appointments - where it is clinically appropriate.

For information on MTW's visiting policy, and latest news across the Trust, visit: **www.mtw.nhs.uk**

NHS Maidstone and Tunbridge Wells NHS Trust

Respect and Remember at home

In light of current government restrictions and social distancing guidelines a small but respectful Remembrance Service was held at the Cenotaph in Brenchley Gardens, Maidstone, on the morning of Sunday 8 November 2020. The service was limited to six people which included the Mayor of Maidstone Marion Ring, representatives of 36 Engineer Regiment, a bugler, and the Minister leading the service.

The event was live streamed on social media, encouraging people to respect and remember at home this year to protect their health and well-being whilst Coronavirus is still present.

Maidstone Rotary Clubs delivered for the community

During the pandemic we saw the very best of human camaraderie and community spirit. The individuals who make up Maidstone Rotary Clubs were a wonderful example of this, collecting boxes of food and medicines and delivering them to the homes of people most in need.

They worked with the Community Hub, which was set up by Maidstone Borough Council within days of the Coronavirus lockdown and helped thousands of residents.

The Council was overwhelmed at the offers of help from many volunteers, community groups, charities, Councillors and Parish Councils and is truly grateful for all the support received for the Community Hub.

Thank you so much to the Rotary Club members and the many other offers of help we received across the borough.

There are three clubs in Maidstone, Maidstone Riverside (evening club), Dawn Patrol, morning club) and The Maidstone Club, (lunchtime) which is almost 100 years old.

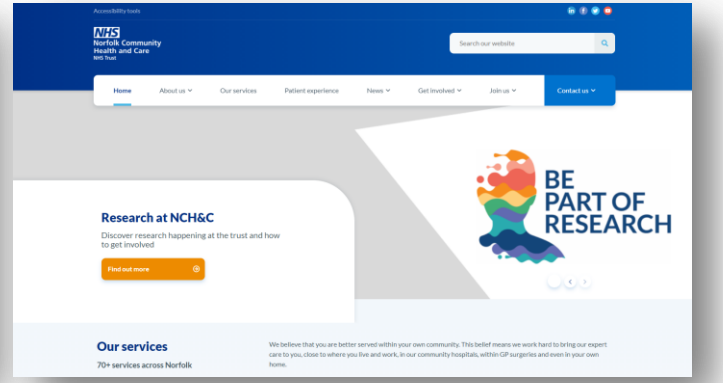
Rotary Clubs are a global organisation with more than 1.2million members. It is open to men and women of any age who want to improve lives in communities near and far.

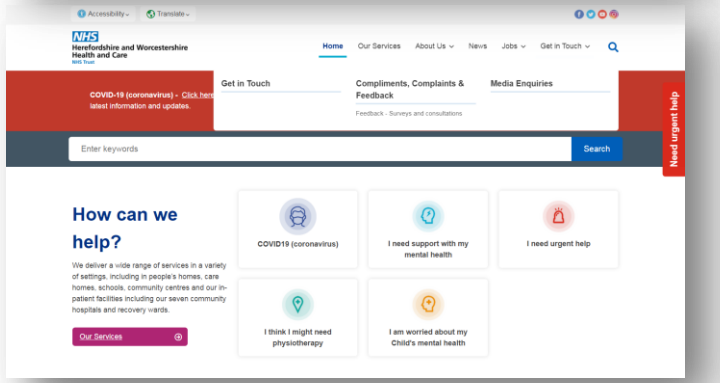
For more information on a local club, please visit **www.riversiderotary.co.uk, www.maidstonerotary.co.uk** and **www.dawnpatrolrotary.co.uk**

www.maidstone.gov.uk 27

Improving our internet and intranet are key to our plans

- It was recognised that the website and Intranet are key tools in communicating to both external and internal audiences and were not fit for purpose – they were old and unsupported making updating difficult
- Orders have now been placed for a new branded website and Intranet
- The new intranet will allow log in from home and mobile devices and a host of features to allow divisions to communicate
- PMO and bank staff are in place to support the project
- The intention is to use the patient experience committee to test and feedback on the new website & staff networks on the Intranet
- While a mock up of the new internet site is not yet available examples of other sites built by the same company are shown to the right and feature a more patient centred and visual design





We are prioritising improving the Trust environment to enhance patient and staff experience

Improving the look

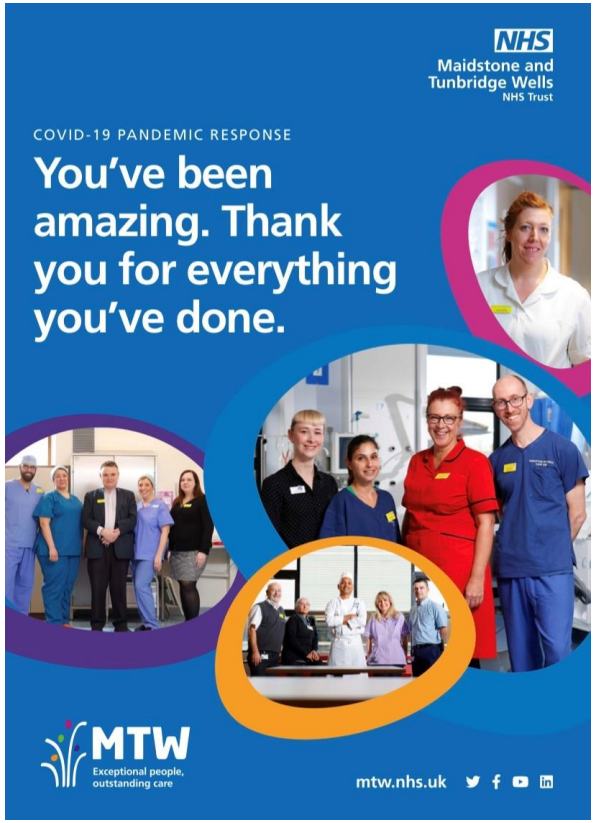
The trust brand has been revised and new frames will ensure the corridors remain clean and fresh with dedicated places to display posters and information. In addition, new wall graphics if successful in the trial will improve identity and inspire a sense of pride in areas. The introduction of electronic display boards to deliver impactful communications to people at the press of a button has been noted.

Recruitment of in-house graphic designer

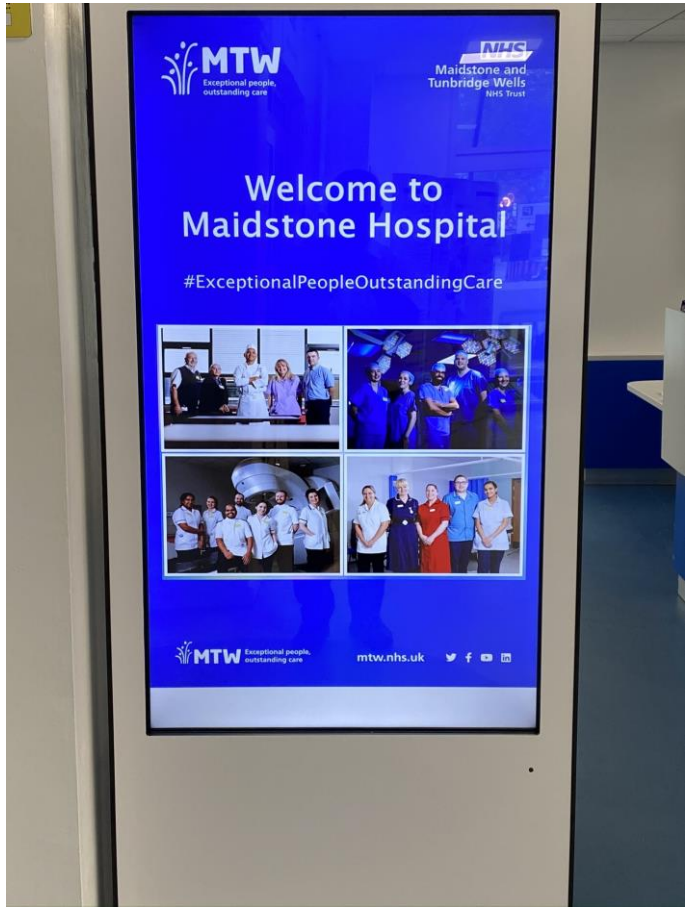
There is a business case in process to recruit a dedicated in-house graphic design person that can help transform the way communications is presented and produce info graphics etc.

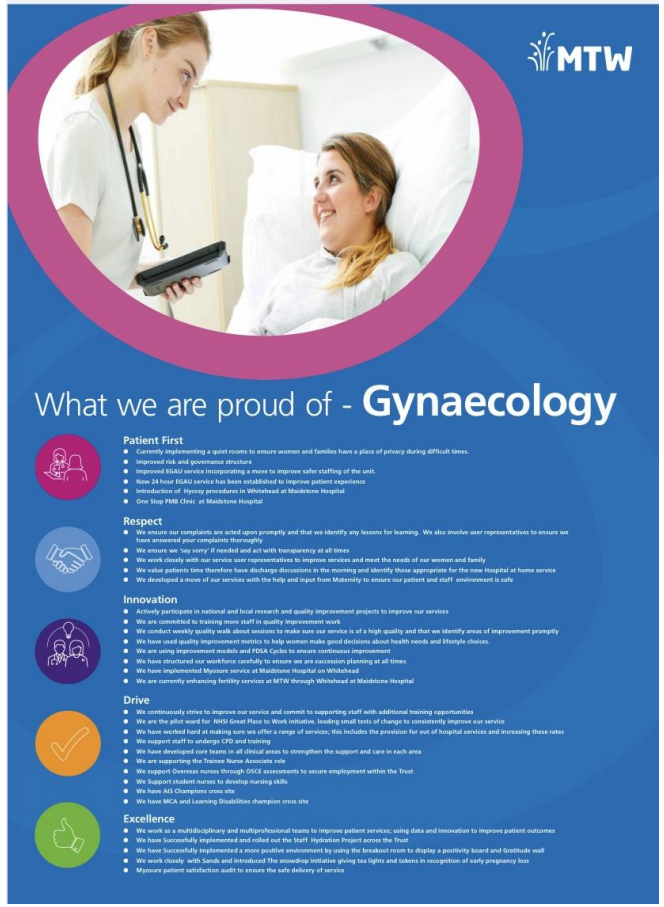
Use of the staff breakout areas

The use of the wingman marquees and staff restaurants to post significant information has again been popular. The intention is to make these permanent so the way we can use these will adapt – so we are already running displays and infographic boards.

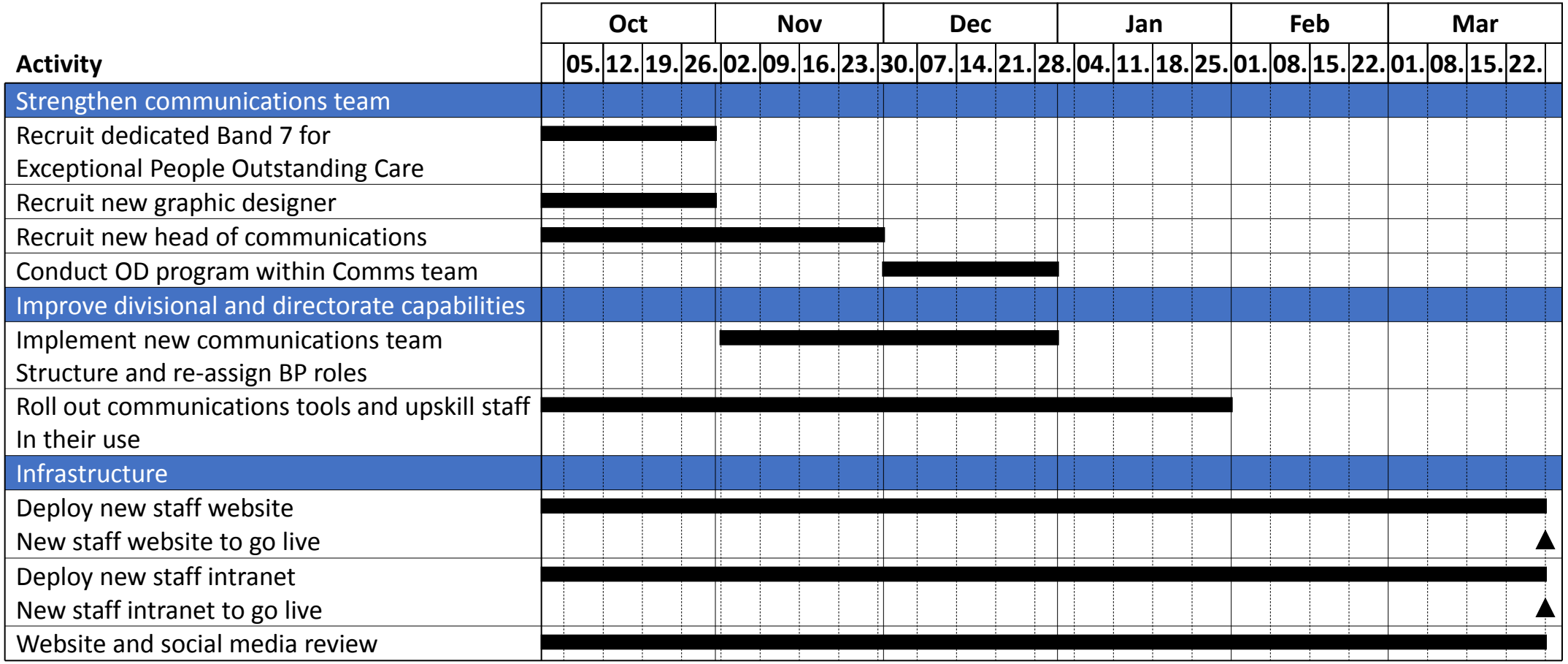


Improving the look of clinical areas is central to the strategy





Our workplan to deliver a new and improved Communications service



Review of the Board Assurance Framework 2020/21	Chair of the Audit and Governance Committee

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

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

Format of the BAF for 2020/21

The format of the BAF for 2020/21 has been affected by four main factors:

1. At the Trust Board meeting in February 2020, it was agreed that the Chief Finance Officer and Trust Secretary should liaise to explore how the ratings within the BAF could be synchronised with the forecast ratings within the Integrated Performance Report (IPR). Liaison duly occurred and it was intended that the format of the BAF should be adapted to align with the forecast ratings within the IPR. However, the IPR itself has been subject to change during 2020/21, and the new format that was first submitted to the Trust Board in July 2020 (and which was well-received by the Trust Board) does not contain a forecast rating. In keeping with the Trust Board's wishes, the rating of "Confidence that the objective will be achieved by the end of 2020/21" has been removed from the BAF for 2020/21.
2. The Audit and Governance Committee agreed that the feedback from the Committee's consideration of the BAF at its meeting on 07/08/19 be considered as part of the planning process for construction of the BAF 2020/21. The feedback was considered. However, the discussion at the Audit and Governance Committee on 07/08/19 was more directly related to the objectives within the BAF, rather than the format of the BAF itself, and the Trust Board approved the objectives to feature in the 2020/21 BAF at its meeting in July 2020.
3. The format of the objectives approved by the Trust Board (see below) marked a return to the BAF focusing on high-level objectives, and a move away from focusing on low-level objectives as proxies for indicators of wider performance (a model which has been applied to the BAF for the past few years). This makes the BAF far more comprehensive in its scope, but reduces its specificity, as the objectives are less SMART than the objectives that featured in the 2019/20 BAF. That is not necessarily a concern, but does reflect a change in approach that should be recognised. In addition, as the revised objectives are connected to the 'reset and recovery' programme, there is significant potential for duplication between the reporting from that programme and the BAF. The BAF is therefore intended to be more of a high-level summary than a comprehensive source of information, but contain the necessary sign-posting to other sources of information available to Trust Board members.
4. A desire to simplify the format of the BAF has resulted in some aspects of the BAF that remained primarily unchanged during 2019/20 being removed, as they were not considered to add any value to Trust Board members' understanding of the BAF, or to the assurance that could be obtained from such information. These aspects are: the associated PRIDE value/s; whether the Trust has all the data needed to judge performance; and whether specific assurance exists on the data quality of the performance information. The "Person responsible for empowering our staff" has also been renamed as "Member of the Executive Team responsible for delivery of the project aim". These changes can however be reversed should the Trust Board so wish.

[1] HM Treasury: Assurance frameworks

Objectives for 2020/21

The Trust Board originally approved key objectives for 2020/21 at its meeting on 30/04/20, subject to some changes being made to the format of the objectives' structure, and enhancing the precision of one of the proposed objectives. However, the objectives agreed by the Trust Board at that point did not take into account the objectives within the 'reset and recovery' programme. The Executive Team Meeting (ETM) considered a set of objectives that were related to the Trust's 'reset and recovery' programme on 07/07/20, and the Chief Executive confirmed that such objectives would be submitted to the Trust Board, on 23/07/20, for approval. The Trust Board duly considered some revised objectives at its meeting on 23/07/20. It was agreed that the objectives should be amended, to reflect the comments at that meeting, but the Trust Board agreed that the "Project aims" associated with the objectives should form the basis of the 2020/21 BAF. Ten "Project aims" were submitted to the Trust Board, but two[2] have since been combined, to reflect the comments made at the meeting. The nine current "Project aims" are therefore as follows:

1. Finance and Contracts: To deliver the Trust's financial plan, which is set within the context of its financial strategy, and underpinned by a robust, sustainable recurrent surplus.
2. Operational Performance: To improve the management of our patient journeys through the utilisation of evidence-based practice to ensure good quality care and achievement of the constitutional access standards within agreed resources.
3. Quality and CQC: To deliver high quality care to our patients and carers and be recognised as an outstanding organisation.
4. Electronic Patient Record (EPR): Delivery of Allscripts' EPR solution "Sunrise"; aligning and supporting the wider strategic objective of digitally transforming MTW to improve patient outcomes through providing safer and more efficient care.
5. Education/Kent and Medway Medical School (KMMS): To enable fulfilment of MTW's role in the delivery of an integrated reputable, high quality educational programme and student experience for KMMS students in line with the KMMS curriculum; provision of necessary student accommodation and teaching infrastructure at Maidstone Hospital (MH) and Tunbridge Wells Hospital (TWH) in time for the first intake of KMMS students on 01/09/22.
6. Strategy - Estates: To define an estates and facilities strategy and plan for MTW informed by both the clinical strategy and Reset and recovery workstreams.
7. Strategy – Clinical: To define the future state (short medium and long term) configuration options for a range of clinical services with timelines and plans for implementation.
8. Integrated Care Partnership (ICP)/External: To oversee and enable the ICP Development in West Kent and ensure appropriate stakeholder engagement and participation in MTW's work (e.g. in clinical strategy development).
9. Organisational Development and Workforce: Make MTW a great place to work - For MTW to be an excellent organisation that puts staff engagement, well-being and experience at the fore front to nurture a place where people want to come to work, stay, be proud and enable staff to be exceptional by recruiting, retaining and developing exceptional people to deliver outstanding care for our communities.

Process for oversight

Although the objectives within the BAF for 2020/21 were not approved by the Trust Board until 23/07/20, the objectives within the BAF have still been devolved for oversight by one or more Trust Board sub-committees (and reports on the objectives are submitted to each sub-committee meeting). The full BAF is then considered by the Audit and Governance Committee, and then by the Trust Board, with the report presented by the Chair of the Audit and Governance Committee (supported by the Trust Secretary and relevant members of the Executive Team). The Audit and Governance Committee met on 04/11/20 and duly considered the full BAF. The Committee noted that objectives 7 and 8 were not allocated for oversight to a Trust Board sub-committee, because of their subject matter, and agreed that the Trust Board should be asked whether it wished to receive further assurance on these objectives, via direct update reports.

Submission to other forums

The BAF was submitted to the following forums prior to being submitted to the Trust Board:

- The ETM on 29/09/20 and 27/10/20 (the full BAF)

[2] "For MTW to be an excellent organisation that puts staff engagement, well-being and experience at the fore front to nurture a place where people want to come to work, stay, be proud and enable staff to be exceptional, to provide outstanding care and services to our patients and communities." and "To recruit and develop the exceptional people we need to deliver outstanding care for our community"

- The 'main' Quality Committee on 16/09/20 and 11/11/20 (objective 3)
- The Trust Management Executive (TME) on 14/10/20 (the full BAF)
- The Finance and Performance Committee on 22/09/20, 20/10/20 and 24/11/20 (objectives 1, 2, 4 and 6)
- The People and Organisational Development Committee/Workforce Committee on 15/10/20 and 20/11/20 (objectives 5 and 9)
- The Audit and Governance Committee on 04/11/20 (the full BAF)

Review by the Trust Board

This is the first time during 2020/21 that the Trust Board has seen the populated BAF. Trust Board members are asked to review and critique the content, by considering the following prompts:

- Are the "Project aims" appropriately described? Should the wording of any be amended?
- Does the content reflect the situation as understood by the Board (and its sub-committees)?
- Is the Board assured that actions reported as being undertaken are satisfactorily evidenced?
- Does any of the content require further explanation?
- Does the format of the BAF need to be amended?

The Board is reminded of the options available to it, in terms of a response, which include:

- Accepting the information or requesting amendments
- Requesting further information on any of the BAF items
- Requesting that a Trust Board sub-committee review any aspect in more detail

Which Committees have reviewed the information prior to Board submission?

- The Executive Team Meeting (ETM) on 29/09/20 and 27/10/20 (the full BAF)
- The 'main' Quality Committee on 16/09/20 and 11/11/20 (objective 3)
- The Trust Management Executive (TME) on 14/10/20 (the full BAF)
- The Finance and Performance Committee on 22/09/20, 20/10/20 & 24/11/20 (objectives 1, 2, 4 & 6)
- The People and Organisational Development Committee / Workforce Committee on 15/10/20 & 20/11/20 (objectives 5 & 9)
- The Audit and Governance Committee on 04/11/20 (the full BAF)

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [3]

1. Review and discussion (considering the prompts listed above).
2. To consider whether further assurances are required for objectives 7 and 8.

[3] 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

Board Assurance Framework 2020/21

NHS Maidstone and Tunbridge Wells NHS Trust

Project aim *Objective*

1 Finance and Contracts: To deliver the Trust's financial plan, which is set within the context of its financial strategy, and underpinned by a robust, sustainable recurrent surplus

What could prevent this project aim being achieved? (including external factors) *Risks to objective*

1. Uncertainty of the change in finance regime for 2020/21.
2. If there was a lack of senior leadership and commitment.
3. If there were poor financial controls (or if good controls were poorly applied).
4. The additional funding to support COVID-19 could reduce the focus on meeting the financial plan.
5. If the Trust's plans for 2020/21 had been developed without consideration of best practice elsewhere.
6. If there was insufficient engagement with external stakeholders, particularly given the Clinical Commissioning Group (CCG) restructuring taking place in 2020/21.
7. If there is a change in the financial circumstances of commissioners, requiring them to take further action to manage demand.

What actions have been taken in response to the above issues? *Controls*

a. The Trust has an internal financial plan for months 1 to 6 approved by the Trust Board in line with the revised financial arrangements.
b. Directorate budgets have been set for months 1 to 6.
c. External stakeholder engagement continues, although contracts are paused nationally, the Trust is working with its Kent and Medway Sustainability and Transformation Partnership (STP) partners. This includes an agreed STP plan for capital.
d. To support the finance department there is currently additional senior finance resource supporting Integrated Care Partnership (ICP) development and the Estates review.
e. A Financial Improvement plan, known as "Future Finance" is being developed.
f. A Financial Strategy is being developed to support future years.
g. The Trust's leadership development programme is expected to benefit the delivery of all the Trust's key objectives.

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*

1. Monthly financial performance reports to the Finance and Performance Committee and Trust Board.
2. Monthly Divisional Performance Reviews.
3. The weekly financial 'flash' report considered at the Executive Team Meeting (ETM).

Member of the Executive Team responsible for delivery of the project aim: Chief Finance Officer / Deputy Chief Executive

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

Update on progress with the project aim (at October 2020)

- The Trust has delivered a break-even position for months 1 to 6
- Financial arrangements for month 7 onwards have now been confirmed. The Trust has submitted a draft financial plan for months 7 to 12 of 20/21. A further submission is planned for 22/10/2020
- A 'reset and recovery' Investment Plan has been agreed to support the 'reset and recovery' workstreams.

Project aim *Objective*

2 Operational Performance: To improve the management of our patient journeys through the utilisation of evidence-based practice to ensure good quality care and achievement of the constitutional access standards within agreed resources

What could prevent this project aim being achieved? (including external factors) *Risks to objective*

1. Lack of managerial focus or clinical engagement.
2. COVID-19.
3. Shortage of capacity during winter.

What actions have been taken in response to the above issues? *Controls*

a. Operational performance meetings are held across cancer, the Emergency Department (ED), Referral to Treatment (RTT) and outpatients.
b. A number of investments have been made to support operational targets.
c. Reset and recovery transformation forums have been set up.
d. The Trust's leadership development programme is expected to benefit the delivery of all the Trust's key objectives.

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*

1. Weekly reports to the Executive Team Meeting.
2. Monthly reports to each Finance and Performance Committee and Trust Board.

Member of the Executive Team responsible for delivery of the project aim: Chief Operating Officer

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

Update on progress with the project aim (at October 2020)

- The Trust is in the top three Trusts in the country for its Emergency Department (ED) 4-hour waiting time target performance.
- The Trust is one of only two Trusts in the country to meet the 62-day cancer waiting time target for 12 months in a row.
- There will be a focus on outpatients and elective activity over the next three months with a view of eliminating 52-week waiting time breaches.
- There is a plan to recover the RTT position to 87% by March 2021.

Board Assurance Framework 2020/21

NHS Maidstone and Tunbridge Wells NHS Trust

Project aim *Objective*

3 Quality and CQC: To deliver high quality care to our patients and carers and be recognised as an outstanding organisation

What could prevent this project aim being achieved? (including external factors) *Risks to objective*

1. The potential for teams to lose focus on quality improvement plans due to competing priorities.
2. Further surge of COVID-19 cases resulting in potential redeployment of staff.
3. Uncertainty in the future changes in the Care Quality Commission (CQC) inspection methodology.
3. Over-reliance on the corporate team leading on the improvement work.
4. Reduced local ownership and engagement with action plans.

What actions have been taken in response to the above issues? *Controls*

a. Local development and ownership of action plans.
b. Embedding the 'business as usual' approach to quality improvement – revisiting the Key Lines of Enquiry (KLOE) self-assessments.
c. Implementation of a range of initiatives to observe and share best practice.
d. Regular planned engagement and communication with our CQC colleagues.
e. Support to divisions with 'deep dive' reviews of services as identified and report to the Quality Committee 'deep dive' meeting.
f. The Trust's leadership development programme is expected to benefit the delivery of all the Trust's key objectives.

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*

1. Monthly progress reports on action plans to the Quality Improvement Committee.
2. The 'main' Quality Committee will receive progress reports bi-monthly.
3. Monthly progress reports to the divisional performance reviews.
4. Monthly report to the Executive Team Meeting.
5. Divisional reporting in clinical governance meetings.

Member of the Executive Team responsible for delivery of the project aim: Chief Nurse / Medical Director

Trust Board sub-committee responsible for oversight: Quality Committee

Update on progress with the project aim (at October 2020)

- There has been 100% completion of self-assessments against KLOEs completed for each division.
- Directorate and Divisional actions have been completed by teams and are currently being reviewed in readiness for reporting progress to the Quality Improvement Committee.
- Key areas of organisation focus are addressed with agreed workstreams in place as needed.
- The most recent CQC engagement event was on 03/09/20 and the next one is scheduled for December 2020.

Board Assurance Framework 2020/21

NHS Maidstone and Tunbridge Wells NHS Trust

Project aim *Objective*

4 Electronic Patient Record (EPR): Delivery of Allscripts' EPR solution "Sunrise"; aligning and supporting the wider strategic objective of digitally transforming MTW to improve patient outcomes through providing safer and more efficient care

What could prevent this project aim being achieved? (including external factors) *Risks to objective*

1. The Trust's capacity and capability to manage the volume of change required for EPR & other high-priority initiatives.
2. A second wave of COVID-19 cases resulting in staff not being able to be released for testing or training over the next six months
3. A lack of operational management engagement resulting in subject matter experts and clinical staff not being made available to the EPR Programme Team.
4. A lack of clinical engagement leading to the Trust's requirements not being properly understood and poor-quality solutions being provided.
5. Windows 10 rollout & its alignment with Sunrise.
6. The capacity and capability of the IT Team to deliver and support the Sunrise Infrastructure.

What actions have been taken in response to the above issues? *Controls*

a. The Trust's reset of priorities includes EPR as a core deliverable for 2020/21.
b. COVID-19 secure facilities are internally being identified to support EPR testing and training.
c. Divisional leads have been appointed to support implementation plans including releasing staff for testing and training.
d. The redevelopment of the Digital Transformation Strategy as part of the Trust's focus on the reset agenda.
e. The Chief Clinical Information Officer (CCIO) is actively engaged with the programme communication and messaging, and there is Directorate representation on the Programme Boards.
f. EPR Showcase and demo events are planned through the run up to go-live.
g. A detailed EPR communications plan is in place.
h. Milestones have been set to ensure there is no impact on Sunrise.
i. A weekly technical IT meeting is held that feeds into EPR Enablers Board, ensuring progress against milestones is achieved (including reviewing the IT resource to support the Sunrise deployment).
j. The Trust's leadership development programme is expected to benefit the delivery of all the Trust's key objectives.

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*

1. Monthly clinical workstream meetings.
2. Monthly update to EPR Programme Board.
3. Monthly update reports to the Executive Team Meeting (ETM).
4. Monthly Digital Transformation Board meetings.
5. Bi-monthly reporting to the Finance and Performance Committee.

Member of the Executive Team responsible for delivery of the project aim: Medical Director

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

Update on progress with the project aim (at October 2020)

- Unit testing is scheduled to commence as planned for September / October 2020.
- The configuration of the build is now completed. Refinement and end to end testing has been carried out during Sept and October with subject matter experts within the Trust
- Data priming round 4 has been completed and issues identified for Allscripts and internal Data Quality Board to address
- User acceptance testing is due to start on 09/11/20
- The upgrade to Sunrise 18.4 and Windows 10 remains on track
- Over 30 Sunrise showcase events were held in September, with engagement of more than 200 staff
- The Digital Transformation Strategy is due to go to Trust Board in October for approval

Project aim *Objective*

5 Education/Kent and Medway Medical School (KMMS): To enable fulfilment of MTW's role in the delivery of an integrated reputable, high quality educational programme and student experience for KMMS students in line with the KMMS curriculum; provision of necessary student accommodation and teaching infrastructure at Maidstone Hospital and Tunbridge Wells Hospital in time for the first intake of KMMS students on 01/09/22

What could prevent this project aim being achieved? (including external factors) *Risks to objective*

1. Lack of timely information from KMMS re student numbers and curriculum & learning objectives, to enable early resource planning and accommodation scoping.
2. Availability of resources required by individual specialities/Departments to provide for student placements.
3. Inadequate infrastructure / space (in particular outpatient/ clinic space) to support teaching.
4. The need to co-ordinate where possible to maximise opportunities to develop learning environment with other developments in the Trust.
5. Job plan risks re incorporation of additional Programmed Activities (Pas) for medical student Educational/Clinical Supervisor responsibilities.
6. Insufficient accommodation available for students' arrival on placement in September 2022.

What actions have been taken in response to the above issues? *Controls*

a. Executive oversight and scrutiny through appointment of Medical Director as chair of the KMMS Steering Group and for senior liaison with KMMS (numbers and accommodation data were last pursued on 23/09/20)
b. Establishment of a formal structure for management of the project with three key workstreams and associated governance (Estates & Facilities; Engagement; and Placements)
c. Detailed planning undertaken to assure that the Trust has the capacity re accommodation & clinical infrastructure to meet the expected significant increase in the number of students on placement.
d. Involvement of the Trust's outpatients lead to proactively address concerns re outpatient/clinic space.
e. Recognition of KMMS as core deliverable within the Trust's reset of priorities.
f. Job planning risks will be addressed by the Engagement workstream.
g. The Trust's leadership development programme is expected to benefit the delivery of all the Trust's key objectives.

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*

1. Bi-monthly steering group meetings, with subsequent report to the Executive Team Meeting (ETM).
2. Bi-monthly review of progress with accommodation project by the ETM.

Member of the Executive Team responsible for delivery of the project aim: Medical Director

Trust Board sub-committee responsible for oversight: People and Organisational Development Committee

Update on progress with the project aim (at October 2020)

- A detailed response to a KMMS questionnaire regarding the evidence-base for the number of student placements was submitted jointly by the Medical Director and Director of Medical Education at end of September 2020.
- The Specialty Leads Group meeting is now split into year sub-group meetings, to allow more detailed planning and identification of resource implications for each of the Year 3, 4 & 5 students year groups to take place.
- The assumptions in site basing of students for accommodation and additional teaching/clinical facilities have been agreed

Board Assurance Framework 2020/21

NHS Maidstone and Tunbridge Wells NHS Trust

Project aim *Objective*

6 Strategy - Estates: To define an estates and facilities strategy and plan for MTW informed by both the clinical strategy and Reset and recovery workstreams

What could prevent this project aim being achieved? (including external factors) *Risks to objective*

1. Failure to perform in the allotted time scale, carry out due diligence, proof reading and formation of the document.
2. To incorrectly interpret the strategy direction and congruence of the clinical strategy and the 'reset and recovery' programme workstreams producing a document that is not fit for purpose.
3. Failure to engage and work with external NHS partners and sister trusts in forming the Estates strategy.
4. A sustained re-emergence of the COVID-19 pandemic deflecting the project and causing a prolongation in time to complete the strategy document.

What actions have been taken in response to the above issues? *Controls*

a. Effective project management implementation for the development of the Estates strategy with project milestones and a fixed delivery date.
b. Ensuring the Estates Strategy milestones for development are met by regular review.
c. Implementation at the early stages and following through with the regular peer review of the Estates Strategy with colleagues in the Strategy, Planning and Partnerships Directorate.
d. The regular proof reading and tailoring of the Estates strategy from constructive advice and criticism received by peer reviews.
e. Regular contact with external NHS partners and the Sustainability and Transformation Partnership (STP) as the Estates document is formed.
f. The incorporation of the Estates strategy into the overall redevelopment work that has been undertaken in the formation of a Trust wide control development plan and effective creation of an estates asset space register.
g. The Trust's leadership development programme is expected to benefit the delivery of all the Trust's key objectives.

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*

1. From the documentation that is being incorporated into the Trust's Premises Asset Model (PAM) document which is maintained in the Estates department.
2. Estates Strategy documentation can be actioned on the Estates shared network drive for scrutiny.
3. Estates strategy files are retained in the Director of Estates and Facilities office for inspection.
4. The Estates Strategy plan is incorporated in the Estates and Facilities annual operational plan where progress is referenced.
5. The "Update on the response to the external Estates and Facilities review" reports which are scheduled at the Finance and Performance Committee every three months
6. The "Six-monthly update on Estates and Facilities" submitted to the Trust Board

Member of the Executive Team responsible for delivery of the project aim:	Chief Executive (through the Director of Estates and Facilities)
Trust Board sub-committee responsible for oversight:	Finance and Performance Committee (on the basis that the Trust Board agreed in June 2020 that future "update on the response to the external Estates and Facilities review" reports should be submitted to the Finance and Performance Committee instead of the Trust Board.

Update on progress with the project aim (at October 2020)

- The objective is to complete the Estates Strategy by 31/12/20
- Progress has been consistent despite the imposition of the COVID-19 pandemic.
- Regular meetings take place with the Director of Strategy, Planning Partnerships Directorate.

Project aim *Objective*

7 Strategy – Clinical: To define the future state (short medium and long term) configuration options for a range of clinical services with timelines and plans for implementation

What could prevent this project aim being achieved? (including external factors) *Risks to objective*

1. Lack of clarity on future state options due to COVID-19.
2. Lack of availability of capital for implementation.
3. Lack of project management support and disconnect between strategy and implementation.
4. Lack of Divisional and Directorate engagement.

What actions have been taken in response to the above issues? *Controls*

a. Short to medium term options to incorporate ongoing effects of COVID-19 while long term options do not.
b. Alternative funding options to NHS capital are being explored in parallel to strategy development.
c. A plan for hand off between strategy development and implementation is being worked up with the Director of Transformation.
d. Divisions and Directorates are identifying their own internal project lead to ensure that strategic developments are owned by Divisions with individuals being directed by the Strategy and Transformation teams.
e. The Trust's leadership development programme is expected to benefit the delivery of all the Trust's key objectives.

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*

1. The Executive Team Meeting (ETM) Finance and Performance Committee and Trust Board will review Business Cases developed as a result of Strategy development.
2. All plans are to be placed on the Aspyre IT system to ensure transparency and ability for scrutiny at any time.

Member of the Executive Team responsible for delivery of the project aim: Director of Strategy, Planning and Partnerships

Trust Board sub-committee responsible for oversight: N/A – Trust Board to provide oversight

Update on progress with the project aim (at October 2020)

- Cardiology is progressing with discussions scheduled to explore non-NHS funding.
- The Digestive Diseases Unit is progressing with next stages to be an options appraisal on gastroenterology centralisation and a bariatrics proposal for Kent and Medway Clinical Commissioning Group – Both completed as of 15th October 2020
- Imaging is progressing with a Strategic Outline Case (SOC) for partnership being prepared and Divisional engagement taking place.

Project aim *Objective*

8 Integrated Care Partnership (ICP) /External: To oversee and enable the ICP Development in West Kent and ensure appropriate stakeholder engagement and participation in MTW's work (e.g. in clinical strategy development).

What could prevent this project aim being achieved? (including external factors) *Risks to objective*

1. Lack of Sustainability and Transformation Partnership (STP) /Clinical Commissioning Group (CCG) funding for essential purposes (e.g. clinical backfill).
2. Lack of appropriate population health data for decision making and priority setting.
3. Lack of Trust between system partners.
4. Lack of delegated authority to support streamlined and quick decision making.

What actions have been taken in response to the above issues? *Controls*

a. A proposal for funding key elements of ICP development has been created and agreed with all three other ICPs and being considered by CCG.
b. Discussions are being held with Kent and Medway CCG on the importance of a centralised data function and West Kent analytic function being set up in conjunction with the Head of Business Intelligence and the GP Federation.
c. The governance of ICP has been evolved from pre-existing structures to ensure that the trust. generated over the preceding years is not denuded
d. A Scheme of Delegation is being created to allow for rapid decisions and actions to support transformational change.
e. The Trust's leadership development programme is expected to benefit the delivery of all the Trust's key objectives.

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*

1. The ICP Development Board (which is attended by the Trust's Chief Executive as the Senior Responsible Officer (SRO)) oversees the development of the West Kent ICP.

Member of the Executive Team responsible for delivery of the project aim: Director of Strategy, Planning and Partnerships

Trust Board sub-committee responsible for oversight: N/A – Trust Board to provide oversight

Update on progress with the project aim (at October 2020)

- The ICP has successfully moved to phase two of its governance structures.
- Transformational priorities have been defined in conjunction with clinical and professional board reviewing population health data.
- The resourcing for ICP development is being discussed with Kent and Medway CCG – Final resource allocations are expected to be ratified by the end of October 2020

Project aim *Objective*

9 Organisational Development and Workforce: Make MTW a great place to work - For MTW to be an excellent organisation that puts staff engagement, well-being and experience at the fore front to nurture a place where people want to come to work, stay, be proud and enable staff to be exceptional by recruiting, retaining and developing exceptional people to deliver outstanding care for our communities

What could prevent this project aim being achieved? (including external factors) *Risks to objective*

1. The impact of COVID-19 and 'reset and recovery' needs.
2. The failure of staff to engage specifically with the engagement, wellbeing & staff experience agenda or broader 'People Agenda', including the Equality, Diversity and Inclusion initiatives required by the NHS People Plan and the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).
3. A national shortage of certain staff groups.
4. Failure to implement the Exceptional People Outstanding Care (EPOC) programme or engagement plans, including the Culture and Leadership Programme (CLP) and Exceptional Leaders, Outstanding Care (ELOC) programme, especially on key themes of trusting staff, leadership behaviours and compassionate and inclusive leadership.
5. Lack of support or visibility of senior leaders to ensure golden thread of 'Board to Ward' of 'People Agenda' and key themes of trusting staff and compassionate and inclusive Leadership, as well as patient experience.
6. Insufficient communications of actions and information to staff.
7. Insufficient investment to date in senior leadership development, middle management development or Culture and Leadership Programme actions.
8. Staff not empowered to implement or deliver service changes.

What actions have been taken in response to the above issues? *Controls*

a. The establishment of EPOC workstream to deliver the Organisation Development and COVID-19 'reset and recovery' agendas to support the Trust's strategic objectives and planned partnership working with Western Sussex Hospitals NHS Foundation Trust.
b. Within EPOC and CLP, including Phase 1 (Discover) completion and the commissioning of Phase 2 (Design) with the team.
c. Within EPOC, Exceptional Leaders, Outstanding Care (Seniors Leadership Development Programme), including Phase 1 (Discovery) and the commissioning of Phase 2 (Design) to launch in November 2020, to integrate with Trust strategic agenda and contextualised accordingly.
d. Draft Leadership & Talent Development Strategy.
e. National NHS staff survey planning, including new COVID-19 and patient experience focus.
f. Better consistency, coordination and integration with engagement and communications, including the National Staff Survey and quarterly pulse surveys, including 'you said, we did' feedback and liaison with the Culture and Ethnic Minorities Network (CEMN).
g. Review of feedback and planning to address disconnect between Bullying and Harassment and aspiration for the Trust to be a great place to work and 'outstanding' on all five of the CQC domains.
h. Review of coaching and mentoring to specifically support COVID-19 'reset and recovery', CEMN, and middle manager groups.
i. Agreeing a book of work with communications and Social Distancing and Homeworking Workstream.
j. The Trust's leadership development programme is expected to benefit the delivery of all the Trust's key objectives.

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*

1. CLP Phase 1 Discovery Report and Feedback.
2. ELOC Phase 1 Discovery Report and Feedback.
3. Agreement of Integrated Performance Report (IPR) metrics for EPOC/OD with effect from September 2020.
4. Staff survey data, including the national NHS staff survey data and quarterly pulse surveys data (to be rebranded as 'climate survey').
5. Divisional Performance Reviews.
6. Updates to the Executive Team Meeting and People and Organisational Development Committee.
7. Minutes of the Engagement & Retention Group.
8. Staff Friends and Family Test (FFT) and patient FFT integration.

Member of the Executive Team responsible for delivery of the project aim: Chief Finance Officer / Deputy Chief Executive

Trust Board sub-committee responsible for oversight: People and Organisational Development Committee

Update on progress with the project aim (at October 2020)

- CLP: Phase 2 starting September 2020, focussing on four areas for Development.
- ELOC: Phase 2 (Design) commissioned, engagement in September to November 2020, delivery from late Quarter 3.
- National NHS staff survey: Launches September 2020 and runs through to November 2020.
- Next quarterly pulse / climate survey: September 2020.

NHS Maidstone and Tunbridge Wells NHS Trust

Update from the Senior Information Risk Owner (SIRO) (incl. the current position on the Data Security and Protection Toolkit for 2020/21)	**Chief Nurse (SIRO)**

The Trust Board will recall that in 2015 the Information Governance Alliance (IGA) published guidance for NHS Board members highlighting that ultimate responsibility for IG in the NHS rests with the Board of each organisation.

Please find enclosed an update from the Senior Information Risk Owner (SIRO) in relation to the six key areas of responsibility.

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

The Board will recall that whilst ownership of Information Governance matters rests with the Board, responsibility in MTW has been delegated to the Information Governance Committee (IGC) and that I have been tasked to represent the Board and do so in my role as Chair of the Committee and Senior Information Risk Owner (SIRO) and Board member with responsibility for data and cyber security.

The Information Governance Committee meets every other month and receives reports and presentations relating to the ongoing work being undertaken to ensure the Trust is compliant with legislative and regulatory requirements regarding information processing, including, but not limited to, the Data Protection Act 2018, the General Data Protection Regulations and the Data Protection and Security Toolkit.

The Trust made a 'Standards Met' Data Protection and Security Toolkit (DSPT) submission for the year 2019/20 on 29 September 2020.

The Toolkit allows organisations to measure their performance against the National Data Guardian's 10 data security standards which contain three leadership obligations:

1. People: ensure staff are equipped to handle information respectfully and safely, according to the Caldicott Principles.
2. Process: ensure the organisation proactively prevents data security breaches and responds appropriately to incidents and near misses.
3. Technology: ensure technology is secure and up-to-date.

The Board will recall that a workplan was developed for 2019/20, predicated upon the 10 data security standards.

Standard	Action	Status/Update
1. Personal Confidential Data	IG policies and procedures to be reviewed to ensure they meet relevant guidance in regard to data security and protection	A number of policies were reviewed and updated in year and have completed the approvals and ratification process. Other policies have been retired as no longer required. A couple of policy documents have yet to complete the review, approve and ratify cycle.
	Privacy notices are reviewed and updated	The Trust Data Protection Officer and Head of Information Governance meet regularly and have reviewed the Privacy notices which are available on the Trust public facing web site.
	Access to information processes to be reviewed and updated to ensure statutory duties are being met.	The Trust processes for handling requests for access to information have been reviewed. A number of staff have received specialist training.
	A Data Quality Dashboard to be developed to assess and improve data quality.	A Data Quality Dashboard has been developed by the BI team to show performance and trends for each of the metrics that had been

		requested by the Data Quality Steering Group. This dashboard will be refreshed monthly. A Divisional view is being developed, this will figure in the Divisional Performance Review packs in the future.
	The Trust will review and amend its processes to ensure it is able to uphold the National Data Opt-Out by March 2020.	The Trust has a procedure in place to ensure it is able to comply with the National Data Opt-Out.
2. Staff Responsibilities	Information asset registers to be reviewed and updated	This is ongoing work.
3. Training	At least 95% of all staff have completed their annual Data Security awareness training in the period 1 April to 31 March.	The 95% training compliance target remains in place and is a mandatory requirement of the DSPT.
	Review specialist roles associated with data security and protection and ensure staff are appropriately trained or that the Trust has access to the necessary services.	Basic Cyber awareness training is incorporated within the annual Mandatory Information Governance Training. Specialist staff are encouraged to maintain their skill levels and complete additional training in year.
4. Managing Data Access	Review systems access controls and undertake audits including log-in and password misuse.	System managers are required to regularly monitor system access and, at least annually, complete an audit of system access.
5. Process Reviews	Analyse incidents and near misses to identify root causes in order that these may be addressed	All incidents and near misses raised as a Datix that contain an IG element are reported to the IG Committee. These reports are shared more widely with the Divisions and Directorates and where themes and trends are identified these are examined and where possible processes are adjusted to reduce the likelihood of reoccurrence.
	Systems vulnerabilities are identified during testing and technical solutions implemented to ensure issues cannot arise again in the same way.	
6. Responding to Incidents	Anti-virus and other technical protection solutions are deployed and updated regularly.	The Trust has implemented anti-virus protection across its IT estate. Security patches are also deployed on a regular basis. The Trust has a process for receiving and acting upon Cyber security alerts issued by NHS Digital.
7. Continuity Planning	A continuity plan is in place and tested once a year.	In November 2019 a cyber security table top exercise was held. A number of risks and

		interventions were identified during the exercise and actions developed to help further improve the business continuity effectiveness across the Trust
8. Unsupported Systems	Review all software and hardware to understand if it is supported and up to date. Where unsupported software and hardware are identified plans are put in place to manage the risks.	The Trust has identified all software and hardware in use across its networks. Plans are in place to manage risks associated with hardware and software in use.
9. IT Protection	The Trust will continue to take steps to improve cyber security.	A business case is just being finalised that, if approved, will support the creation of a specialist Cyber Security Team within the Trust with the analysis tools they will need to fully support them.
10. Accountable Suppliers	IT contracts are reviewed and suppliers held accountable for protecting the personal confidential data they process.	Processes are in place to review contracts and ensure suppliers are held accountable for the personal confidential data they process on behalf of the Trust.

The Toolkit for the year 2020/21 was expected to be formally released on 1 October 2020 with a submission deadline of 30 June 2021. Release has, however, been delayed awaiting Ministerial sign off with an issue relating to on-site assessment to support Cyber Essentials Plus accreditation. It is anticipated that the Trust will be required to complete a baseline submission by 28 February 2021. The draft toolkit contains 155 individual evidence requirements which will require completion. TIAA will once again be asked to complete a review and audit of the evidence the Trust posts in support of the Toolkit. The audit will take place during March and May 2021.

A number of key performance indicators are reviewed at the IGC as standing agenda items. When indicators have shown that the Trust is not performing as we would wish actions have been agreed and regular updates received. IG KPIs are also monitored on a monthly basis as part of the Executive Performance Review meeting for the Health Informatics Directorate. There are currently no concerns to bring to the Board's attention.

The Head of Information Governance participates in a number of networks, the Kent Strategic IG Network, the Surrey and Sussex Strategic IG Network, the East of England Strategic IG Network and the Kent and Medway IG Partnership (a forum established for Local Authority, Borough Councils, Police, Fire and Health to foster collaboration and sharing of best practice).

I and the Head of Information Governance attended an IG conference in July 2019 organised by the Sussex-wide Information Governance Group, which was very informative and contributed to our CPD and personal training. A virtual conference is being held this year on 17 November. Again this will contribute to CPD and personal training.

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from Workforce Committee, 15/10/20 (incl. quarterly report from the Guardian of Safe Working Hours)	**Committee Chair (Non-Exec. Director)**

The Workforce Committee met on 15th October 2020 (virtually, via webconference).

The key matters considered at the meeting were as follows:

- The **actions from previous meetings** were reviewed, and the Committee agreed to a proposal to reverse its previous decision to establish an Inclusion Committee as a sub-committee. It was however agreed that the Director of Workforce should liaise with the Chairs of the Trust's Staff Networks to explain the rationale for the Committee's reversal of its previous decision. Following a discussion on another action, it was also agreed to ensure that regular updates on recruitment and retention were scheduled for consideration at the Committee.
- **Updated Terms of Reference** were agreed, to reflect the change referred to above and to also change the Committee's name to "People and Organisational Development Committee" (the Terms of Reference were then approved by the Trust Board on 22/10/20).
- The **plans to develop the workforce Key Performance Indicators** were reviewed, and commended.
- The Director of Workforce gave an **update on their initial reflections on the Trust's Human Resources function** (and notification of initial priorities), and it was agreed to add an "Update on the plans to improve the Human Resources function" as a standing item on the Committee's forward programme
- An **update on recruitment and retention** was given a detailed discussion was held on the plans.
- The Director of Strategy, Planning and Partnerships and Director of Emergency Planning & Communications attended for the first **quarterly review of internal communications**, which included details of the plans to improve communication across the Trust.
- The latest **review of the findings from staff exit interviews** outlined the plans to review the exit interview system, which included considering the questions leavers were asked, and to ensure there was alignment with the '100 day' survey given to new starters. The new process will start in January 2021.
- The latest **quarterly update from the Guardian of Safe Working Hours** was noted (and this is enclosed in Appendix 1, for information and assurance).
- The **Director of Medical Education gave their latest quarterly update**, which noted that planned changes to GP Training would have a significant impact on secondary care placements.
- The **relevant aspects of the Board Assurance Framework (BAF)** were reviewed, and it was noted that as workforce issues were undergoing considerable change it was important for the BAF to adapt to such changes as required. It was confirmed that the BAF was dynamic.
- The Committee's **forward programme** was noted, and it was agreed to schedule an "Update on the Trust's flu vaccination campaign" item at the Committee's meeting in November 2020.

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

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

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

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

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

Appendix 1: Quarterly update from the Guardian of Safe Working Hours

WORKFORCE COMMITTEE – OCTOBER 2020

NHS Maidstone and Tunbridge Wells NHS Trust

QUARTERLY UPDATE FROM THE GUARDIAN OF SAFE WORKING HOURS (COVERING JULY TO SEPTEMBER 2020)	**GUARDIAN OF SAFE WORKING HOURS**

The enclosed report covers the period July TO September 2020

- A total of 58 exception reports were received in this period
- Surgery raised 23 exception reports (ERs)
- Medicine raised 35 ERs
- 40 ERs were from FY1 doctors
- 18 ERs from FY2
- There were no issues with inadequate senior supervision
- No fines were incurred during this period, or work schedule reviews needed

Reason for submission to the Workforce Committee

Reporting Period: July – September 2020

This report covers the period July – September 2020 in which time 58 exception reports were raised.

Directorate	Exception reports raised
Medicine	35
Surgery	23

This quarter has traditionally a higher number of ERs raised, as it is the time FY1 and FY2 doctors start as newly qualified doctors and go into new posts/adapt to the working style of a new trust.

I am happy to report numbers of reports submitted is not in excess of previous years and none of the reports have warranted my immediate intervention of contacting educational/clinical supervisors. However I will be contacting supervisors again, as the numbers show that a good proportion of ERs are not being replied to again in a timely manner.

Breaking these down by grade, all exception reports were raised by FY1/FY2 doctors.
ERs submitted 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.

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: July – September 2020				
Specialty	Carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Medicine	0	35	24	11
Surgery	0	23	11	12
Total	**0**	**58**	**35**	**23**

Exception reports by grade: July – September 2020				
Grade	Carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	40	19	21
F2	0	18	16	2
Total	**0**	**58**	**35**	**23**

Exception reports (response time)				
Grade	48 hours	Within 7 days	longer than 7 days	Still open
F1	0	0	19	21
F2	0	0	16	2
Total	**0**	**0**	**35**	**23**

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from Quality Committee, 16/10/20 Committee Chair (Non-Exec. Director)

The Quality Committee met (virtually, via webconference) on 16th October 2020 (a Quality Committee 'deep dive' meeting).

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

- The **progress with previous actions** was noted, and following a discussion of one of the actions, it was agreed that the Trust Secretary should liaise with the Deputy Director of Quality Governance to schedule a review of the findings from the audit to test staff learning at a future Quality Committee 'deep dive' meeting.
- The Chief of Service, Women's Children's and Sexual Health and Divisional Director of Midwifery, Nursing and Quality / Head of Midwifery attended for a **Review of maternity services – update** (which followed a previous item at the Quality Committee 'deep dive' meeting in June 2020). The progress made recently was noted, but it was agreed that a further "Review of maternity services – update" item should be scheduled at the Quality Committee 'deep dive' meeting in April 2021.
- The Director of Estates and Facilities and Deputy Director of Infection Prevention and Control attended for a **review of water safety/quality**. The presentation given included a proposal to reinforce operational improvements and governance arrangements for water safety, via the appointment of a full-time Water Safety Manager and the establishment of a Water Management Committee (to replace the current Water Hygiene Group and Water Hygiene Steering Group). The proposals were supported but the risk that reporting water safety issues to both the Infection Prevention and Control Committee and Health and Safety Committee could lead to duplication or ambiguities regarding responsibilities was discussed and it was agreed that the Committee's Vice Chair should raise her concerns at the weekly Non-Executive Directors meeting. It was also agreed that the Director of Estates and Facilities should liaise with representatives from East Kent Hospitals University NHS Foundation Trust to confirm what assurance they required in relation to water quality within their satellite Renal Unit at Maidstone Hospital.
- The General Manager for Outpatients and Divisional Director of Nursing and Quality for Cancer Services attended for a **review of the quality-related plans for outpatient services** (including the plans regarding virtual outpatient clinics). The plans to improve the outpatient services were commended and supported but it was agreed to schedule an update on such plans at the Quality Committee 'deep dive' meeting in February 2021.
- A discussion was held on the **items that should be scheduled for scrutiny at future Quality Committee 'deep dive' meetings**, and it was agreed that the Medical Director and Chief Nurse should liaise to confirm the items that should be scheduled for the Quality Committee 'deep dive' meeting in December 2020 and beyond.

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, 11/11/20	Committee Chair (Non-Executive Director)

The Quality Committee met on 11th November (a 'main' meeting), via virtual means.

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

- The issues raised from the **reports from the clinical Divisions** included staffing issues; the challenges to effective patient flow; the ongoing problems with the Child and Adolescent Mental Health Services; the pressures faced by the ultrasound service, the potential for increased demand for maternity services, and the formal notification of the latest Never Event (which related to the misplacement of an NG tube). The discussion of Surgery's report led to their Divisional Director of Nursing & Quality (DDNQ) agreeing to arrange for the Theatres and Critical Care risk relating to poor patient flow through the Intensive Care Units to be reviewed, and ensure that the mitigations in place to manage the risk were appropriately documented in the Division's future reports to the Committee. The DDNQ also agreed to liaise with the Matron for Safeguarding Adults to pursue the final feedback on the concern raised by community services for the General Surgery directorate about alleged rough handling of a patient during their inpatient stay
- The **update on the 'MTW new normal'/'reset and recovery' programme** report from the Chief Operating Officer focused on the good progress being made with Phase three (of NHS response to COVID-19) activity.
- The Medical Director reported on the **output from the COVID-19 Ethics Committee and Clinical Reference Group**.
- The Divisional Director of Operations for Surgery attended to give an **update on harm reviews for patients who have waited a long time**, and acknowledged that her initial trajectory had been very optimistic and under-estimated the level of resource required to complete the large number of reviews needed. The additional actions planned to increase such resources were however reported.
- The Deputy Chief Nurse gave an **update on the work to achieve an 'Outstanding' CQC rating**.
- The Chief of Service, Medicine & Emergency Care gave the latest **update on mortality**, which included the impact the new Medical Examiner role was having on mortality reviews.
- The latest **Serious Incidents (SIs)** were reported by the Deputy Director of Quality Governance.
- The **relevant aspects of the Board Assurance Framework** and report from the last **Quality Committee '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 Joint Safeguarding Committee; the Drugs, and Therapeutics and Medicines Management Committee; and the Infection Prevention and Control Committee), and revised Terms of Reference for the latter Committee were approved.
- The **summary report from the Patient Experience Committee** meeting held on 03/09/20 was noted.
- The Committee agreed to undertake its **evaluation for 2020** using the same methodology and survey used in 2019.

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

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

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

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

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

NHS
Maidstone and Tunbridge Wells NHS Trust

To approve a proposal for the Quality Committee to replace the People and Organisational Development Committee as the 'parent' committee of the Health and Safety Committee — **Trust Secretary**

At its meeting on 31/10/19, the Trust Board approved a proposal (following a recommendation from the Executive Team Meeting) that the then Workforce Committee become the 'parent'[1] committee of the Health and Safety Committee (instead of the Trust Management Executive). The Health and Safety Committee has therefore submitted a summary report to the Workforce Committee (which is now called the People and Organisational Development Committee) since that time (although the Chair of the Health and Safety Committee is not a member of the People and Organisational Development Committee).

However, some concerns were raised at the Quality Committee 'deep dive' meeting on 16/10/20 regarding a proposal that the Water Management Committee should provide reports to both the Infection Prevention and Control Committee (which is a sub-committee of the Quality Committee) and Health and Safety Committee. It was therefore agreed that the Vice Chair of the Quality Committee should ensure those concerns were discussed at the weekly Non-Executive Directors' meeting. Such discussions have been held, and the Chair of the Trust Board, Chair of the Quality Committee and Chair of the People and Organisational Development Committee have agreed that the Health and Safety Committee should become a sub-committee of the Quality Committee instead of the People and Organisational Development Committee. The Chair of the Health and Safety Committee (the Divisional Director of Nursing & Quality for Medicine & Emergency Care) is already a member of the 'main' Quality Committee.

As this change involves amendments to the Terms of Reference of the Quality Committee and People and Organisational Development Committee, which are approved by the Trust Board, the Trust Board needs to approve the change. The Trust Board is therefore asked to approve the proposal that the Health and Safety Committee become a sub-committee of the Quality Committee instead of the People and Organisational Development Committee.

Which Committees have reviewed the information prior to Board submission?

- Quality Committee 'deep dive' meeting, 15/10/20 (in brief, as part of the discussion held under the "A review of water safety/quality" item)
- People and Organisational Development Committee, 20/11/20 (in brief)

Reason for submission to the Board (decision, discussion, information, assurance etc.) [2]
Approval

[1] A "Parent Committee" is a Committee that sits directly above another Committee in the Trust's Committee structure (the Trust Board is therefore the Parent Committee to its sub-committees). A Parent Committee would generally be expected to have a broader scope and have more authority than its sub-committees. The Parent Committee should determine how (including how often) it wishes to receive reports of the output from its sub-committees. This should include provision for escalating matters of urgency/importance in between the agreed reporting frequencies. If a Parent Committee determines that a matter reported to it is important enough for it to report on, to its own Parent Committee, it should be able to do so, via the reporting arrangements that exist between it and its Parent. The Parent Committee may also wish to approve the Terms of Reference of its sub-committees. Each Committee can only have one Parent Committee (however, it is possible for the output from a committee to be reported to multiple committees, if this is considered to be required).

[2] 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

Audit and Governance Committee, 04/11/20 (incl. approval of revised Terms of Reference)	**Committee Chair (Non-Executive Director)**

The Audit and Governance Committee met on 4th November 2020.

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

- Under the **Review of actions from previous meetings** it was agreed that the Assistant Trust Secretary should ensure that the Committee's action log was updated to reflect the decision that action 07-4d ("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") should be reopened until further assurance was provided.
- The **Terms of Reference** were reviewed as part of the annual process and some proposed amendments were agreed, it was also agreed that the Trust Secretary should ensure that the Committee's Terms of Reference are updated to clarify that Committee members can approach External and Internal Audit in private, should they feel this necessary, prior to submission to the Trust Board for approval in November 2020. The revised Terms of Reference, with the requested amendment incorporated are enclosed in Appendix 1 (with the proposed changes 'tracked'), for the Trust Board's approval.
- The Committee agreed a **request to defer the annual review of the Standing Orders (SOs), Standing Financial Instructions (SFIs) and Reservation of Powers and Scheme of Delegation (SoD)** until at least early 2021, and the Trust Board is asked to approve that request. The rationale is included in Appendix 2.
- The Director of Estates and Facilities attended the meeting to provide a **response to the "Estates Procurement" Internal Audit review & the July 2020 "The latest single tender/quote waivers data"** where the Committee was provided with assurance regarding the measures being implemented to improve the "Estates Procurement" process.
- The committee reviewed the **Board Assurance Framework (BAF) for 2020/21** wherein it was agreed that the Trust Secretary and Chair of the Committee should arrange for the Trust Board to be asked whether it wished to receive further assurance on objectives 7 and 8 via direct update reports (this query has been posed in the BAF report to the Trust Board).
- An **Update on progress with the Internal Audit plan for 2020/21 (incl. progress with actions from previous Internal Audit reviews)** was reported, wherein it was agreed that the Trust Secretary should invite the "Server and Systems Architect" to the March 2021 Committee meeting to respond to the "Active Directory Outstanding Audit Recommendations" within the November 2020 "Update on progress with the Internal Audit plan for 2020/21 (incl. progress with actions from previous Internal Audit reviews)" report. The list of recent Internal Audit reviews is shown below (in section 2).
- The Committee confirmed the intended process for the **review/survey of the Internal Audit service** as submitted.
- The latest **Counter Fraud update** was received wherein it was agreed that the Director of Audit, Tiaa Ltd (Head of Internal Audit) should ask the Local Counter Fraud Specialist to email the outcome of fraud investigation #85099 (use of a third party wig supplier) to the Trust Secretary, for onward circulation to Audit and Governance Committee members. It was also agreed that the Chair of the Audit and Governance Committee should Consider whether (and what) further action should be required following review the outcome of fraud investigation #85099 (use of a third party wig supplier).
- There were no areas of concern reported under the **"Audit Progress Report and Sector Update" from External Audit** however it was agreed that the Director, Audit, Grant Thornton UK LLP should check and confirm, to the Chief Finance Officer, that the "Independent Examination" of the Charitable Fund Annual Report and Accounts for 2019/20 will be completed to enable the outcome to be considered by the Charitable Funds Committee on 24/11/20. It was also agreed that the Chief Finance Officer should liaise with the Head of Financial Services, Deputy Director of Finance (Financial Governance) and Trust

Secretary to develop the scope of a self-assessment in relation to the "Value for Money" assessment in the National Audit Office's revised Code of Audit Practice and provide an update to the March 2021 Committee meeting.

- The Committee confirmed the intended process for the r**eview/survey of the External Audit service** as submitted.
- The Chief Finance Officer provided a **summary of the latest financial issues** which included details of the COVID-19 financial regime, the changes to the regime from month 7 onwards and the increased expenditure related to the restart of services.
- Under the **latest losses & compensations data** it was agreed that the Chief Finance Officer should investigate the purchase of held hand metal detectors to be used on wards to scan used laundry to reduce the number of hearing aid losses incurred by the Trust.
- The **latest single tender / quote waivers data** was reviewed.
- The latest **details of gifts, hospitality and sponsorship** were declared including an update on the "Managing Conflicts of Interests Policy and Procedure", wherein the Chief Finance Officer agreed to continue to pursue action 07-13 "confirm the timeline for the implementation of the "My ESR" self-service portal.".
- The Committee re-affirmed the method of **Committee self-assessment / compliance with Terms of Reference** (which was to use the same method as the previous year), however it was agreed that the Trust Secretary should bring forward the scheduling of "Confirmation of the intended process for the review/survey…" of the internal and external audit services, and "To re-affirm the method of Committee self-assessment…" items to the March 2021 Committee meeting, to enable the surveys/assessment to be used in 2021 to be informed by the findings from the 2020 surveys/assessment.
- Under the **forward programme** it was agreed that the Trust Secretary should schedule an item for the March 2021 meeting to consider what, if any, action was required by the Committee following the discussion on the Integrated Care System/Integrated Care Partnership that was scheduled for the Trust Board 'Away Day' on 02/12/20. It was also agreed that the Assistant Trust Secretary should amend the Committee's forward programme to correct the date errors that were highlighted at the November 2020 meeting.
- The Committee undertook an **Evaluation of the meeting**.

2. The Committee received details of the following completed Internal Audit reviews:

- "Clinical Governance Arrangements" (which received a "Reasonable Assurance" conclusion)
- "Data Quality of Key Performance Indicators" (which received a "Reasonable Assurance" conclusion)
- "Estates Procurement" (which received a "Limited Assurance" conclusion due to the need for improved consistency in the adherence to processes)
- "Mandatory Estates Safety Checks" (which received a "Reasonable Assurance" conclusion)

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

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

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

- The Committee's Terms of Reference are enclosed under Appendix 1 for approval
- The Committee agreed to defer the annual review of the SOs, SFIs and SoD
- It was agreed that the Trust Board should be asked whether wishes to receive further assurance on objectives 7 & 8 of the 2020/21 BAF via direct update reports (this will be covered via the BAF report)

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 the Committee's revised Terms of Reference (see Appendix 1)
3. To approve the deferral of the annual review of the SO, SFIs and SoD (see Appendix 2)

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

Appendix 1: Revised Terms of Reference (for approval)

Audit and Governance Committee

Terms of Reference

NHS
Maidstone and Tunbridge Wells NHS Trust

1. Constitution / Purpose

1.1 The Audit and Governance Committee has been established by the Trust Board as a non-executive sub-committee of the Trust Board. The Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

1.2 The Committee supports the Trust Board by critically reviewing the governance and assurance processes on which the Trust Board places reliance. This therefore incorporates reviewing Governance, Risk Management and Internal Control (including the Board Assurance Framework (BAF)); & oversight of the Internal and External Audit, and Counter Fraud functions.

1.3 The Committee also undertakes detailed review of the Trust's Annual Report and Accounts.

1.4 The Trust Board has also appointed the Audit and Governance Committee as the Trust's Auditor Panel, in accordance with Schedule 4, Paragraph 1 of the Local Audit and Accountability Act 2014. The Auditor Panel will advise the Trust Board on the selection, appointment and removal of External Auditors, and on the maintenance of independent relationships with such Auditors.

2. Authority

2.1 The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2.2 The Committee is authorised to undertake all relevant actions to fulfil its role as the Trust's Auditor Panel.

3. Membership

3.1 The Committee shall be appointed by the Trust Board from amongst the Non-Executive Directors of the Trust (other than the Chair of the Trust Board), and shall consist of not less than three members. A Non-Executive Director Chair of the Committee will be appointed by the Chair of the Trust Board, together with a Vice-Chair. If a Non-Executive Director member is unable to attend a meeting they will be responsible for finding a replacement to ensure quoracy for the meeting. The Chair and Vice-Chair of the Committee will also act as Chair and Vice-Chair (respectively) of the Auditor Panel.

3.2 Other individuals may be co-opted to become formal members of the Committee, to address issues of specific concern, at the discretion of the Committee Chair.

3.3 When undertaking the role of the Auditor Panel, the membership shall comprise the entire membership of the Audit and Governance Committee, with no additional appointees. This means that all members of the Auditor Panel are independent, Non-Executive Directors.

3.4 Conflicts of interests relevant to agenda items must be declared and recorded at the start of each meeting (including meetings of the Auditor Panel). If a conflict of interest arises, the Committee Chair may require the affected member to withdraw at the relevant discussion or voting point.

4. Quorum

4.1 The Committee shall be quorate when two Non-Executive members are present (including either the Committee Chair or Vice Chair).

4.2 However, when the Committee is undertaking the role of the Trust's "Auditor Panel", the Committee shall be quorate when three Non-Executive members are present (including either the Committee Chair or Vice Chair)[1].

5. Attendance

5.1. The following will routinely attend meetings of the Committee (but will not be members):

- Associate Non-Executive Directors
- Deputy Chief Executive / Chief Finance Officer
- Deputy Director of Finance (Financial Governance)
- Head of Internal Audit and/or other appropriate representatives
- External Audit Engagement Lead and/or other appropriate representatives
- Local Counter Fraud Specialist
- Trust Secretary

5.2 Members (listed above) are expected to be present at all meetings of the Committee. Those listed in section 5.1 are expected to be in attendance at all meetings of the Committee.

5.3 The Chief Executive, other members of the Executive Team, or any other member of staff will be invited to attend if the Committee is discussing areas of risk or assurance that are the responsibility of that individual and it is felt that their attendance is necessary to fully understand or address the issues

5.4 The Chief Executive may be invited to attend to discuss the process for assurance that supports the Annual Governance Statement; and the agreement of the Internal Audit annual plan. The decision as to whether to invite the Chief Executive for these items rests with the Committee Chair.

5.5 The Committee will, if requested by the External and Internal Auditors, meet privately with thosee ~~External and Internal~~ Auditors ~~regularly,~~ at the start of each meeting. A private session with the External and Internal Auditors will however be held once a year, ahead of the first Audit and Governance Committee meeting that reviews the draft Annual Report and Accounts, regardless of whether the Auditors have any issues to raise. Individual Committee members can however approach the External or Internal Auditors in private, should such members consider this necessary.

5.6 The Trust Secretary will provide appropriate support to the Chair and Committee members, and will be responsible for the administration of the Committee (see section 10).

5.7 The Chair may also invite others to attend when the Committee is meeting as the Auditor Panel. These invitees are not members of the Auditor Panel

6. Frequency of meetings

6.1 Meetings shall be held not less than four times a year. The Chair of the Committee will have the discretion to agree additional meetings in order to fulfil the 'Committee's purpose and/or meet its duties.

6.2 The External Auditor or Head of Internal Audit may request an additional meeting if they consider that one is necessary. Any member of the Trust Board may also put a request in writing to the Chair of the Committee for an additional meeting, stating the reasons for the request. The decision whether or not to arrange such a meeting will be at the sole discretion of the Chair of the Committee.

[1] Independent members of the Auditor Panel must be in the majority and there must be at least two independent members present or 50% of the auditor panel's total membership, whichever is the highest

6.3 As a general rule, the Auditor Panel will meet on the same day as the Audit and Governance Committee. However, Auditor Panel business shall be identified via a separate agenda, and Audit and Governance Committee members shall deal with these matters as Auditor Panel members, not as Audit and Governance Committee members. The Auditor Panel's Chair shall formally state (and this shall be formally recorded) when the Auditor Panel is meeting in that capacity.

7. Duties

7.1 The duties of the Committee can be categorised as follows:

Governance, risk management and internal control

7.2 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

7.3 In particular, the Committee will review the adequacy of:

7.3.1 All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, External Audit opinion or other appropriate independent assurances, prior to endorsement and/or approval by the Trust Board

7.3.2 The underlying assurance process that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

7.3.3 The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.

7.3.4 The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority (or successor bodies).

7.4 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from members of the Executive Team and managers, as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

7.5 This will be evidenced through the Committee's use of an effective BAF to guide its work and that of the audit and assurance functions that report to it.

7.6 As part of its integrated approach, the Committee will have effective relationships with other key committees, so that it understands processes and linkages. However, these other committees must not usurp the Audit and Governance Committee's role.

Internal Audit

7.7 The Committee shall ensure that there is an effective Internal Audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and Trust Board.

This will be achieved by:

7.6.1 Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal

7.6.2 Review and approval of the Internal Audit Charter (or equivalent), operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the BAF

7.6.3 Consideration of the major findings of Internal Audit work (and management's response), and ensure co-ordination between the Internal and External auditors to optimise audit resources

7.6.4 Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation

7.6.5 Carrying out an annual review of the effectiveness of Internal Audit

External Audit

7.8 The Committee shall review the work and findings of the Trust's External Auditor and consider the implications & management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the External Auditor
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy
- Discussion with the External Auditors of their evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- Review all External Audit reports, including the report to those charged with governance, agreement of the Annual Audit Letter (before submission to the Trust Board) and any work carried outside the annual audit plan, together with the appropriateness of management responses
- Ensuring that there is in place a clear framework for the engagement of external auditors to supply non audit service

Other assurance functions

7.9 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, as it sees fit, and consider the implications to the governance of the organisation, in so far as they affect the Trust's agreed objectives. These will include, but will not be limited to, any reviews by Department of Health and Social Care's Arm's Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

Counter Fraud

7.10 The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud that meet NHS Counter Fraud Authority's (NHSCFA) standards and shall review the outcomes of Counter Fraud work. The Committee will ensure that any suspicions of fraud, bribery and corruption are referred to the NHSCFA.

Management

7.11 The Committee shall request and review reports and positive assurances from members of the Executive Team and managers on the overall arrangements for governance, risk management and internal control.

7.12 They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

Annual Report and Financial Reporting

7.13 The Committee shall monitor the integrity of the financial statements of the Trust and the formal announcements relating to the Trust's financial performance (in so far as they may affect the Trust's Annual Report and Accounts).

7.14 The Committee should ensure that the systems for financial reporting to the Trust Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Trust Board. This duty will usually be met via the commissioning of, and reviewing the outcome of, the Core Financial Assurance reviews within the annual internal audit programme.

7.15 The Committee shall review the Annual Report and Financial Statements before submission to the Trust Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- Changes in, and compliance with, accounting policies and practices
- Unadjusted mis-statements in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit
- The letter of Management Representation
- Explanations for significant variances
- Qualitative aspects of financial reporting

Freedom to Speak Up

7.16 The Committee shall support the People and Organisational Development ~~Workforce~~ Committee and Trust Board in reviewing the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently. The usual method of meeting this duty would be to commission an Internal Audit review of the arrangements, as the Committee sees fit.

Auditor Panel

7.17 As the Auditor Panel, the Committee shall advise the Trust Board on the selection and appointment of the Trust's External Auditor. This includes:

- Agreeing and overseeing a robust process for selecting the External Auditors in accordance with the Trust's normal procurement rules
- Making a recommendation to the Trust Board as to who should be appointed (ensuring that any conflicts of interest are dealt with effectively)
- Advising the Trust Board on the maintenance of an independent relationship with the appointed External Auditor
- Advising (if asked) the Trust Board on whether or not any proposal from the External Auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable
- Advising on (and approving) the contents of the Trust's policy on the purchase of non-audit services from the appointed External Auditor
- Advising the Trust Board on any decision about the removal or resignation of the External Auditor

8. Parent committee and reporting procedure

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

8.2 The minutes of Committee meetings shall be formally recorded by the Trust Secretary. The Chair of the Committee shall also provide a brief written report to the Trust Board, summarising the issues covered at the meeting and drawing to the attention of the Trust Board any issues that require disclosure to the full Board, or require executive action.

8.3 The Committee will report to the Trust Board annually (via a written Annual Report) on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the BAF, the completeness and embeddedness of risk management in the organisation, and the integration of governance arrangements. The Annual Report should also describe how the Committee has fulfilled its Terms of Reference, and give details of any significant issues that the Committee considered in relation to the financial statements, and how these were addressed. The work of the Committee as the Trust's Auditor Panel should also be included.

8.4 The Committee shall undertake an annual self-assessment to ensure the objectives of the Terms of Reference are being met.

8.5 The Chair must report to the Trust Board on how the Auditor Panel has discharged its responsibilities.

8.6 The Chair must draw to the attention of the Trust Board any issues that require disclosure to the Board in relation to Auditor Panel duties.

9. Sub-committees and reporting procedure

9.1 The Committee has no sub-committees.

10. Administrative arrangements

10.1 The Committee shall be supported administratively by the Trust Secretary, whose duties in this respect will include:

- Maintenance of a forward programme of work, setting out the dates of planned meetings and key agenda items
- Agreement of agenda for next meeting with Chair, allowing adequate notice for reports to be prepared which adequately support the relevant agenda item.
- Collation and distribution of agenda and reports one week before the date of the meeting
- Ensuring the minutes are taken and that a record is kept of matters arising and issues to be carried forward
- Advising the Committee on all pertinent areas

11. Emergency powers and urgent decisions

11.1 The powers and authority which the Trust Board has delegated to the Audit and Governance Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least one other Non-Executive Director member. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Audit and Governance Committee, for formal ratification.

12. Review of Terms of Reference and Monitoring Compliance

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

History

Terms of Reference agreed by Audit and Governance Committee: April 2013
Terms of Reference approved by the Board: May 2013
Terms of Reference agreed by the Audit and Governance Committee, November 2014
Terms of Reference approved by the Trust Board, December 2014
Terms of Reference agreed by the Audit and Governance Committee, November 2015
Terms of Reference approved by the Trust Board, November 2015
Terms of Reference agreed by the Audit and Governance Committee, February 2016 (N.B. the Board had already authorised the Audit and Governance Committee to agree changes in relation to the Committee's role as Auditor Panel)
Terms of Reference agreed by the Audit and Governance Committee, November 2016
Terms of Reference approved by the Trust Board, November 2016
Terms of Reference agreed by the Audit and Governance Committee, November 2017
Terms of Reference approved by the Trust Board, November 2017
Terms of Reference agreed by the Audit and Governance Committee, December 2018
Terms of Reference approved by the Trust Board, December 2018
Terms of Reference agreed by the Audit and Governance Committee, November 2019
Terms of Reference approved by the Trust Board, November 2019
Terms of Reference agreed by the Audit and Governance Committee, November 2020
Terms of Reference approved by the Trust Board, November 2020

Appendix 2: Rationale for request to defer the annual review of the Standing Orders, Standing Financial Instructions and Reservation of Powers and Scheme of Delegation

AUDIT AND GOVERNANCE COMMITTEE – NOVEMBER 2020

NHS
Maidstone and Tunbridge Wells NHS Trust

REQUEST TO DEFER THE ANNUAL REVIEW OF THE STANDING ORDERS, STANDING FINANCIAL INSTRUCTIONS AND RESERVATION OF POWERS AND SCHEME OF DELEGATION

TRUST SECRETARY

Committee members will be aware that an annual review of the Trust's Standing Orders, Standing Financial Instructions and Reservation of Powers and Scheme of Delegation takes place, usually in the autumn. These are then submitted to the November meeting of the Audit and Governance Committee, for approval, before being submitted to the November meeting of the Trust Board, for ratification. The annual review is an internal requirement, based on good practice.

It is however proposed that the 2020 annual review be deferred until at least early 2021, given the uncertainty regarding the future financial regime, and the development of the wider healthcare system (in terms of the Integrated Care Partnership and Integrated Care System). Previous experience of external changes has demonstrated that the optimum method for reflecting such changes in the three aforementioned documents is to enable such changes to be discussed and debated in other forums before being included in revised versions of the documents.

The Committee is therefore asked to approve a request to defer the annual reviews until early 2021 in the first instance. At that point, the situation will be assessed, to determine whether the reviews should proceed or be subject to a further deferral (e.g. if any significant changes are likely or expected).

As noted above, the annual review is an internal requirement, so deferral will not cause any external issues. The Chair of the Audit and Governance Committee has already confirmed his support for the proposed deferral, but the Committee is asked to do likewise.

If the request is approved, the Trust Board will be asked (via the summary report from the Audit and Governance Committee) to confirm its support at its meeting in November 2020.

Reason for submission to the Audit and Governance Committee
To approve a request to defer the 2020 annual review of the Trust's Standing Orders, Standing Financial Instructions and Reservation of Powers and Scheme of Delegation

NHS
Maidstone and Tunbridge Wells NHS Trust

To approve revised Terms of Reference for the Remuneration and Appointments Committee (annual review)	Committee Chair (Chair of the Trust Board)

The review of the Remuneration and Appointments Committee's Terms of Reference is due. The Terms of Reference have therefore been reviewed and some changes are proposed, which are shown as 'tracked' on the following pages. These include one 'housekeeping' change, but the proposed removal of "…and other staff appointed on Very Senior Manager (VSM) contracts" text under the "Duties" section reflects the Trust Secretary's review of the Code of Conduct and Code of Accountability, which confirms that the Committee's role should focus on "…the appointment, appraisal and remuneration of the chief executive and (with the latter) other executive board members".

The proposed changes were agreed by the Remuneration and Appointments Committee on 19/11/20 and the Trust Board is therefore asked to approve the changes.

Which Committees have reviewed the information prior to Board submission?
- Remuneration and Appointments Committee, 19/11/20

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
Approval of the revised Terms of Reference to the Remuneration and Appointments Committee

[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

REMUNERATION AND APPOINTMENTS COMMITTEE

TERMS OF REFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

1. Purpose

In accordance with the Code of Conduct and Code of Accountability[2], a Remuneration and Appointments Committee is constituted by the Trust Board.

2. Membership

- The Chair of the Trust Board (Chair of Committee)
- All Non-Executive Directors

The Vice Chair of the Committee will be the Vice Chair of the Trust Board.

Members are expected to attend all relevant meetings.

3. Quorum

The Committee shall be quorate when the Chair and two Non-Executive Directors are in attendance.

4. Attendance

The following are invited to attend each main meeting:

- Chief Executive
- Director of Workforce
- Associate Non-Executive Directors

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

5. Frequency of Meetings

Meetings will be scheduled according to need, but there will be a minimum of one meeting per year.

6. Duties

6.1 To review, on behalf of the Trust Board, the appointment of members of the Executive Team ~~and other staff appointed on Very Senior Manager (VSM) contracts~~, to ensure such appointments have been undertaken in accordance with Trust Policies.

6.2 To review, on behalf of the Trust Board as required, the remuneration, allowances and terms of service of members of the Executive Team ~~and other staff appointed on VSM contracts~~, to ensure that they are fairly rewarded for their individual contribution to the organisation; and by having proper regard to whether such remuneration is justified as reasonable.

6.3 To review, with the Chief Executive, the performance of members of the Executive Team ~~and other staff appointed on VSM contracts as required~~.

6.4 To oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments, taking account of such national guidance, as appropriate. Any non-contractual payment to a staff member must be first reviewed and approved by the Committee.

6.5 To consider and approve, on behalf of the Trust Board, proposals on issues which represent significant change e.g. "Agenda for Change" implementation, Consultant contract/incentive scheme[3].

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[2] Department of Health, 1994 (and subsequent revisions)

[3] The Committee will not consider matters relating to individual posts covered under the Agenda for Change national framework, or matters relating to individual medical staff

7. Parent Committee and reporting procedure

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

The Chair of the Remuneration and Appointments Committee will determine the extent (and format) to which the detailed activities of the Committee are reported to the Trust Board.

8. Sub-committees and reporting procedure

The Remuneration and Appointments Committee has no sub-committees, but may establish fixed-term working groups, as required, to support the Committee in meeting the duties listed in these Terms of Reference

9. Administration

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

The Committee will be serviced by administrative support from the Trust Secretary.

10. Emergency powers and urgent decisions

The powers and authority of the Remuneration and Appointments Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted the Committee's Vice Chair or the Chair of the Audit and Governance Committee. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Committee, for formal ratification.

11. Review of Terms of Reference

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

History

- Revised Terms of Reference agreed by the Remuneration Committee, 24/06/15
- Revised Terms of Reference approved by the Trust Board, 22/07/15
- Revised Terms of Reference agreed by the Remuneration and Appointments Committee, 25/01/17
- Revised Terms of Reference approved by the Trust Board, 22/02/17
- Revised Terms of Reference agreed by the Remuneration and Appointments Committee, 23/01/18
- Revised Terms of Reference approved by the Trust Board, 01/03/18
- Revised Terms of Reference agreed by the Remuneration and Appointments Committee, 29/03/18 (to list Chief Executive among those invited to attend each meeting, and note the change in secretariat function)
- Revised Terms of Reference approved by the Trust Board, 26/04/18
- Revised Terms of Reference agreed by the Remuneration and Appointments Committee, 19/12/19
- Revised Terms of Reference approved by the Trust Board, 30/01/20
- Revised Terms of Reference agreed by the Remuneration and Appointments Committee, 19/11/20
- Revised Terms of Reference approved by the Trust Board, 26/11/20